Enforcing the ISM Code, and Improving Maritime Safety, with an Improved Corporate Manslaughter Act: A Safety Culture Theory Perspective

Volume 1 of 2

by

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A thesis submitted in partial fulfilment for the requirements for the degree of Doctor of Philosophy at the University of Central Lancashire

February 2018

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Type of Award **Doctor of Philosophy**

School **Lancashire Law School**

1. Concurrent registration for two or more academic awards

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ABSTRACT

The International Safety Management (ISM) Code was introduced in 1998 in response to a number of high-profile maritime disasters, with the aim of establishing minimum standards for the safe operation of ships and creating an enhanced safety culture. It was the first piece of legislation introduced by the International Maritime Organisation that demanded a change in the behaviour and attitude of the international maritime community. Whilst there is no doubt that the ISM Code has been successful at improving maritime safety, there is now an increasing problem with complacency. The aim of this thesis is to consider how complacency with the ISM Code in the UK can be tackled by using reformed corporate manslaughter legislation.

This thesis adopts a Safety Culture Theory approach and uses a multi-model research design methodology; a doctrinal model and a socio-legal model. The thesis hypothesis and the author's proposed corporate manslaughter reforms are tested through case studies and a survey.

The thesis proposes the introduction of secondary individual liability for corporate manslaughter, in addition to existing primary corporate liability. If the proposed provisions were to be implemented, a gap in the law would be filled and, for the maritime industry, both the ship company and its corporate individuals would be held accountable for deaths at sea that are attributable to non-implementation of the ISM Code. It is suggested that this would deter further ISM complacency and so encourage the ISM Code's intended safety culture.

This thesis contributes to the intellectual advancement of the significant and developing interplay between criminal and maritime law, by adding to the scholarly understanding of the safety culture operating within the international maritime community, and examining how corporate manslaughter legislation could be used to improve implementation of the ISM Code. It offers sound research for consideration by legal researchers and scholars, and also by those working within the field of maritime safety regulation.

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ACKNOWLEDGEMENTS

Undertaking this PhD has been a truly life-changing experience for me and, although very stressful and demanding at times, overall I have enjoyed every minute of it. It would not have been possible without the support and guidance of so many people.

First and foremost, I would like to thank my supervisors, Professor Keyuan Zou and Professor Richard Taylor, for their patience and support throughout my seven years working on this thesis. Without their expert guidance and feedback, I would not have been so challenged to develop my levels of intellectual argument, and so this thesis would not have been achievable.

I am also indebted to Mr Arne Sagen and Mr Jan Harsem of the Skagerrak Safety Foundation. They have been a primary source of information for my research, and they have kindly introduced me to many networking opportunities and career opportunities. They are two of the most helpful and most interesting people that I have ever had the pleasure to get to know, and they certainly made my time writing this thesis more enjoyable.

I would also like to express my gratitude to the Nautical Institute and Nautilus for helping promote my research project, and for inviting me to write articles in their publications. Although they cannot all be mentioned by name, I wish to thank all those who participated in the survey as part of this thesis, as well as those who contributed to the quality of the research by providing their expert opinion and insight throughout the seven years.

I will forever be thankful to my former lecturer and dissertation supervisor, Dr Phil Anderson. Phil has been helpful in providing advice and information many times since I first met him at Northumbria University back in 2008. Phil was the reason I fell in love with maritime law and research, and the reason I decided to pursue a career in academia. His enthusiasm is both inspiring and contagious.

Finally, but by no means least, I would like to thank my parents, Christine and Jake, for their unconditional support and encouragement during my academic journey. Beyond my studies, my mum has helped and supported me in countless ways, and for this I am truly grateful. She is the most amazing mum in the world and so, to her, I dedicate this thesis.

LIST OF ABBREVIATIONS

ACSNI	Advisory Committee for Safety in Nuclear Installations
AIS	Automatic Identification System
ARES	Automated Search and Rescue System
AWS	Automatic Warning System
CBI	Confederation of British Industry
CCA	Centre for Corporate Accountability
COSS	Committee on Safe Seas and the Prevention of Pollution from Ships
DOALOS	United Nations Division of Ocean Affairs and the Law of the Sea
DOC	Document of Compliance
DPA	Designated Person Ashore
EEZ	Exclusive Economic Zone
EMSA	European Maritime Safety Agency
EU	European Union
GNER	Great North Eastern Railway
GWT	Great Western Trains
HSE	Health and Safety Executive
IACS	International Association of Classification Societies
ILO	International Labour Organisation
IMCO	Inter-Governmental Maritime Consultative Organisation
IMO	International Maritime Organisation
INS	Integrated Navigation System
INSAG	International Nuclear Safety Advisory Group
ISM	International Safety Management
KR	Korean Register of Shipping
KSA	Korean Shipping Association
KSSTA	Korea Ship Safety Technology Administration
LUMLPG	London Universities Maritime Law and Policy Group
MCA	Maritime and Coastguard Agency
MEPC	Maritime Environmental Protection Committee
MOU	Memorandum Of Understanding
MRSC	Maritime Rescue Sub Centre

MSC	Maritime Safety Committee
PSC	Port State Control
RMS	Royal Mail Ship
SMC	Safety Management Certificate
SMS	Safety Management System
SOLAS	The Safety of Life at Sea Convention 1974
STCW	The International Convention on Standards of Training, Certification and Watchkeeping for Seafarers 1978
TFEU	The Treaty on the Functioning of the European Union
UN	United Nations
UNCLOS	The United Nations Conference on the Law of the Sea
VTS	Vessel Traffic Service
WAGN	West Anglia Great Northern

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'Charlotte' v 'Theory' [1921] 9 Lloyd's Rep 341.

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Resolution A.1071(28), Revised Guidelines on the Implementation of the International Safety (ISM) Card by Administrations.

Resolution A.304(III), International Conference on Safety if Life at Sea, 1974.

Resolution A.358(IX), Amendments to the IMCO Convention.

Resolution A.371(X), Correction of Assembly Resolution A.358(IX).

Resolution A.443(XI), Decisions of the Shipmaster with Regard to Maritime Safety and Marine Environment Protection.

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The Convention on the International Maritime Organisation 1958.

The International Code for the Construction and Equipment of Ships Carrying Liquefied Gases in Bulk 1985.

The International Code for the Construction and Equipment of Ships Carrying Dangerous Chemicals in Bulk 1985.

The International Convention for the Prevention of Pollution from Ships 1973.

The International Convention for the Safety of Life at Sea 1974.

The International Convention on Load Lines 1966.

The International Convention on the Inter-Governmental Maritime Consultative Organization 1948.

The International Regulations for Preventing Collisions at Sea 1972.

The International Safety Management (ISM) Code 2002.

The UN Convention on the Law of the Sea 1956.

EU

Council Decision 1999/468/EC of 28 June 1999 laying down the procedures for the exercise of implementing powers conferred on the Commission [1999] OJ L200/11.

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Council Directive 95/21/EC of 19 June 1995 concerning the enforcement, in respect of shipping using Community ports and sailing in the waters under the jurisdiction of the Member States, of international standards for ship safety, pollution prevention and shipboard living and working conditions (port State control) [1995] OJ L157/1.

Council Regulation (EC) No 1255/2011 of the European Parliament and of the Council of 30 November 2011 establishing a Programme to support the further development of an Integrated Maritime Policy [2011] OJ L321/1.

Council Regulation (EC) No 1406/2002 of the European Parliament and of the Council of 27 June 2002 establishing a European Maritime Safety Agency [2002] OJ L208/1.

Council Regulation (EC) No 336/2006 of the European Parliament and of the Council of 15 February 2006 on the implementation of the International Safety Management Code within the Community and repealing Council Regulation (EC) No 3051/95 [2006] OJ L64/1.

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UK

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CHAPTER 1
INTRODUCTION

1.1 INTRODUCTION

The shipping industry has a fairly good safety record and recent years have seen a sustained downward trend in the overall number of accidents involving UK-registered ships.[1] However, maritime disasters world-wide have a high potential for catastrophes,[2] and a series of such disasters in the late 1980s and early 1990s, and their subsequent inquiries, revealed that 'human error'[3] was a significant causal factor. This prompted a demand by the international maritime community for a change in the regulatory framework governing maritime safety. The capsizing of the *Herald of Free Enterprise* ferry in 1987 is commonly accepted as having had the most significant impact in this area, and it subsequently led to the development of the International Maritime Organisation (IMO)'s International Management Code for the Safe Operation of Ships and Pollution Prevention 1993; non-binding initially, but which later developed into the binding International Safety Management (ISM) Code 2002. This ISM Code is a focus of this thesis.

Before the ISM Code came into force, the number of world shipping fatalities was at a consistently high rate.[4] However, when it came into force, attitudes towards the ISM Code by those within the community were overall positive and welcoming. This resulted in the establishment of the Code's desired 'safety culture'[5] and a consequent fall in the number of maritime accidents. Statistics sourced from the IMO show that in the year 2002 (the year that the ISM Code came fully into force), the number of maritime fatalities recorded by the IMO was 1,274. This fell year on year until 2005, when the lowest number of fatalities of 173 was recorded; representing a decrease of over 86%. This is significant when it is considered that the world's merchant fleet

[1] P Townsend et al., 'A regulatory approach to the human element' (World Maritime Technology Conference, London, March 2006).
[2] C Hetherington et al., 'Safety in shipping: The human element' (2006) 37 Journal of Safety Research 401 at p. 401.
[3] Discussed below.
[4] See CWGSP 13/2, Review of Planned Outputs and Indicators During the 2012-2013 Biennium (The International Maritime Organisation 2013) and C105/3(a)/1, Strategy of Planning: (a) Monitoring of Performance (The International Maritime Organisation 2010).
[5] As discussed below.

increased by over 12% during the same period.[6] However, despite the significant initial success of the ISM Code, there is now a general consensus amongst ship companies and seafarers that the Code is overly burdensome.[7] This has led to complacency with regards to safety,[8] as evidenced by the rate of non-compliance with the Code returning to the rate of when it initially came into force in 2002, and the number of recorded fatalities rising to 1,401 in 2012 (and continuing to rise).

The first stage of the author's research examines the ISM Code's impact on the international maritime community; determining whether an effective safety culture is present, and what factors are adversely affecting this. The second stage of the research concerns the potential interaction between the ISM Code and a reformed Corporate Manslaughter and Corporate Homicide Act; using the two legal instruments together to improve maritime safety and to encourage the adoption of an enhanced safety culture.

1.2 THE BACKGROUND AND ORIGINS OF SAFETY CULTURE THEORY

During the early stages of the author's research, various theoretical approaches to research were explored, relevant to the scope and theme of this thesis. Initially, Organisational Culture Theory was chosen to guide, explain and provide understanding to the author's research. However, upon a more thorough examination of the literature pertaining to Organisational Culture Theory, the author was introduced to Safety Culture Theory. Although Safety Culture Theory is a sub-theory of Organisational Culture Theory, its perspective is more focused on issues of safety and, therefore, more relevant to the theme of this thesis. It is this theoretical approach to research, therefore, that is adopted by this thesis.

Safety Culture Theory advocates that an organisation's culture arises from the attitudes, beliefs, perceptions and values that its members share in relation to safety. For a good safety culture to exist, the whole organisation needs to be committed to shared safety beliefs and values, and it needs to support good safety culture behavioural expectations.

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[6] N Butt et al., *15 Years of Shipping Accidents: A Review for WWF* (Southampton Solent University 2013) at p. 22.
[7] P Anderson, 'Managing Safety at Sea', (DProf Thesis, Middlesex University 2002).
[8] Discussed in the following chapter.

Although Safety Culture Theory was first developed by Zohar, as part of his research into the Israeli manufacturing industry in 1980,[9] and as a sub-theory of Organisational Culture Theory,[10] it is more widely associated with the Chernobyl nuclear power plant disaster in 1986. Having had such a severe political and social impact on Europe at the time, it was imperative that the causes of the disaster were fully understood in order that such disasters could be avoided in the future. From the inquiries into the disaster, it was revealed that "inadequate organisational safety culture" was a possible major cause. In its report, the International Nuclear Safety Advisory Group (INSAG) describe safety culture as:

> "That assembly of characteristics and attitudes in organisations and individuals which establishes that, as an overriding priority, […] safety issues receive the attention warranted buy their significance."[11]

Since the Chernobyl disaster, there has been a large amount of research undertaken into safety culture, with various definitions emerging. Three key additional examples of these definitions are considered.

The Confederation of British Industry defines safety culture as "the ideas and beliefs that all members of the organisation share about risk, accidents and ill health."[12]

The Advisory Committee for Safety in Nuclear Installations (ACSNI) provides a somewhat lengthier definition, which has subsequently been adopted by the UK Health and Safety Commission:

> "… the product of individual and group values, attitudes, competences, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's health and safety programmes. Organisations with a positive safety culture are characterised by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventative measures."[13]

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[9] D Zohar, 'Safety climate in industrial organizations: theoretical and applied application implications' (1980) 65 Journal of Applied Psychology 96.
[10] See FW Guldenmund, 'The nature of safety culture: a review of theory and research' (2000) 34 Safety Science 215 at p. 255.
[11] *No75-INSAG-4: Safety Culture* (The International Nuclear Safety Advisory Group 1991) at p. 1.
[12] See MD Cooper, 'Towards a model of safety culture' (2000) 36 Safety Science 111 at p. 114.
[13] Report 367: A review of safety culture and safety climate literature for the development of the safety culture inspection toolkit (Human Engineering, The Health and Safety Executive 2005) at p. 3.

A leading specialist 'safety culture change consultancy', Safety Journey, has more recently defined safety culture as:

> "A culture that understands that safety does not 'go without saying', it must be actively maintained; one that can positively and constructively acknowledge, discuss and learn from *human error* [(emphasis added)]; and one in which employees and contractors at all levels genuinely believe that the company's number one priority is the safety of its people."[14]

This 'human error' factor is what the IMO has been focused on for the past three decades and it forms a core element to this thesis. Accordingly, this is discussed in the proceeding section of this chapter, and in greater detail in the review of the literature below, as well as reference to it being made throughout this thesis.

1.3 SAFETY CULTURE THEORY IN A MARITIME CONTEXT

The first time that the concept of a safety culture operating specifically within the international maritime community was discussed, was when William O'Neil, then Secretary General of the IMO, stated in 1995:

> "What we are talking about is the creation of a safety culture in shipping – an environment where nothing is done or introduced without its safety implications being assessed and where safety becomes a way of life rather than an afterthought."[15]

A better definition of safety culture within a maritime context, is that which is put forward by Mathiesen, who defines it as:

> "A situation where owners are engaged in a continuous process to improve safety and see this as their management philosophy and operational mode to reduce losses […] This implies focus on the entire management chain, from the board room to the ship […] To control safety is the answer to regain credibility for the shipping industry."[16]

[14] M Farley, 'How to reduce human error with safety culture' (Safety in Action, Sydney, September 2014).
[15] JL Veiga, 'Safety Culture in Shipping' (2002) 1 WMU Journal of Maritime Affairs 17 at p. 29.
[16] TC Mathiesen, 'Safety in Shipping: an investment on competitiveness' (1994) BIMCO Review 56.

The reason that the IMO put in place an instrument to govern mandatory maritime safety requirements (the ISM Code), was to instigate the adoption of an enhanced safety culture by the international maritime community (as discussed in the review of the academic literature below). This was to address the alarmingly high number of maritime accidents that were occurring in the maritime community at the time. It is therefore apt to examine here, statistics pertaining to the number of maritime disasters prior to the coming into force of the ISM Code.

1.3.1 THE STATISTICS

In a research paper by Håvold, various sources are listed as providing statistical evidence as to the percentage of these maritime accidents that are attributable to human error.[17] Although the percentage varies greatly from source to source (from 50%[18] to 90%[19]), the most widely accepted view is that around 80% of all maritime disasters and accidents are in fact attributable to what the industry terms 'human error'.[20] This is a view that is reinforced by Perrow, a leading academic in the field of accident causation,[21] as well as the IMO itself. Whether human error is responsible for 50% or 90% of maritime accidents, or somewhere in between, the percentage is too high, and by understanding why these accidents occur, it should be easier to prevent them from recurring.

It is important at this stage to establish what those within the maritime community understand 'human error' to mean. A variety of definitions were sourced[22] and the author has depicted the concept of 'human error' by combining these definitions with Barnett's classification model of human error:[23]

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[17] JI Håvold, 'Culture in maritime safety' (2000) 27 Maritime Policy & Management 79.
[18] The Norwegian Maritime Directorate's database (see ibid at p. 84).
[19] A claim made on a Norwegian television programme, *Schrødinger's katt spesiel*, in Spring 1997 (see ibid at p. 84).
[20] See Safety Digest: Lessons from Marine Accident Reports I/2005 (The Marine Accident Investigation Branch 2005).
[21] C Perrow, *Normal accidents: living with high-risk technologies* (Princeton University Press 1999) at p. 224.
[22] S Kiosses, 'Human Error and Marine Safety' (International Conference on Environmental and Energy in Ships, Athens, May 2015), AH Mokhtari and HR Khodadadi Didani, 'An Empirical Survey on the Role of Human Error in Marine Accidents' (2013) 7 TransNav 363, ML Barnett, 'Searching for Root Causes of Maritime Casualties' (2006) 4 WMU Journal of Maritime Affairs 131, and AM Rothblum, 'Human Error and Marine Safety' (Maritime Human Factors Conference, Linthicum, March 2000).
[23] M Barnett, 'Hindsight and Forecast: The "Janus Principle" in Maritime Safety' (The Inaugural Professorial Lecture of Mike Barnett, Southampton, January 2005).

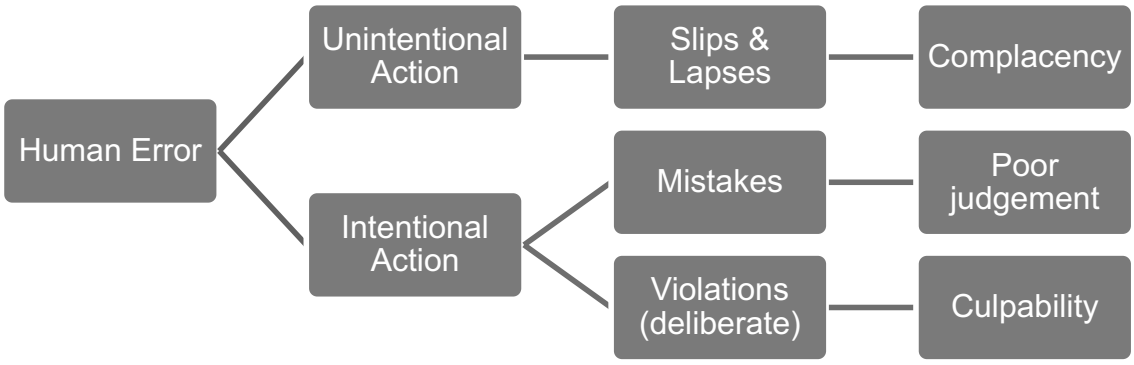

Diagram 1.1: The Author's depiction of 'Human Error' using Barnett's Classification Model

The issue of complacency as an element of human error is key to the research underpinning this thesis. Complacency in the maritime industry with regards to the implementation of the ISM Code is examined in detail in the review of the literature, and at various points throughout the thesis.

It is widely recognised that there is a mathematical relationship between the occurrence of the most serious maritime incidents, less serious accidents, and hazardous occurrences.[24] Whilst there is debate amongst academics as to the actual ratios, an industry-accepted ratio can be depicted using Bird's Safety Triangle, from his research into industrial accidents,[25] as adapted for a maritime-safety context by Anderson:[26]

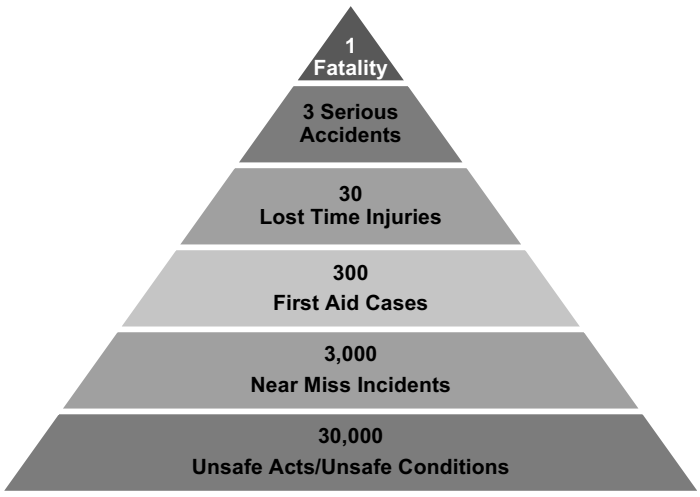

Diagram 1.2: Anderson's Safety Triangle

[24] P Anderson, 'A question of culture' *Maritime Risk International* (1 October 2008).
[25] See FE Bird and RG Loftus, *Loss Control Management* (International Loss Control Institute 1976).
[26] See Anderson, 'Managing Safety at Sea' at p. 21.

In-depth research undertaken by Springett, of the UK Maritime and Coastguard Agency (MCA) reveals that 25% of maritime accidents can be attributed to complacency, and 31.25% of all 'human error' accidents can be attributed to complacency.[27] Theoretically, therefore, using the figures provided by Springett, and the ratios provided by Anderson, if complacency was eradicated within the maritime industry, there *could* (emphasis added) be a situation where there are zero fatalities:

Diagram 1.3: The Author's 'Zero Complacency' Safety Triangle based on Springett's Statistics

The question, which is the focus of this thesis, is how the maritime community can tackle complacency with the aim of working towards a zero-fatalities situation (in a 'human error' context).[28] Although it is accepted that in reality there will never exist a zero-fatalities situation, because it is human nature that mistakes will eventually occur in complex systems like those on board ships, this is something the community could aim towards; in the hope of improving the implementation of the ISM Code and its safety culture.

1.4 RESEARCH AIMS

The research undertaken as part of this thesis aims to:

1. Assess the extent to which the ISM Code has impacted upon maritime safety and the number of fatalities since it fully entered into force on 1 July 2002.

[27] See T Springett, 'Complacency & Maritime Accidents' (MCA Human Element Advisory Group 14th Session, London, May 2011).
[28] It should be observed, however, that the aim of zero fatalities is within a 'human error' context.

2. Determine the extent of the change in attitude and behaviour within the international maritime community towards on-board safety, from the time when the ISM Code initially came into force to the present day, and the impact this change has had upon ISM-compliance.
3. Consider how corporate manslaughter legislation could be used alongside the ISM Code as a tool to tackle complacency and encourage: i) UK ship companies, and those ships operating in UK territorial waters; ii) individual seafarers; and ultimately iii) the international maritime community as a whole,[29] to implement fully the ISM Code, thus improving maritime safety and reducing the number of deaths at sea.

Although the primary focus of the research undertaken is on UK ship companies, and ships operating within UK territorial waters, there is the possibility that action taken by the UK may, ultimately, influence, in the longer term, the international maritime community as a whole. Historically, this influence has existed, and this is examined in the review of the existing literature below.

1.4.1 THE THESIS HYPOTHESIS

In addressing the above research aims, the author initially attempted to support the hypothesis that:

> A reformed Corporate Manslaughter Act, which included both corporate *and* individual liability, could be used as an effective tool to improve maritime safety and reduce maritime fatalities; compelling both shore-based and ship-based management to implement the ISM Code fully, and thus maintain the 'safety culture' that the drafters of the Code envisaged.

However, during the course of the research project, the thesis hypothesis evolved to take into consideration the author's research and developed understanding of the subject matter. It is this final thesis hypothesis that is outlined in Chapter 6 and tested in Chapter 7 of this thesis:

> **A 'Proposed and Improved Corporate Manslaughter and Corporate Homicide Act', which were to include both primary liability for the company and secondary liability for the individual, could work alongside the ISM Code to appropriately punish companies and corporate individuals who operate unsafe ships and death occurs as a result; and this would act as**

[29] To be fully effective at improving and maintaining standards of safety, regulators cannot work alone and must be involved at an international level. This includes not only at a regional level (in the UK's case this would be the European Union), but also the wider scope for influence and debate afforded to the UK by its membership of the IMO.

a sufficient deterrent and so ensure that complacency with safety is replaced with an effective safety culture in the maritime community.

1.5 THE OBJECTIVE AND SIGNIFICANCE OF THE RESEARCH

Maritime safety is an issue that has been brought to the public's attention more recently with disasters such as the *Costa Concordia* in 2012 and the *Sewol* in 2014. This thesis is the first to address the failings of implementation of the piece of international legislation that sets the minimum safety standards for merchant ships (the International Safety Management (ISM) Code 2002) and the effect of complacency upon maritime safety. Consequently, this thesis contributes to the intellectual advancement of the significant and developing interplay between criminal and maritime law, by adding to the scholarly understanding of the safety culture currently operating within the maritime community, and examining how corporate manslaughter legislation could be used to improve this. It offers sound research for consideration by legal researchers and scholars, and also by those working within the field of maritime safety regulation. The author invites research studies to test the validity of the thesis hypothesis further.

1.6 RESEARCH DESIGN METHODOLOGY

The research undertaken involved critical analysis of the legal regulation of both maritime safety and corporate manslaughter. This was primarily achieved through the adoption of doctrinal and socio-legal approaches; identifying the need for such regulation and the reasons why such regulation falls short in practice. The two approaches, discussed below, facilitated the author's increased understanding of how effective recent developments in both international and national law have been at reducing the number of maritime fatalities, attributing corporate criminal liability to those responsible for breaching safety regulations where a death at sea occurs as a result, and imposing an appropriate punishment on those deemed culpable.

To address the aims of this research, both doctrinal and socio-legal models were adopted, using two particular methods – case studies and a survey – in order to test, and ultimately support, the thesis hypothesis.

1.6.1 DOCTRINAL MODEL

The doctrinal approach is an important method of conducting legal research; identifying and describing the law *in theory*, rather than exploring it in practice. Adopting this model allowed the author to interpret the relevant law relating to maritime safety regulation and corporate manslaughter, the highlighting of the activity and developments in both areas, and the placing of them into the context of Safety Culture Theory. The review of the related literature allowed for a detailed doctrinal account of the development of the law in these areas; serving as a preparatory foundation for the primary research of this thesis.

This part of the research, being explanatory in nature, required flexibility in order to respond to an evolving understanding of inquiry when needed. Therefore, this strategy incorporated an emergent design; providing for an understanding of the area that developed and evolved throughout the research-conducting process. Each collection and analysis of literature guided subsequent searches for literature.

The validity of the academic literature was assured through confirmation of the authors' area of research and expertise. The authors were chosen purposefully for their contribution to their fields of expertise relevant to this thesis, and the case studies for their relevance to the issues covered. Saturation occurred when no additional theories or perspectives could develop the research or the author's understanding significantly further.

The doctrinal approach to this research complements the second facet of the research strategy; the socio-legal approach.

1.6.2 SOCIO-LEGAL MODEL

The socio-legal approach to the research allowed the author to examine the law *in practice*, as opposed to examining it in theory. This involved the investigation of the application and effect of relevant maritime safety regulations and corporate criminal liability legislation (as revealed by the doctrinal research) on the number of maritime fatalities within a real-life context. It is supported by documentary evidence in the form of maritime casualty statistics and reports, and reports from investigations and inquiries

into maritime disasters. The findings from this approach provided better guidance as to the areas in maritime safety governance where improvement is needed.

Although it is accepted that in research, statistics do not always reflect all variables accurately, the statistics used in this research are official statistics collated by the UN's IMO, and other intergovernmental and governmental organisations, and therefore they are reliable to a greater extent than other sources available.[30] Furthermore, the statistics used relate to: i) Port State Control (PSC) inspections,[31] which are monitored and verified by each Flag State Administration, the PSC regime where relevant, and the IMO; and ii) the number of lives lost due to safety-related accidents on board those ships subject to the ISM Code. These statistics, therefore, are wholly relevant to this thesis and do not include, for example, suicide or deaths caused by natural causes. As a result of the methods of collating this data and producing the statistics being governed and overseen by the IMO, the different administrations/organisations that have published the statistics used in this thesis, have adopted the same terminology when classifying, compiling and collating the data they have sourced. This further evidences the accuracy and reliability of the statistics.

It should also be observed that although the number of fatalities have been represented in terms of numerical values, the statistics have not been used to state definitively the actual number of fatalities; the statistics have been used only to identify correlations and trends in the increases and decreases in the number of maritime fatalities, and to look for the reason behind such trends.

1.6.3 CASE STUDIES

A case study approach was the main socio-legal method of research undertaken and provided a clearer understanding of the areas of law covered. A thorough investigation into the effect of the law relating to maritime safety and corporate criminal liability, as revealed through the examination and review of academic literature, was achieved through the analysis of disasters where these laws were applicable and highly relevant. The individual cases analysed in this thesis were chosen because of their relevance, as demonstrated by the review of the academic literature, and based on, *inter alia*, the

[30] Compared with statistics from marine insurance firms and classification societies, for example.
[31] Defined and discussed in the following chapter.

publicity and media coverage of the disaster, the investigation and inquiry that followed, its subsequent contribution to maritime safety, the academic commentary pertaining to the disaster, and the resulting recommendations and legislative developments that followed.

As discussed above, the author considered various theoretical approaches to research, relevant to this research project. Whilst the author chose Safety Culture Theory as the main approach to the research, and the perspective from which this thesis is written, there are several other related perspectives and models. One such model is Reason's model of accident causation. This model suits the scope of a detailed analysis of a maritime disaster, like the author's in Chapter of this thesis, whereby human errors are examined in order to explore wider systemic, organisational issues.

Reason's model focuses on organisational accidents in complex technological systems, such as those found in the maritime (transport) industry. He hypothesises that organisational accidents occur as a result of multiple errors, and defines organisational accidents as:

> "Situations in which latent conditions (arising from aspects such as management decisions or *cultural* influences) combine adversely with local triggering events (such as weather or location etc) and with active failures (errors and/or procedural violations) committed by individuals."[32]

Reason suggests that accidents occur due to holes in barriers and safeguards, which he terms 'defences', and he uses his illustrate model of accident causation to depict this concept:[33]

[32] JT Reason, Managing the risks of organizational accidents (Ashgate Publishing 1997) at p.1.
[33] ibid at p. 9.

Diagram 1.4: Reason's Illustrative Model of Accident Causation[34]

For the purposes of this research project, 'latent conditions' would include, *inter alia*, gaps in supervision, unworkable procedures, clumsy automation, and shortfalls in training. Active failures are the 'unsafe acts'[35] caused on board as a result of mistakes or complacency.[36]

The individual case studies were analysed from a Safety Culture Theory perspective in order to strengthen the reliability of the research data and, in doing so, they served two primary purposes: they were intrinsic, in that they provided a better understanding of the areas of law covered in this thesis; and they were instrumental as they provided information and insight for the refinement of the research questions that were to be addressed, which ultimately contributed to the author's evolving thesis hypothesis.

The doctrinal and socio-legal research developed the author's understanding of the subject matter and resulted in the author revising the initial thesis hypothesis (discussed above). To test this revised thesis hypothesis, the *Herald of Free Enterprise* scenario is examined, in a hypothetical context; as if the ISM Code and the author's proposed Corporate Manslaughter Act were both in force at the time that the *Herald* was being operated.[37]

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[34] This image is taken from A Di Lieto, *Costa Concordia Anatomy of an organisational accident* (Australian Maritime College 2012) at p. 4. A simplified version of this illustrative model is provided in Chapter 4 of this thesis.
[35] See Anderson's Safety Triangle above.
[36] Reason, Managing the risks of organizational accidents at p. 10.
[37] See Chapter 7 of this thesis.

1.6.4 THE SURVEY

The case study was supported by a survey, in the form of a short questionnaire, comprised of 16 questions, and involving participants concerned with the study and practice of maritime safety, and its regulation. Surveys are generally considered an effective means for collecting information from individuals or small groups,[38] and provide instant quantified results that enable a researcher to produce medians and averages.[39] The survey was therefore used to contribute to the author's evolving theory that the enforcement of maritime safety would be more effective if failure to comply with the ISM Code, and other maritime safety legislation, resulted in the criminal prosecution of both the company and the key individuals concerned for corporate manslaughter. The survey was used to generate discussion around the research questions, obtain experiential insight into the relevant laws as they operate in practice, and to test the thesis hypothesis.

The survey involved the distribution of a questionnaire, with specific questions being asked, and with the option for the participant to provide their personal views and commentary. Although Håvold has claimed that questionnaires have been the predominant instrument used to measure an organisation's safety culture, he also once claimed that they have not been particularly successful in such research projects.[40] However, since Håvold's initial claim, researchers have subsequently implemented questionnaires effectively in their assessment of the safety culture operating within ship companies, including, most notably, Anderson[41] and even Håvold himself.[42] Furthermore, the author's survey was not relied upon as the only means of testing the thesis hypothesis, but rather it was used alongside other means of gathering data, evolving theories, and testing the thesis hypothesis.

All methods of sourcing, compiling and storing data were approved by the University of Central Lancashire's Business, Arts, Humanities and Social Science (BAHSS) ethics committee.

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[38] See D Burton, *Research Training for Social Scientists* (Sage Publications 2000).
[39] FW Guldenmund, 'The use of questionnaires in safety culture research: an evaluation' (2007) 45 Safety Science 723 at p. 726.
[40] ibid at p. 741.
[41] See Anderson, 'Managing Safety at Sea'.
[42] See JI Håvold, 'From Safety Culture to Safety Orientation: Developing a Tool to Measure Safety in Shipping' (PhD Thesis, Norwegian University of Science and Technology 2007).

1.7 LIMITATIONS

The research design methodology that was adopted provided the author with knowledge, understanding and data, used to effectively develop the research, address the research aims and to test the thesis hypothesis. Due to the nature of the survey and the limited number of participants, the author has not been able to make statistical generalisations, like Anderson in his survey-orientated doctoral research,[43] or the IMO in its ISM-impact survey.[44] However, the survey in this thesis is used only to support the doctrinal and socio-legal research, alongside the hypothetical case study, in testing/supporting the thesis hypothesis and, as such, the author has given appropriate weight and value to the survey and the statistics obtained from it.

1.8 THESIS STRUCTURE

This thesis is comprised of eight chapters. The first chapter is an introduction to the thesis, in which the context of the research is established, the author's research methodology, aims and hypothesis are outlined, the structure of the thesis is described, and a review of the existing academic literature is provided. Chapter 2 establishes the legal frameworks for the ISM Code. Chapter 3 outlines and discusses the implementation of the ISM Code internationally, regionally, and nationally (within a UK context). Chapter 4 demonstrates the need for better implementation of the ISM Code by both Flag States and ship companies, using two key case studies to address the research aims. Chapter 5 examines and critiques the corporate manslaughter legislation currently in force in the UK, as a foundation for which the author's thesis hypothesis is partly based. Chapter 6 outlines the author's thesis hypothesis in great detail. Chapter 7 uses a hypothetical case study and the analysis of the author's survey to test the thesis hypothesis. Chapter 8 provides conclusions to the thesis.

[43] Anderson, 'Managing Safety at Sea'.
[44] Discussed in Chapter 3 of this thesis.

1.9 REVIEWING THE LITERATURE

The remainder of this chapter provides a detailed review of the literature that already exists in relation to the regulation of maritime safety within the UK. It highlights the existing research in the area of the regulation and enforcement of maritime safety, and further demonstrates the gaps in the research. It is these gaps that provide the context for the more in-depth discussion and analysis within this thesis, and which forms the author's contribution to this developing area of research.

1.9.1 KEY TERMS

This thesis examines the interaction of two areas of law – maritime and criminal – where there is a death at sea as a result of a failure on the part of an individual or a ship company to comply with the requirements of the ISM Code. As a result, current academic literature was sourced that relates to both areas, using established key terms. These key search terms are:

> Maritime Safety Regulations, Maritime Safety Legislation, Maritime Safety Policy, Safety at Sea, the ISM Code, and Death(s) at Sea.

For the purposes of the literature review, these terms were used to search for literature in relation to the regulation of maritime safety by the UK only, but for the wider research, the results relating to regulation by the European Union and the IMO were included, as well as literature relating to corporate manslaughter.

1.9.2 THE LITERATURE REVIEWED

As the overall research involves different areas of law and policy, and different legal systems, there is a large amount of literature that could be considered relevant to this thesis. Therefore, careful selection had to be made when deciding which literature to consider for the literature review. This choice was based on the literature's relevance to the research, and recent developments in, and considerations of, the relevant areas of law. Key academics, who have contributed significantly to the field of maritime safety, were chosen. For the literature review itself, only literature relating to the regulation of maritime safety in the UK was chosen so as to allow for a more focused and in-depth

review from the wide range of material available. Appropriate weight has been given to the literature according to the level of research involved in the production of the material and the author's experience within their fields of expertise.

1.10 A REVIEW OF THE EXISTING ACADEMIC LITERATURE RELATING TO THE REGULATION OF MARITIME SAFETY

A number of high-profile maritime disasters in the late 1980s and early 1990s had a substantial impact upon the international maritime community, and resulted in calls for a change in the regulatory framework that governed maritime safety. These disasters include, *inter alia*, the *Herald of Free Enterprise*,[45] the *Marchioness*,[46] the *Scandinavian Star*,[47] the *Jan Heweliusz*,[48] and the *Estonia*.[49] The sinking of the *Herald* in 1987 is widely accepted as the disaster that had the most significant impact on the development of maritime safety internationally (as well as on the development of corporate manslaughter legislation in the UK). Mitroussi examines in great detail the concept of a safety culture within the maritime industry, and aptly claims that the *Herald of Free Enterprise* disaster underlined the significance of proactively promoting and governing safety management at an international level, and resulted in the IMO moving away from a mere advisory role within the maritime community, to being the community's supervisory and auditing body.[50] Thébault, a lawyer specialising in the EU's regulated markets, makes the observation that the IMO's change in role brought with it a new philosophy of anticipating and preventing disasters; taking a proactive rather than a reactive stance on the development and improvement of maritime safety legislation.[51]

However, a number of years have passed since the ISM Code became mandatory[52] and the initial effect/'honeymoon period' has been, to some extent, undermined by waning enthusiasm and an increase in complacency by ship companies and seafarers alike. This

[45] Capsized on 6 March 1987.
[46] Sank on 20 August 1989.
[47] Caught fire on 7 April 1990.
[48] Sank on 14 January 1993.
[49] Sank on 28 September 1994.
[50] K Mitroussi, 'The evolution of the safety culture of IMO: a case of organisational culture change' (2003) 12 Disaster Prevention and Management 16 at p. 21.
[51] L Thébault, Maritime Safety Culture in Europe' (2004) 46 Managerial Law 1 at p. 5.
[52] For all ships of 500 or more gross tonnage.

supposition was put forward by the British Chamber of Shipping in 2011[53] and is a theme that is examined in greater detail in Chapter 3 of this thesis.

1.10.1 THE HERALD OF FREE ENTERPRISE DISASTER (1987)

On 6 March 1987, the *Herald of Free Enterprise*,[54] a *Spirit*-class roll-on roll-off ferry,[55] was working the route between the English port of Dover and the Belgian port of Zeebrugge. Whilst preparing to leave the port of Zeebrugge, the *Herald*'s master called 'harbour stations'[56] but the assistant bosun, whose duty it was to close the bow doors before departure, remained asleep in his cabin. The master, unaware that the bow doors had not been closed, erroneously assumed that the ship was safe to leave port. The *Herald* left its berth and, when it reached the outer port, seawater immediately flooded its decks. Within 90 seconds it had listed to port and capsized, ending up half-submerged in shallow water. The disaster resulted in the death of 192 passengers and crew.

Goulielmos et al. make the observation that during the inquiry into the sinking of the *Herald* (the Sheen Inquiry),[57] analysts were unable to blame the "usual characteristics" that were often found to be the leading cause of a maritime disaster (i.e. the ship's age, its maintenance, the nationality of its crew, weather conditions etc.).[58] There was only one thing that the Inquiry could blame, and this was 'human error'.[59] Both this argument, and the conclusion put forward by Goulielmos, are rather simplistic and undeveloped in their current form, and one must draw on other literature to examine and elaborate on the point further. Therefore, a better, more detailed analysis of the situation, as provided by Prasad, is considered.

Prasad notes that the Inquiry concluded that the underlying, or 'cardinal', faults lay with the senior management of the ship company, Townsend Thoresen, as it was they who

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[53] See Springett, 'Complacency & Maritime Accidents'.
[54] Herein referred to as the '*Herald*'.
[55] Commonly referred to as a 'ro-ro ferry'.
[56] The order issued for crew to attend to their assigned duties prior to the ship arriving or leaving the harbour.
[57] Named after Lord Justice Sheen who chaired the inquiry: *Report 8074: Herald of Free Enterprise* Department of Transport 1987).
[58] AM Goulielmos et al., 'The quest of marine accidents due to human error, 1998-2011' (2012) 1 International Journal of Emergency Services 39 at p. 48.
[59] Defined as an action that was "not intended by the actor; not desired by a set of rules or an external observer; or that led to the task or system outside its acceptable limits." (JW Senders and NP Moray, *Human Error: Cause, Prediction, and Reduction* (Lawrence Erlbaum Associates 1991) at p. 25.).

failed to appreciate their responsibility for the safety of the company's fleet.[60] What was more worrying for the Inquiry was that Townsend Thoresen had a total disregard for improving upon safety through learning from its past incidents. Goulielmos et al. claim that the culture adopted by management company Townsend Thoresen was centred wholly on maximising profit by reducing crossing times.[61] This was evidenced by an incident that took place only four years before the sinking of the *Herald* where, in 1983, one of Townsend Thoresen's other *Spirit*-class ferries, the *Pride of Free Enterprise*,[62] had left port in similar circumstances i.e. with its bow doors open[63] because the assistant bosun had remained asleep in his cabin. Although this did not result in the sister ship sinking,[64] passengers and crew were nevertheless put in considerable danger. Following the *Pride* incident, Townsend Thoresen, however, did not take any corrective action, nor did it put in place any safety measures to prevent this from recurring.

Clark points out that the report that came from the inquiry into the *Herald of Free Enterprise* disaster (the 'Sheen Report') was a "fairly comprehensive damnation" of Townsend Thoresen.[65] It was observed during the Inquiry that Townsend Thoresen had been made aware of the safety concerns regarding the bow and stern doors on other occasions too.[66] Following the *Pride* incident, and prior to the sinking of the *Herald*, three senior masters of the *Spirit*-class ferries – Captains Blowers, Kirby and de Ste Croix – on separate occasions, wrote to the senior management of Townsend Thoresen and requested indicator lights to be installed on the bridge, as a matter of urgency, in order to show whether the watertight bow and stern doors were open or closed. In all three instances, senior management acted irresponsibly, and with total disregard as to the implications on safety; dismissing the requests, with thought only to the financial 'burden' of installing the indicator lights on the bridges of the company's fleet.[67]

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[60] R Prasad, *From Compliance Culture Towards Safety Culture* (Dokuz Eylül University 2012) at p. 4.
[61] AM Goulielmos and MS Goulielmos, 'The accident of m/v Herald of Free Enterprise: A failure of the ship or the management?' (2005) 14 Disaster Prevention and Management 479 at p. 480.
[62] Herein referred to as the '*Pride*'.
[63] And in this instance, its stern doors also.
[64] Owing to its ballast tanks not being as full and therefore it was not as low in the water as the *Herald*.
[65] A Clark, 'The Herald of Free Enterprise – A Defective Product?' (1987) 137 New Law Journal 891.
[66] Report 8074: Herald of Free Enterprise at para 18.
[67] ibid at para 18.

Furthermore, Wang observes that following the subsequent 'Carver Report',[68] it was realised by the UK Government that a new conceptualisation of safety needed to be introduced, at both national and international levels.[69] As a direct result of this report, the UK began implementing changes in national policy, whilst at the same time lobbying the IMO[70] on the international stage for the establishment of a global minimum standard of maritime safety.[71]

1.10.2 THE UK'S RESPONSE

Following the *Herald of Free Enterprise* disaster, the UK became a leading maritime State in formal safety assessment, and the UK Maritime Coastguard Agency (MCA) a leading agency in the lobbying for increased safety measures on the international stage.

In addition to the Sheen Report, a House of Lords Committee in 1992, under the chairmanship of Field Marshall Lord Carver, published a report of its own investigation into the capsize of the *Herald*.[72] In this report, Lord Carver called for a necessary framework of primary safety goals to be established, regulated and enforced by the IMO, as a necessary first step in reducing maritime casualties.[73] Chen observes that English courts too took their cue from the Government, and began taking into consideration the concept of safety management (or safety culture) in their judicial decisions relevant to maritime disasters.[74] A key example can be seen in the case of the *Toledo*,[75] where Mr Justice Clarke held that the failure to set up or carry out a proper system of inspection of ships constituted a want of due diligence in making the *Toledo* seaworthy.[76] Although this case was primarily concerned with the issue of seaworthiness, which is beyond the scope of this thesis, it was the court's examination of a 'proper *system* of inspection' that evidences a cultural change. In the case of the *Lydia Flag*,[77] it was held by Mr Justice Moore-Bick that the failure of the crew to report

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[68] Discussed below.
[69] J Wang, 'The current status and future aspects in formal ship safety assessment' (2001) 38 Safety Science 19 at p. 21.
[70] And the European Union, as discussed later in this thesis.
[71] Wang, 'The current status and future aspects in formal ship safety assessment' at p. 22.
[72] *Safety Aspects of Ship Design and Technology* (The House of Lords Select Committee on Science and Technology 1992). Herein referred to as the 'Carver Report'.
[73] Lord Donaldson of Lymington, 'The ISM Code – The Road to Discovery? (The Inaugural Memorial Lecture of Professor Cadwallader, London, March 1998) at p. 10.
[74] L Chen, 'Legal and practical consequences of not complying with ISM code' (2000) 27 Marine Policy & Management 219 at p. 221.
[75] *The Toledo* [1995] 1 Lloyd's Rep 40.
[76] ibid at p. 50.
[77] Martin Maritime Ltd v Provident Capital Indemnity Fund Ltd (The Lydia Flag) [1998] 2 Lloyd's Rep

the ship's defects was the fault of the ship company, due to the company having no *system* in place that required the reporting of defects, or outlined procedures for such reporting.[78] These two cases clearly demonstrate the increasing acceptance, at least in the UK, that safety management systems, akin to those required now by the ISM Code, were deemed necessary in order to ensure that safety was managed effectively by ship companies.

Goulielmos and Lun note that the British Government believed, at the time, that the EU, and the collective international maritime community as a whole, should undertake a commitment to the promotion and enforcement of minimum safety standards.[79] Therefore, on the international stage, the UK lobbied and pressured the IMO (as the international rule-making body and 'setter' of maritime safety standards) to undertake the responsibility of legislating maritime safety with the purpose of reducing maritime casualties. An example of this can be seen with the MCA's proposal to the IMO, made in 1993 in the wake of the Carver Report, that formal safety assessments should be applied to ships in order to ensure a "strategic oversight of safety prevention."[80]

These formal safety assessments were initially designed to be applied to safety issues common to a specific ship class (e.g. ro-ro ferries) or to a specific hazard (e.g. fire).[81] The formal safety assessment framework proposed by the MCA[82] consisted of: i) the identification of hazards; ii) the assessment of risks associated with those hazards; iii) the identification of ways to manage these risks; iv) a cost-benefit assessment of the options; and v) a decision on which options to select.[83]

The IMO later drafted this framework into 'Guidelines' at its 67th Maritime Safety Committee[84] and, in doing so, made it clear that the IMO considered formal safety assessment an effective tool to facilitate the organisation's development of safety regulations. As a result of this lobbying for formal safety assessment by the MCA, and because of further disasters such as the capsizing of the *Estonia* in 1994, the IMO

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[78] ibid at p. 657.
[79] AM Goulielmos and YHV Lun, 'The Common Marine Policy of the European Union since 2005' (2012) 1 International Journal of Ocean Systems Management 289 at p. 293.
[80] Wang, 'The current status and future aspects in formal ship safety assessment' at p. 21.
[81] ibid at p. 22.
[82] To the IMO's 62nd Maritime Safety Committee in May 1993.
[83] Wang, 'The current status and future aspects in formal ship safety assessment' at p. 23.
[84] MSC/Circ.1023/MEPC/Circ.392, Guidelines for the Formal Safety Assessment (FSA) for use in the IMO Rule-Making Process (The International Maritime Organisation 2002) (as amended).

ordered a complete review of ro-ro safety. Although this review was confined to one class of ship, the review itself was an unprecedented step that saw the IMO's shift towards proactive safety management, and its long-term commitment to a 'safety culture' within the effective regulatory framework that is now the ISM Code.[85]

1.10.3 SAFETY CULTURE

To reiterate a point made earlier in this thesis, it is appropriate to consider Mathiesen's definition of a 'safety culture':

> "The situation where [ship] owners are engaged in a continual process to improve safety and see this as their management philosophy."[86]

Etman and Halawa assert that an effective safety culture is the product of individual and group values, attitudes and perceptions.[87] This can be said to be the active collaboration between management and crew. Etman and Halawa later expand upon this definition, and stress that a safety culture is the establishment of a safe and secure environment through good ergonomics and safe working practices; asserting that it is the ship company's responsibility to provide these safe and secure working conditions.[88]

Mitroussi observes that in the 1990s, it became a commonly accepted view that regulatory activity was insufficient, and that a more safety-orientated attitude by all parties concerned was needed in order to make safety an integral part of the day-to-day activities on board.[89] With this in mind, the IMO adopted a draft Resolution in November 1995,[90] which recommended that Member States initiate work with the aim of establishing a safety culture in and around passenger ships. This, Etman and Halawa argue, evidences the IMO's clear adoption of, and implanting of, the concept of a safety culture within the international maritime community.[91] This safety culture was first

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[85] See Mitroussi, 'The evolution of the safety culture of IMO: a case of organisational culture change' at p. 18 and K Mitroussi, 'Quality in shipping: IMO's role and problems of implementation' (2004) 13 Disaster Prevention and Management 50 at p. 51.
[86] Veiga, 'Safety Culture in Shipping' at p. 30.
[87] E Etman and A Halawa, 'Safety Culture, the Cure for Human Error: A Critique' (The 8th Annual General Assembly and Conference of the International Association of Maritime Universities, Odesa, September 2007) at p. 121.
[88] ibid at p. 117.
[89] Mitroussi, 'The evolution of the safety culture of IMO: a case of organisational culture change' at p. 19.
[90] Resolution A.788(19), Guidelines on Implementation of the International Safety Management (ISM) Code by Administrations.
[91] Etman and Halawa, 'Safety Culture, the Cure for Human Error: A Critique' at p. 115.

conceived as a means of reducing maritime casualties; to address the common factor of human error in shipping through, *inter alia*, commitment, values and beliefs,[92] and is now to be found within the ISM Code.[93]

1.10.4 THE ISM CODE

In December 2000, William O'Neil, the (then) Secretary General of the IMO, after various consultations with the key members of the international maritime community, drafted the ISM Code[94] and had it attached to the Safety of Life at Sea Convention 1974,[95] as Chapter IX, entitled 'Management for the Safe Operation of Ships and Pollution Prevention'.[96] That the Secretary General of the international maritime community's legislative body was wholly unopposed in using the fast-track 'tacit acceptance procedure', rather than the usual procedure of adopting a new international instrument (with the intricate diplomatic initiatives involved and all the years required for negotiation and ratification[97]), evidences the sense of urgency that was felt at the time, and the support and momentum[98] behind calls for putting in place a governing instrument for a mandatory standard of safety management.

The ISM Code came into force in two phases:

> **Phase One**: From 1 July 1998 – the ISM Code was binding on passenger ships and certain cargo ships of 500 or more gross tonnage;
>
> **Phase Two**: From 1 July 2002 – the ISM Code was binding on all cargo ships of 500 or more gross tonnage.

The ISM Code was formulated with the sole purpose of improving and extending standards of maritime safety,[99] and was aimed at targeting ship companies directly.[100] It sought to introduce a new culture of ship management throughout the community by

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[92] ibid at p. 121.
[93] D Christodoulou, The International Safety Management (ISM) Code and the Rule of Attribution in Corporate Criminal Responsibility Under English Law (Ant. N. Sakkoulas 2000) at p. 17.
[94] A copy of the ISM Code is included in Appendix 1.
[95] Herein referred to as the 'SOLAS Convention'.
[96] Note that the issue of pollution prevention is beyond the remit of this thesis.
[97] 'ISM Code brings change - and for the better' *Fairplay* (7 June 2001).
[98] GP Pamborides, *International Shipping Law Legislation and Enforcement* (Kluwer Law International 1999) at p.147.
[99] And addressing environmental/protection issues, as a secondary purpose.
[100] See Paragraph 1.2.2 of the ISM Code.

establishing a universally acceptable, and mandatory, code of practice. The IMO described this new culture in the following terms:

> "Effective implementation of the ISM Code should lead to a move away from a culture of "unthinking" compliance with external rules towards a culture of "thinking" self-regulation of safety – the development of a 'safety culture'. The safety culture involves moving to a culture of self-regulation, with every individual – from the top to the bottom – feeling responsible for actions taken to improve safety and performance."[101]

It is worth noting here Anderson's research examining the (then) *potential* (emphasis added) effectiveness of the ISM Code at improving safety standards and discussing the benefits of ship companies being ISM-compliant.[102] In this research, Anderson, who is heralded by the international maritime community as the leading expert on the ISM Code, aptly suggests that although the primary objectives of the ISM Code are set out in its preamble, to understand the Code's intention fully, it is appropriate to examine the summary of the Code, as put forward by Lord Donaldson in his inaugural memorial lecture of Professor Cadwallader on 26 March 1998:

> "… In the short and medium term, it [the ISM Code] is designed to discover and eliminate substandard ships, together with substandard owners and managers, not to mention many others who contribute to their survival and, in some cases, prosperity… In the long term its destination is to discover new and improved methods of ship operation, management and regulation, which will produce a safety record more akin to that of the aviation industry. But, as I readily admit, that is very much for the future…"[103]

The Code contains 16 short Paragraphs, the key provisions of which are:

> **Paragraph 1.4:** every company should develop, implement and maintain a Safety Management System (SMS).
>
> **Paragraph 4:** every company should designate a person or persons ashore to monitor safety aspects of the operation of each ship.
>
> **Paragraph 7:** the company should establish procedures, plans and instructions for key shipboard operations concerning safety.

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[101] 'The Human Element' (*The International Maritime Organisation*), <www.imo.org/humanelement/mainframe.asp?topic_id=62> (accessed 18 September 2013).
[102] P Anderson, *Cracking the Code* (The Nautical Institute 2003).
[103] Donaldson, 'The ISM Code – The Road to Discovery?' at p. 3.

Paragraph 9: accidents, near-misses and non-conformities with the SMS should be reported to the company.

Paragraph 12: the company should carry out internal safety audits.

Paragraph 13: companies with a valid SMS will be issued with a Document of Compliance (DOC); ships complying with the company's SMS should be issued with a Safety Management Certificate (SMC).

In brief, the ISM Code establishes safety-management objectives and requires a SMS to be implemented by the ship company. The company is then required to establish and implement a policy for achieving these objectives. Both the SMS, and each ship's implementation of that SMS, are audited and certified[104] by the Flag State Administration[105] i.e. the single institution, or collection of agencies forming that institution, that implements and enforces the State's national maritime laws, and its commitments to international maritime regulations, over those ships which are registered under the State's flag. In the case of the UK, this is the MCA.

Contained within its preamble are two key characteristics of the ISM Code. These are that the Code is "based on general principles and objectives"[106] and that the Code is "expressed in broad terms."[107] In essence, the Code recognises that no two ship companies are the same, and that ships operate under a wide range of varying conditions. In order for a company to comply with the requirements laid down by the Code, it is necessary merely to have in place an effective SMS.

When it came into force, the ISM Code represented a new management practice in shipping, but it was never intended to act as a means of dictating to ship companies how to run their operations. This is why the language contained in the Code is specific only when referring to its general principles and objectives. In his work, Anderson discusses the advantages and disadvantages of these general principles and objectives. He argues that the Code's generality and flexibility allows for individual ship companies to implement a SMS more appropriate to the needs of the company workings, and therefore achieve a more successful level of safety culture implementation. However,

[104] 'Development of the ISM Code' (*The International Maritime Organisation*) <http://www.imo.org/blast/mainframe.asp?topic_id=182#background> (accessed 27 February 2014).
[105] This task, however, is often delegated to Classification Societies, as discussed in Chapter 3 of this thesis.
[106] Paragraph 4 of the Preamble to the ISM Code.
[107] Paragraph 5 of the Preamble to the ISM Code.

Anderson goes on further to warn that with this generality comes many individual interpretations and applications of the Code. It is this caveat that can result in difficulty when trying to measure a company's ISM implementation and success.[108]

Therefore, on one level, the ISM Code provides great latitude – recognising that there are many different types and sizes of ship companies, which operate in different ways – but, on another level, it requires each company to achieve certain common objectives, as expected by the international maritime community as a bare minimum, through the development of the company's SMS. Anderson reiterates his belief that despite the ISM Code's objectives being loosely defined, it is a "strength" of the ISM Code that the specific details are left to each individual ship company to work out and develop.[109]

Although the support for the adoption of a mandatory safety culture was great, the ISM Code has been greeted differently by the key members of the international maritime community since its adoption. Many ship companies lack enthusiasm; viewing the Code as an administrative burden amounting to what has often been referred to as a 'paper exercise',[110] and this has had a negative effect on the apparent success of the Code's implementation. For the purposes of this literature review, it is important to examine the reaction of the academic community to this important piece of IMO legislation.

According to Mauritzson, the main advancement for safety came with the development of the company-specific and ship-specific SMS, which is monitored by the very same people that are affected by them.[111] He terms this "safety by self-regulation" and argues that it allows companies to create safety standards that are better tailored to fit the individual company, similar to Anderson's argument above.[112] However, it is suggested that the ISM Code does not allow companies to create their own safety 'standards', but rather that it allows them to create their own 'policies and procedures' for implementing those safety standards, which are set by the maritime community through the IMO. The

[108] Anderson, *Cracking the Code* at p. 47.
[109] P Anderson, 'ISM and ISPS Codes: Influence on the Evolution of Liabilities' (International Colloquium on Maritime Legal Liabilities, Swansea, September 2006) at p. 3.
[110] See, for example, Håvold, 'From Safety Culture to Safety Orientation: Developing a Tool to Measure Safety in Shipping' at p. 91.
[111] B Mauritzson, 'The Master's Perception of Maritime Safety - An explorative study', (MSc Thesis, Chalmers University of Technology 2011) at p. 9.
[112] ibid at p. 7.

author's point here finds support from Chen, who argues that, under the ISM Code, ship companies are left to design a way as to how to "achieve such a [safety] standard."[113]

Knudsen and Hassler claim that over several decades, maritime accident rates have fallen "markedly".[114] Contrast this with Goulielmos, who claims that although the ISM Code has had some success, evidenced by a decline in the number of maritime accidents from 942 in 1998 (the year when the ISM Code's Phase 1 became mandatory) to 847 accidents in 2005, the decline in maritime casualties has in fact been merely "slight"[115] (13 and 6 for the same years respectively).[116]

Although mere semantics, the choice of wording used by Goulielmos would appear to raise doubts about the success of the ISM Code. The opinion of the majority of the academic community is that of Knudsen and Hassler, however. Their claim is supported by, for example, academics such as Schröder-Hinrichs, who argues that the ISM Code is a "major achievement" and has been successful in having "a positive impact on the maritime community."[117] In addition, Knudsen and Hassler claim that the ISM Code has directly resulted in a significant reduction in the number of accidents.[118] Further support for this claim comes from Etman and Halawa, who recognise that there has been a "marked" improvement in casualty records and fewer ships with fewer lives being lost at sea, claiming that this is as a direct result of the ISM Code.[119]

Knudsen and Hassler scrutinise the figures they obtained during their research, and argue that although maritime accidents do still exist, they do so for three main reasons. These are, in increasing order of significance, that: i) it is not possible to eliminate all risks and incidents completely due to the very nature of the industry itself; ii) the ISM Code has not been implemented fully by some Flag States or Flag State

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[113] Chen, 'Legal and practical consequences of not complying with ISM code' at p. 221.
[114] OF Knudsen and B Hassler, 'IMO legislation and its implementation: Accident risk, vessel deficiencies and national administrative practices' (2011) 35 Marine Policy 201 at p. 201. Note that Knudsen and Hassler state in this article that they are relying on statistics from Lloyd's when making this statement, but they do not provide these statistics or any reference to them (See Footnote 3 in their article).
[115] Statistics sourced from the MAIB's database. See Goulielmos, 'The quest of marine accidents due to human error, 1998-2011' at p. 60.
[116] ibid at p. 60.
[117] JU Schröder-Hinrichs, 'Human and Organizational Factors in the Maritime World: Are We Keeping up to Speed?' (2010) 9 WMU Journal of Maritime Affairs 1 at p. 1.
[118] Knudsen and Hassler, 'IMO legislation and its implementation: Accident risk, vessel deficiencies and national administrative practices' at p. 201.
[119] Etman and Halawa, 'Safety Culture, the Cure for Human Error: A Critique' at p. 123.

Administrations; and iii) as a result of this poor implementation, individual ship companies are able to operate without the need to comply with ISM Code requirements.[120] Therefore, in summary, it can be said that the ISM Code has been mostly welcomed by the academic community as a positive legal instrument, but its poor implementation by some Flag States and individual ship companies alike has undermined its apparent achievements. The issue of ISM implementation is considered throughout this thesis.

1.10.5 COMPLACENCY

It has been suggested more recently by the British Chamber of Shipping, amongst other organisations, academics and practitioners, that the ISM Code has become less effective at encouraging and maintaining a safety culture within the maritime community and, as a result, safety standards have started to 'slip'.[121] One main reason put forward for this declining impact is that of 'complacency', both ashore and aboard ship. Complacency has been described in the maritime context as the existence of a false sense of security regarding procedures,[122] or knowingly failing to apply such procedures correctly as a "natural human consequence resulting from familiarity with a task or operation."[123] It is suggested that it is the failure to fully implement the ISM Code that is responsible for this complacency, rather than any failings with the Code itself. The author's view here is supported by a qualitative case study conducted by Bhattacharya, whereby managers who were interviewed as part of the study claimed that, in their experience, most accidents were caused by seafarers' non-compliance with the company's SMS; and this was attributable to complacency.[124] This complacency with the ISM Code evidences the need to find a more effective way of ensuring that the Code is implemented fully, in order to achieve its ultimate purpose and aim of maintaining high safety standards and reduce maritime casualties; the enhanced safety culture.

There are five main areas of concern associated with the issue of ISM complacency: i) implementation and enforcement by Flag State Administrations; ii) implementation by

[120] Knudsen and Hassler, 'IMO legislation and its implementation: Accident risk, vessel deficiencies and national administrative practices' at p. 204.
[121] See Springett, 'Complacency & Maritime Accidents'.
[122] See ibid.
[123] *Annual Report* (The Marine Accident Investigation Branch 2008) at p.1.
[124] S Bhattacharya, 'The effectiveness of the ISM Code: A qualitative enquiry' (2012) 36 Marine Policy 528 at p. 531. Note that the exact word quoted by Bhattacharya is "apathy", which is a synonym of the word complacency.

ship companies; iii) ineffective management and training of seafarers; iv) implementation by seafarers; and v) issues with the auditing of ISM compliance. Of these, the issues relating to implementation are the main areas of concern and they are therefore discussed in turn below.

IMPLEMENTATION BY FLAG STATES ADMINISTRATIONS

Examining first the poor implementation of the ISM Code by Flag State Administrations, it is worth noting that whilst the IMO has set the international regulatory framework for ships by developing the ISM Code, the implementation of the Code itself into national law is the responsibility of the Flag State,[125] to the extent that the ISM Code should prevail over any conflicting national legislation.[126] It is then the sole responsibility of the Flag State Administration (i.e. the institution, or collection of agencies forming an institution, responsible for implementing and enforcing the Flag State's maritime laws and regulations) to enforce the ISM Code within the Flag State's jurisdiction.[127] The IMO has, however, prepared guidelines to encourage a unified international standard of implementation. These guidelines are in the form of a Resolution[128] and, although they are not legally-binding in nature, they do highlight the reason why uniform implementation of the ISM Code by Flag States is necessary.

Issues regarding implementation of the ISM Code by Flag State Administrations have also been identified and, although these issues are discussed in detail in Chapter 3, it is appropriate to provide a basic outline of them here.

Despite the overall welcome by the international maritime community of the ISM Code and the guidance offered by the IMO, studies conducted between 2004 and 2009 show situations still exist where the ISM Code[129] is not being fully implemented by certain Flag State Administrations in their ISM audit and certification of ships.[130] Although it is accepted that poor implementation by Flag State Administrations does not necessarily

[125] Pamborides, *International Shipping Law Legislation and Enforcement* at p.147. The ISM Code was implemented into UK national law by virtue of the Merchant Shipping (International Safety Management (ISM) Code) Regulations 1998 under Section 85 of the Merchant Shipping Act 1995.
[126] Chen, 'Legal and practical consequences of not complying with ISM code' at p. 220.
[127] Knudsen and Hassler, 'IMO legislation and its implementation: Accident risk, vessel deficiencies and national administrative practices' at p. 202.
[128] Resolution A.788(19).
[129] As well as other IMO conventions.
[130] Knudsen and Hassler, 'IMO legislation and its implementation: Accident risk, vessel deficiencies and national administrative practices' at p. 201.

mean that ship companies of that State are operating unsafe ships, maritime disasters and accidents are directly attributable to the deficiencies of the ships involved. Therefore, the failure to detect and correct these deficiencies has allowed those ship companies, which do operate unsafe ships, to continue doing so with "grave irregularities"[131] and too often with grave consequences.[132]

It should be noted that there are significant differences amongst Flag States as to their ability to make the necessary institutional changes and to develop human resource support accordingly. It is clear from the literature reviewed, that in order for the ISM Code to be wholly effective, it needs to be both implemented fully and enforced fully by the Flag State Administration, as well as the necessary safety-orientated attitude adopted by the ship companies (this is where the thesis hypothesis comes into play). Yet, although it is beyond the IMO's remit to actively enforce the ISM Code due to the absence of institutional support and enforcement mechanisms present like those in other international organisations (this often being seen as the greatest limitation of the IMO[133]), the enforcement and 'policing' of the ISM Code does exist at the Flag-State level, through the process of Port State inspection and the detention of non-compliant ships.[134] This critical issue is discussed in great detail in Chapter 3 of this thesis.

It is clear from research undertaken by the IMO, including a detailed study undertaken by the Sub-Committee on Flag State Implementation,[135] that harmonious implementation and enforcement of international legislation is best achieved by those Flag State Administrations that adhere to the IMO's published guidelines.[136] The MCA is an example of a Flag State Administration, which has openly welcomed the ISM Code as the most significant step towards an enhanced safety culture within the shipping industry, and which has utilised and adhered fully to the published guidelines from the IMO pertaining to the incorporation of the ISM Code into national law.

[131] ibid at p. 201.
[132] See Anderson's Safety Triangle above for the commonly accepted rations pertaining to unsafe conditions and fatalities.
[133] Knudsen and Hassler, 'IMO legislation and its implementation: Accident risk, vessel deficiencies and national administrative practices' at p. 203.
[134] Anderson, 'ISM and ISPS Codes: Influence on the Evolution of Liabilities' at p. 3.
[135] Discussed in Chapter 3.
[136] Mitroussi, 'Quality in shipping: IMO's role and problems of implementation' at p. 54.

IMPLEMENTATION BY SHIP COMPANIES

Although Flag States and Flag State Administrations have, in the majority of cases, incorporated the ISM Code into their national law successfully, many ship companies and seafarers have been less enthusiastic. A significant example of this waning enthusiasm can be seen with the SMS manuals of some ship companies, of which there are three main causes for concern.

Firstly, it has been noted in major studies that some ship companies have merely used a SMS belonging to another company instead of developing their own tailor-made SMS to satisfy the specific needs of the individual company, which includes specific procedures for each design of ship within the company's fleet and for the specific operations these ships are specifically engaged in.[137]

Secondly, a common issue, which was identified by Anderson's research, is that of certain ship companies purchasing an "off-the-shelf" SMS from consultancy firms, rather than developing their own tailor-made SMS.[138] These SMS's are not specific to the company, are often generic, and they contain no operation manuals for the specific procedures undertaken by the company and its fleet. Accordingly, these off-the-shelf SMS's often result in significant safety problems on board due to the large amount of "unfitting procedures". This finding is supported by Bhattacharya's qualitative study, in which seafarers interviewed as part of the study claimed that the generic off-the-shelf SMS's did not provide any ship-specific instructions, procedures or checklists, and therefore did not help them to address the eventualities that arose as part of their job on a daily basis.[139] This would appear to support the claim that off-the-shelf SMS's are both wholly irrelevant and ineffective,[140] as well as encouraging of complacency.

Thirdly, it has been observed that some ship companies have failed to update their SMS since they were first written for the 1998 or 2002 deadline.[141] As companies have gained more experience since the coming into force of the ISM Code, especially with regards to learning from mistakes and being engaged in the cycle of continual

[137] Goulielmos, 'The quest of marine accidents due to human error, 1998-2011' at p. 56.
[138] Anderson, 'Managing Safety at Sea' at p. 60.
[139] Bhattacharya, 'The effectiveness of the ISM Code: A qualitative enquiry' at p. 531.
[140] J Lappalainen, Transforming Maritime Safety Culture: Evaluation of the impacts of the ISM Code on maritime safety culture in Finland (Centre for Maritime Studies, Turku, 2008) at p. 38.
[141] Outlined above.

improvement, which Anderson aptly claims is necessary in order to maintain a safety culture,[142] it is expected that companies regularly review and improve their SMS. In addition, many companies will have acquired new ships, often of an unfamiliar design/class to them, and it is expected that they would have amended and improved their SMS in order to take this into account.[143]

The nature of this latter concern would appear to suggest that these ship companies are not actually intentionally acting with disregard to the requirements of the ISM Code. However, it does support the theory that complacency with the Code does exist within the international maritime community. All three concerns have a significant impact on the ISM Code's effect. Without a company-specific SMS, which is regularly revised and updated when the company, crew or inspectors identify any problems with it when it is put into operation, the company is failing to comply with the ISM Code.[144] The company is therefore also failing to embrace the ISM Code fully.[145]

IMPLEMENTATION BY SEAFARERS

It is a commonly accepted view amongst academics that the recent increase in regulations governing maritime safety have directly resulted in a significant increase in workload, and many within the industry see the Code as an "administrative burden",[146] amounting to what has often been referred to as a 'paper exercise' i.e. a situation where companies carry out procedures for the sake of keeping inspectors happy, rather than actually improving safety. This attitude results in negative safety implications,[147] and one key survey undertaken by Anderson appears to support this view. It reveals that there are varied perceptions as to the usefulness of the Code itself. Some participants in the survey believed the Code to be "the most important step […] for the implementation of safety at sea", whilst others believed that it is merely an "industrial white wash"[148] paper exercise and incapable of successfully reducing maritime casualties.

[142] P Anderson, 'The ISM Code: Is It Working?' (2000) 7 International Maritime Law 259 at p. 263.
[143] J Gray, 'Missing the point: the failure of regulation' (IFSMA 31st General Assembly, Mariehamn, June 2005) at p. 8.
[144] Specifically, Paragraph 1.2.2.2.
[145] This is discussed in detail in Chapter 3.
[146] Anderson, *Cracking the Code* at p. 2.
[147] Mauritzson, 'The Master's Perception of Maritime Safety - An explorative study' at p. 52.
[148] Anderson, 'Managing Safety at Sea' at p. 6.

One other major concern relates to the number of instances where on-board personnel are failing to report incidents and near-misses, as required by Paragraph 9 of the ISM Code.

> **Paragraph 9: Reports and Analysis of Non-Conformities, Accidents and Hazardous Occurrences**
> **9.1** The safety management system should include procedures ensuring that non-conformities, accidents and hazardous situations are reported to the Company, investigated and analysed with the objective of improving safety and pollution prevention;
> **9.2** The Company should establish procedures for the implementation of corrective action, including measures intended to prevent recurrence.

Reporting incidents and near-misses provides vital feedback information to the company and it offers opportunities for monitoring safety performance, highlighting areas of concern and making improvements where necessary. In essence, Paragraph 9 encompasses the primary intention of the ISM Code i.e. the engagement of a continual cycle of improvement by progressing safety through learning from past mistakes/experience.

Kongsvik et al. estimate that rates of underreporting are currently between 59% and 70%,[149] and an analysis of accident data from certain databases[150] reveals that only 30% of accidents are actually reported.[151] They cite van der Schaaf and Kanse's research in this area as revealing four main reasons for such a high rate of underreporting: i) seafarers often fear disciplinary action for incidents if they report them; ii) incidents are regarded as part of the job so there is a belief that there is actually no need to report them; iii) shore-based management do not act on incident reports submitted to them, so it actually serves no purpose to submit them; iv) the reporting of incidents is seen as unnecessary and time-consuming.[152] These are discussed in turn below.

Firstly, drawing specifically upon the research undertaken by Bhattacharya, both of the ship companies surveyed as part of the research study made statements in their SMS to the effect that the company recognised the importance of a 'no-blame culture' and

[149] T Kongsvik et al., 'Between a rock and a hard place: Accident and near-miss reporting on offshore service vessels' (2012) 50 Safety Science 1839 at p. 1839.
[150] The Lloyd's Register Fairplay (LRFP) and the Norwegian Maritime Directorate (NMD).
[151] HA Oltedal and DP McArthur, 'Reporting practices in merchant shipping, and the identification of influencing factors' (2011) 49 Safety Science 331 at p. 331.
[152] Kongsvik, 'Between a rock and a hard place: Accident and near-miss reporting on offshore service vessels' at p. 1839.

stressed that the importance of reporting accidents and non-conformities with the SMS was to identify their underlying causes in the hope of preventing them from reoccurring. Statements were also made in the companies' SMSs regarding not apportioning blame. However, when the actual reporting procedures themselves were examined, it was clear that in practice both companies adopted a contrary position. These procedures, and those used for investigating accidents and/or non-conformities, suggested that in both cases the company's primary focus was actually on the identification of those seafarers who were at fault and to apportion blame to them.[153]

For both of these ship companies, the practice of adopting a 'blame culture' resulted in the seafarers fearing disciplinary action, including dismissal, if they reported accidents and non-conformities to the company ashore.[154] This had the undesired effect of encouraging underreporting, which further resulted in undermining the very purpose of the ISM Code.[155] Although Bhattacharya's research was limited to the study of two ship companies, and therefore general assumptions cannot be made, the claim is supported by other leading experts, including Anderson, who argues that although the ISM Code was intended to develop a safety culture within the maritime industry, there exists, instead, a culture of blame and fear.[156] This issue is examined in greater detail later in this thesis.

Secondly, seafarers view incidents as a normal part of their job, which cannot be avoided, and so they do not feel the need to report them to shore-based management when they do occur. Although it is accepted that some incidents are often beyond the control of those on board at the time they occur, and therefore are unavoidable, it is suggested that the reporting of these incidents to shore-based management has a two-fold purpose (if the reports are acted upon accordingly[157]): i) it allows for the identification of problems or deficiencies that may exist in relation to the company's SMS and so allows for it to be amended and improved upon; ii) it allows for corrective action to be taken to prevent the same type of incident or near-miss from recurring in the future. This is the cycle of continual improvement envisaged by the drafters of the

[153] Bhattacharya, 'The effectiveness of the ISM Code: A qualitative enquiry' at p. 532.
[154] ibid at p. 532.
[155] ibid at p. 533.
[156] P Anderson, 'The ISM Code: A Seafarers Perspective' (Corporate Structures: Liabilities & Insurance, London, January 2001) at p. 6.
[157] See the following chapter.

ISM Code and heralded by Anderson as a significant indication of a properly functioning (or 'enhanced') safety culture.

The third reason put forward by Kongsvik et al. for the high rate of underreporting within the maritime community concerns the common perception by seafarers that shore-based management often see the reports as merely a required formality under the ISM Code, but they are not actually concerned with the content of such reports, so they therefore fail to act upon them. Understandably, this gives seafarers the impression that they are undervalued and unsupported by shore-based management in their SMS-related duties.[158] This is a significant area of concern as it is a key requirement for the success of the ISM Code that there is good communication and reporting between ship-based crew and shore-based management.[159]

Finally, there are two issues that exist with regards to the additional paperwork that the ISM Code has created (i.e. the relevant records of day-to-day ship management and the communications and checklists pertaining to on-board operations and safety). The first of these concerns the actual *amount* of paperwork seafarers have to complete as part of their duties under the company's SMS. This was a significant issue revealed by Bhattacharya's research study, whereby the majority of the seafarers surveyed as part of the study stated that they were of the opinion that the ISM Code was overly concerned with paperwork.[160] Additional studies have also revealed that seafarers believe ISM paperwork to be mostly "unimportant",[161] actually resulting in their time and focus being taken away from working safely.[162] These perceptions clearly have a negative impact on the Code's effect and its ability to instil a safety culture.

The second issue regarding ISM paperwork concerns seafarers not taking their ISM-related duties seriously and, as a result, not completing the paperwork correctly. It is common practice for seafarers to complete paperwork "long after [it was] meant to be completed"[163] and to say that required checks had been done when in fact they had

[158] Kongsvik, 'Between a rock and a hard place: Accident and near-miss reporting on offshore service vessels' at p. 1840.
[159] Lappalainen, Transforming Maritime Safety Culture: Evaluation of the impacts of the ISM Code on maritime safety culture in Finland at p. 35.
[160] Bhattacharya, 'The effectiveness of the ISM Code: A qualitative enquiry' at p. 532.
[161] C Le Meur, 'Maritime Safety Culture' (LLM Thesis, University of Northumbria 2003) at p. 19.
[162] Bhattacharya, 'The effectiveness of the ISM Code: A qualitative enquiry' at p. 528.
[163] ibid at p. 532.

not.[164] Furthermore, false 'positive answers' are often provided by seafarers in order to gain approval from the company's onshore management.[165] This inaccurate paperwork does not portray the true situation on board and therefore it detracts from the improvement of safety.

It has also been discovered that most seafarers believe that the task of completing ISM paperwork is inconsistent with their professional identity i.e. that this new responsibility of completing paperwork, created entirely by the ISM Code, should not be part of their on-board duties.[166] It is suggested that this feeling that completing large amounts of ISM paperwork is both time-consuming and unnecessary, evidences complacency within the maritime community and detracts from the objectives of the ISM Code.[167]

However, statistics do show that initial implementation of the ISM Code was a success, beyond the levels of earlier predictions: the IMO have calculated that 87% of the world's ships comply with the requirements of the ISM Code and, when it is considered that the signatories to the SOLAS Convention have only 70% of the world's tonnage, the level of compliance with the Code is clearly a significant attainment.[168] Therefore, it can be said that when contrasting these statistics with those discussed above, the ISM Code can be wholly effective in reducing accidents, but only when it is implemented and embraced fully by the ship companies (as well as the Flag State).

1.10.6 CURRENT ATTITUDES OF THE SHIP COMPANY AND CREW TOWARDS THE ISM CODE

THE SHIP COMPANY

Goss argues that the problem is not that the ISM Code is unsuccessful, but that both good and bad companies are operating together within the same industry.[169] This would certainly fit well with the discussion above pertaining to the varied levels of implementation by ship companies. Goss categorises the practice of ship companies

[164] Anderson, 'Managing Safety at Sea' at p. 46.
[165] Kongsvik, 'Between a rock and a hard place: Accident and near-miss reporting on offshore service vessels' at p. 1845.
[166] ibid at p. 1845.
[167] F Knudsen, 'Paperwork at the service of safety? Workers' reluctance against written procedures exemplified by the concept of 'seamanship' (2009) 47 Safety Science 295 at p. 297.
[168] A Cubbin, *The Effects of the Recent Introduction of the ISM Code* (The Insurance Institute of London 1998) at p. 2.
[169] R Goss, 'Social responsibility in shipping' (2008) 32 Marine Policy 142 at p. 143.

into four distinct types, designating them the 'Canadian' policy, the 'cheapskate' policy, the 'Greek' policy and the 'management-intensive' policy. Relevant to this research are the 'cheapskate' and 'management-intensive' policies, and these are therefore discussed below.

The 'management-intensive' policy is that which is adopted by those ship companies, which are "very good at every aspect of shipping": they operate safe ships, they are good employers, they have a good reputation in the maritime industry, and this results in good profits from reputable consumers.[170]

The 'cheapskate' policy described by Goss is that which is adopted by those ship companies that operate unsafe ships: they typically buy cheap second-hand ships, operate them cheaply, skimp on safety measures and, when prospective repairs become expensive, abandon them and continue with the cycle.[171] The culture of these ship companies is focused on maximising profit at the expense of safety, in the same manner as P&O/Townsend Thoresen was with regards to the *Herald*, and it is these companies that undermine the objectives and success of the ISM Code, and prompt the need for stricter enforcement of the Code's implementation.

THE MASTER AND CREW

Anderson claims that the key to the successful implementation of the ISM Code is to target the masters and crew in order to get them "on side" with the company's SMS. This is because it is seafarers who implement the SMS on board their ship and make it an effective tool in the maintenance of a safety culture.[172] Therefore, it is essential that seafarers understand and appreciate the importance of safety; it is the master who plays a vital role in ensuring that this appreciation is understood and realised (as well as shore-based management).[173]

By virtue of Paragraph 9 of the ISM Code, the master is responsible for implementing and maintaining a safety culture and ensuring that the vessel is operated in a safe

[170] ibid at p. 143.
[171] ibid at p. 143.
[172] Anderson, 'The ISM Code: Is it Working?' at p. 260.
[173] Le Meur, 'Maritime Safety Culture' at p. 76.

manner, with overriding authority in all matters relating to safety on board.[174] Mauritzson's in-depth study outlines and examines this responsibility for establishing and maintaining a safety culture on board, with two central methods of achieving this being proffered: i) the use of safety awareness activities, and ii) the use of a 'punishment and reward' system. It is suggested that the two methods would work well with, and ultimately support, a safety culture.

Mauritzson argues that the main method of promoting safety on board is through safety awareness programmes. These involve, *inter alia*, the master holding regular meetings with the crew and discussing safety-related issues, providing information on the consequences of unsafe behaviour with the use of previous incidents that have occurred on board, or within the company fleet, as a visualisation tool.[175] In addition, Mauritzson hypothesises that significant maritime disasters, such as that of the *Herald of Free Enterprise*, have induced higher safety standards in those masters and seafarers who can remember them.[176] If Mauritzson's hypothesis is accurate, then the recent *Costa Concordia* and *Sewol* disasters,[177] amongst others, will have resulted in a marked (albeit temporary) increase in ISM implementation within the maritime industry, and a consequent decline in the level of complacency.

Mauritzson discusses his second method of promoting safety on board with reference to Zohar and Luria's 'principle of maximum expected utility'.[178] In essence, this principle, when applied to the maritime industry, states that masters must encourage seafarers to take ownership of safety and to transform safety awareness into safety behaviour. This is achieved through the use of a 'punishment and reward' system governing safety-related behaviour.[179] With regards to 'rewarding' the crew this would involve, for example, the master (or shore-based management) contributing[180] to the on-board welfare fund[181] when the ship passes ISM audits and inspections; essentially rewarding the whole crew for their efforts made in the common interest of keeping the ship safe.[182]

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[174] P Neocleous and C Stamatiou, 'Legal aspects of the ISM Code' (2006) 17 International Company and Commercial Law Review 215 at p. 216.
[175] Mauritzson, 'The Master's Perception of Maritime Safety - An explorative study' at p. 40.
[176] ibid at p. 40.
[177] Discussed in Chapter 4.
[178] See D Zohar and G Luria, 'The use of supervisory practices as leverage to improve safety behavior: A cross-level intervention model' (2003) 34 Journal of Safety Research 567.
[179] Mauritzson, 'The Master's Perception of Maritime Safety - An explorative study' at p. 31.
[180] From funds provided to him from the ship company for such purposes.
[181] The funds available to the crew collectively to spend on additional personal facilities or provisions.
[182] Mauritzson, 'The Master's Perception of Maritime Safety - An explorative study' at p. 44.

Another example would be to reward individual crew members for their exceptional contribution to safety on board (for example, producing high-quality non-conformity reports), with a small cash prize or a voucher.[183] With regards to 'punishing' the crew for failing to act safely and detracting from the safety efforts on board, Mauritzson suggests identifying individuals and apportioning blame "beyond disciplinary action".[184] Mauritzson does not expand upon this method and so it is unclear as to how this would be achieved. However, it is suggested that any 'punishment' system adopted would need to work symbiotically with a 'reward' system in order to provide for a 'just culture', and to prevent a 'blame culture' becoming the prevalent method of enforcing safety on board, which would ultimately detract from a safety culture.

1.10.7 CONCLUDING REMARKS

In summary, there is no doubt that the ISM Code is a great welcome to the international maritime community. It is the first piece of legislation coming from the IMO that has demanded a change in behaviour from the shipping industry. The legislation is still relatively new and already there has been a significant reduction in the number of maritime casualties. However, the ISM Code was never expected to achieve zero maritime casualties overnight. Its drafters did expect, on the other hand, the establishment of a cycle of continual improvement made through learning from mistakes.

The Code is a tool for the maritime community to use in order to establish a safety culture, and it fulfils this function well. Accidents will continue to exist but, as is the purpose of the Code, lessons will be learnt and the community will progress up a learning curve. The ISM Code is not about zero errors. Failings lie not with the Code itself but with those who fail to take advantage of it and use it properly and, more significantly, those who have become complacent with its implementation. The issue at hand is how to tackle this complacency in order to ensure that an effective and enhanced safety culture is adopted and maintained by the international maritime community.

[183] ibid at p. 43.
[184] ibid at p. 31.

CHAPTER 2
LEGAL FRAMEWORKS

2.1 INTRODUCTION

Commercial shipping is an international business whereby it is standard for ships to be subjected to numerous and varied jurisdictions during each voyage.[185] From the early twentieth century, an international maritime community has been developing and, since the end of the Second World War, it has become increasingly more regulated. Today, this international maritime community is made up of various stakeholders, including maritime States, major international maritime organisations and institutions, ship companies, seafarers, and maritime lawyers and academics.

This chapter first establishes the legal frameworks for the ISM Code and outlines how it has been adopted as an international legal instrument of the International Maritime Organisation (IMO), cascading down to the regional level of the European Union (EU), before action being taken to incorporate the Code's requirements into the domestic law of the UK. The chapter also provides an outline of the key requirements of the ISM Code and its aims, with a particular focus on the concept of the 'safety culture' outlined in the introductory chapter.

2.2 THE INTERNATIONAL LEGAL FRAMEWORK

Adoption and implementation of an international minimum standard for the safe management and operation of ships is necessary in order to ensure that ships are operated safely throughout the international maritime community. To achieve this minimum standard, it first needs to be outlined and then incorporated into an international legal framework. This not only results in the standard becoming internationally legally-binding, but also results in the harmonised implementation and enforcement of that standard.

[185] H Ringbom, *The EU Maritime Safety Policy and International Law*, vol 64 (Publications on Ocean Development, Martinus Nijhoff 2008) at p. 10.

2.2.1 THE ORIGINS OF THE INTERNATIONAL REGULATION OF MARITIME SAFETY: A BRIEF HISTORY

Historically, maritime States devised their own regulations governing the operation of ships registered under its flag.[186] The sinking of the RMS *Titanic* on 14 April 1912, was the catalyst for the formalisation and regulation of maritime safety on an international level. With the loss of more than 1,500 passengers and crew, the disaster raised serious concerns about the lack of safety standards being implemented on board merchant ships, and led to calls for unifying separate safety agreements that related to ship safety, e.g. the mutual recognition of certificates of survey and a more coordinated approach towards safety of life at sea.[187] In taking the first step, the UK Government held a conference to address these calls and to develop international regulations to govern maritime safety.

The first conference, which was held in late 1913, lasted 10 weeks with representatives from 16 countries. The conference introduced new international standards dealing with safety of navigation, the provision of watertight and fire-resistant bulkheads, life-saving equipment, and fire prevention and firefighting equipment on board passenger ships. These standards were adopted in 1914, as the International Convention for the Safety of Life at Sea,[188] which at the time was the most significant step towards the international regulation of maritime safety, and which today is still the most substantial treaty concerning the safety of merchant ships. However, the 1914 version of the Convention never entered into force due to the outbreak of the First World War.

After the war, the maritime industry took a long time to recover, and even more time to return to the subject of safety. A second international conference was eventually held in 1929 and lasted seven weeks. It was attended by 18 countries and focused more fully on issues relating to the safety of life at sea. The resulting Convention contained proposed rules and principles for international observance under the following headings: construction of passenger ships; life-saving equipment on all ships; radio-telegraphy (communication); navigation; and safety certificates. This version of the Convention became known as SOLAS 1929.

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[186] Discussed below.
[187] C Kuo, *Safety Management and its Maritime Application* (The Nautical Institute 2007) at p. 35.
[188] Herein referred to as the 'SOLAS Convention'.

By 1948, more States were accepting the move towards the international governance of maritime safety as a necessary step in the protection of life at sea. This was evidenced by the third international conference on safety of life at sea being attended by representatives from 30 countries, and the fourth conference in 1960,[189] being attended by representatives from 55 countries. Further conferences took place in 1974, 1990 and 1995. This coming together to establish and coordinate the international governance of maritime safety was the first step in establishing an enhanced safety culture within the framework of an international maritime community.

The purpose of the current version of the SOLAS Convention[190] is to promote safety of life at sea by establishing mandatory minimum standards governing the safe construction of ships,[191] the safety equipment which ships are required to be fitted with, and the standards to which they should be operated in order to avoid accidents.[192] Although it is now the responsibility of the IMO to regularly review the SOLAS Convention and to draft any necessary amendments,[193] the responsibility of implementing and enforcing the Convention's requirements nationally, lies with the individual Flag State,[194] and enforcement with the Flag State Administration.[195] The SOLAS Convention requires Flag States to ensure that merchant ships, which operate under its flag (i.e. registered on its flag/ship registry), are inspected when they are first registered, in order to certify that they comply with the requirements laid down in the SOLAS Convention.[196] Flag States, however, are permitted to delegate this inspection and certification to a recognised organisation, which are usually Classification Societies.[197]

[189] The 1960 version of the SOLAS Convention, which entered into force on 27 May 1965, was the first significant achievement for the Inter-Governmental Maritime Consultative Organization (later renamed the International Maritime Organization), following its creation in 1948, as discussed below.
[190] The International Convention on the Safety of Life at Sea 1974, as amended.
[191] Chapter II of the SOLAS Convention.
[192] Chapter III of the SOLAS Convention.
[193] Following the procedures stated in Article VIII of the SOLAS Convention.
[194] F Lorenzon, 'Safety and Compliance' in Y Baatz (ed), *Maritime Law* (2nd edn, Sweet & Maxwell 2011) at p. 387.
[195] The maritime department or agency of a Flag State's government with responsibility for the implementation of international agreements and national regulations on ships entitled to fly the State's flag.
[196] Article I of the SOLAS Convention.
[197] Discussed in greater detail in the following chapter.

2.2.2 THE IMO: THE INTERNATIONAL REGULATOR OF MARITIME SAFETY

Within the United Nations (UN), two specialised agencies are responsible for legislating on maritime affairs: the International Labour Organisation (ILO) and the IMO. The most significant and authoritative contributor to this international legal framework, especially with regards to safety, and consequently the focus for this chapter, is the IMO.

The IMO develops and adopts conventions and guidelines relating to every facet of shipping, which UN Member States are then internationally bound by. The origins of the IMO lie with the creation of the Inter-Governmental Maritime Consultative Organisation (IMCO) on 6 March 1948.[198] The purpose of this international organisation was to, *inter alia*, encourage the general adoption of the highest practicable standards in matters concerning maritime safety.[199] The creation of the IMCO was a significant step for the maritime community, as it was the first time that an international organisation, as a specialised agency of the UN, had been established with the purpose of bringing the regulation of maritime safety into a harmonised international legal framework. The updating and revision of the SOLAS Convention was the IMCO's first task.

The IMCO had concerns as to the enforcement of the amendments to the SOLAS Convention. These concerns resulted in the IMCO adopting Resolution A.304(III),[200] which stated that the following should be included as part of a revised SOLAS Convention: provisions on speedy entry into force of the Convention; and an improved and accelerated procedure on entering amendments to the Convention into force. These provisions subsequently had a direct impact on the implementation of the ISM Code, as discussed below.

With the growth of world trade and shipping activities, the role of the IMCO changed from a consultative role to that of a more authoritative one. With this change in role

[198] By virtue of the International Convention on the Inter-Governmental Maritime Consultative Organization 1948, herein referred to as the 'IMO Convention'.
[199] Article 1 of the IMCO Convention is still applicable to the IMO.
[200] Resolution A.304(III), International Conference on Safety if Life at Sea, 1974.

came the change in the organisation's name in 1982; from the IMCO to the IMO. This was achieved by virtue of Resolutions A.358(IX)[201] and A.371(X).[202]

2.2.3 THE IMO AND THE LAW OF THE SEA CONVENTION

The UN, in order to establish its authority to outline and regulate the rights and responsibilities of States with respect to the use of the world's oceans, convened the UN Conference on the Law of the Sea in 1956, which became known as 'UNCLOS I'. UNCLOS I resulted in the adoption of four treaties, which were eventually concluded in 1958: i) the Convention on the Territorial Sea and Contiguous Zone;[203] ii) the Convention on the Continental Shelf;[204] iii) the Convention on the High Seas;[205] and iv) the Convention on Fishing and Conservation of Living Resources of the High Seas.[206]

In 1960, the UN held the second Conference on the Law of the Sea ('UNCLOS II'). However, this Conference did not result in any new agreements being formed. In 1967, however, the most significant Law of the Sea Conference was held ('UNCLOS III'). It was attended by representatives of more than 160 countries, and lasted nine years. The Conference ended with the adoption of a 'framework convention,'[207] establishing a 'constitution for the seas', named the United Nations Convention on the Law of the Sea.[208] This Convention defines the rights and responsibilities of States with regards to the use of the world's oceans; establishing guidelines relating to businesses, the environment, and the management of marine natural resources. It introduced a number of provisions, the most significant of which covered setting sea areas for territorial and international waters, navigation, archipelagic status and transit regimes, exclusive economic zones (EEZs), continental shelf jurisdiction, deep seabed mining, the protection of the marine environment, scientific research, and the methods of settling disputes.

[201] Resolution A.358(IX), Amendments to the IMCO Convention.
[202] Resolution A.371(X), Correction of Assembly Resolution A.358(IX).
[203] Entered into force on 10 September 1964.
[204] Entered into force on 10 June 1964.
[205] Entered into force on 30 September 1962.
[206] Entered into force on 20 March 1966.
[207] Leg/MISC.7, Implications of the United Nations Convention on the Law of the Sea for the International Maritime Organization (The International Maritime Organisation 2012) at p. 8.
[208] Herein referred to as the 'Law of the Sea Convention'.

The Law of the Sea Convention was opened for signature on 10 December 1982, and came into force on 16 November 1994; 12 months after the deposit of the 60th instrument of ratification or accession, and in accordance with Article 308 of the Law of the Sea Convention. However, it should be observed that the UK did not sign the original Law of the Sea Convention in 1982, owing to its objections over deep seabed mining provisions.[209] When revisions were made to the Convention, which were deemed acceptable by the British Government at the time, the UK signed, and thus formerly ratified, the Convention on 25 July 1997. With the accession to the Law of the Sea Convention by Azerbaijan on 16 June 2016, there are 168 parties[210] to it; 167 States and the European Union.

In order to avoid any conflict between this UN Convention and the work of the IMO (as the UN's specialised agency responsible for maritime safety), several provisions in the Convention were worded so as to reaffirm the IMO as the "competent international organisation" responsible for the adoption of international shipping rules and standards for matters concerning maritime safety.[211] This suggests that the UN accepts that the IMO has exclusive competence in such matters.[212] The Law of the Sea Convention acknowledges the exclusive competence of the IMO further; requiring Flag States to ensure safety at sea by taking measures that conform to "generally accepted international regulations, procedures and practices."[213] These include, *inter alia*, the SOLAS Convention, as the international maritime community's accepted instrument governing maritime safety.[214]

The UN's Division of Ocean Affairs and the Law of Sea (DOALOS) created a table to assist Member States and to provide a better understanding as to the implications of the Law of the Sea Convention for those organisations, both within and outside the UN system, which deal with maritime affairs within their respective fields of competence.[215] However, the area of maritime safety is not specifically listed in the table, and therefore

[209] PM Leitner, 'A Bad Treaty Returns: The Case of the Law of the Sea Treaty' (1998) 160 World Affairs 134 at p.134.
[210] But only 157 signatories.
[211] As well as navigation and the prevention and control of marine pollution from ships.
[212] Leg/MISC.7, Implications of the United Nations Convention on the Law of the Sea for the International Maritime Organization at p. 7.
[213] Articles 94(3), (4) and (5) of the Law of the Sea Convention.
[214] See Leg/MISC.7, Implications of the United Nations Convention on the Law of the Sea for the International Maritime Organization at p. 15.
[215] *Law of the Sea: Bulletin No. 31* (Division of Ocean Affairs and the Law of the Sea Office of Legal Affairs 1996) at p. 79.

the issue of the IMO's exclusive competence in this area is not affirmed by the DOALOS. Although the DOALOS does not affirm the IMO's exclusive competence, the IMO's Secretariat claims that the following factors indicate the uncontested legitimacy of the IMO as the organisation responsible for the regulation of maritime safety: i) as of 9 November 2016, with the ratification by Belarus, 172 Member States (and three Associate Member States) are party to the IMO Convention and are accordingly members of the IMO; ii) all IMO members are able to participate in the meetings of the IMO bodies, which are responsible for drafting and adopting recommendations relating to safety; and iii) all States, whether or not they are members of the IMO and/or the UN, are invited to participate in the IMO conferences responsible for adopting new IMO conventions.[216] Therefore, it is clear that States are delegating their sovereignty in the area of maritime affairs to the IMO.

However, it is suggested that the strongest affirmation that the IMO has exclusive competence in the international regulation of maritime safety comes from the IMO Convention itself, which to date has been signed by 172 Member States and three Associate Member States. The UN acknowledges the IMO's competency in Article 45 of the IMO Convention, where it is stated that the IMO shall be brought into relationship with the UN in accordance with Article 57 of the UN Charter, as "the Specialised Agency in the field of shipping." Articles 1(b) and 2(b) further support this argument:

> **Article 1(b)**: The purpose of the organization [the IMO] is […] to encourage and facilitate the general adoption of the highest practicable standards in matters concerning the maritime safety, […] and to deal with administrative and legal matters related to the purposes set out in this Article.
>
> **Article 2(b)**: The organization [the IMO] shall […] provide for the drafting of conventions, agreements, or other suitable instruments, and recommend these to Governments and to intergovernmental organizations, and convene such conferences as may be necessary.

These three Articles can be read as effectively confirming that the IMO is the organisation with sole responsibility for establishing and maintaining the international legal framework relating to maritime safety, through its adoption of safety standards in the form of internationally binding conventions, as well as other legal instruments.

[216] Leg/MISC.7, Implications of the United Nations Convention on the Law of the Sea for the International Maritime Organization at p. 8.

With 175 Member States signing the IMO Convention containing these three Articles, it is clear that the international community acknowledges that the IMO has exclusive competence in the area of maritime safety regulation. Therefore, for the purposes of this thesis, the Law of the Sea Convention does not need to be examined in any greater detail.

2.2.4 THE ISM CODE

The most substantial development in the IMO's regulation of maritime safety came with the adoption of the ISM Code in 1998, as discussed in the review of the existing academic literature in the previous chapter.

Although the IMO had some initial success in establishing an international legal framework to regulate maritime safety through various conventions, it became evident from the casualty records of the 1980s and early 1990s, that the IMO conventions in force at the time were becoming increasingly less effective[217] at preventing the large proportion of those maritime accidents, which were attributable to human error and negligence.[218] However, it should be observed that no significant research was undertaken during this time to determine why these conventions were becoming less effective or why maritime casualties were rising. Nevertheless, the IMO embarked on a campaign to "introduce international legislation which would be capable of [effectively] addressing the problem"[219] of unnecessary and unfortunate disasters. This came in the form of the ISM Code and its establishment of a safety culture.[220]

The ISM Code was attached as an amendment to the SOLAS Convention, by virtue of the Convention's Article VIII(b)(iv), as Chapter IX, and entitled 'Management for the Safe Operation of Ships and Pollution Prevention'. As the Code was not implemented through the creation of a new convention, but attached as an amendment to a pre-existing one, it meant that the 'tacit acceptance procedure' (introduced by Resolution 4 to the 1974 SOLAS Convention) could be used to bring the Code into force. This 'tacit acceptance procedure' facilitates the quick and simple modification of conventions and provides that an amendment shall enter into force on a particular date, unless before that

[217] GP Pamborides, *International Shipping Law Legislation and Enforcement* (Kluwer Law International 1999) at p. 147.
[218] Approximately 80%.
[219] Pamborides, International Shipping Law Legislation and Enforcement at p. 147.
[220] As discussed in the previous chapter.

date objections to the amendment are received from a specified number of Member States.[221]

In the case of the ISM Code, this amendment was introduced by an IMO Resolution.[222] It stated that the Code, contained in Annex 2 of the Resolution, would be deemed adopted under Article VIII(b)(vi)(2)(bb) of the SOLAS Convention on 1 January 1998, unless more than one third of contracting States to the Convention, or contracting States the combined merchant fleets of which constituted one less than 50% of the gross tonnage of the world's merchant fleet, notified their objections. Evidencing the community's support of the Code, and its desire to adopt a safety culture, there was no opposition met, and so the ISM Code was successfully attached to the SOLAS Convention. The text of Annex 2 further stipulated that the ISM Code would come into force in two phases. It would be mandatory for: i) certain cargo ships[223] of 500 gross tonnage and upwards, and all passenger ships, by 1 July 1998; and ii) all cargo ships of 500 gross tonnage and more by 1 July 2002. Therefore, from 1 July 2002, all contracting States to the SOLAS Convention were bound to apply the ISM Code to cargo ships of 500 gross tonnage or more, and all passenger ships, either registered on the State's flag registry,[224] and/or visiting the ports of that State.[225]

2.2.5 THE IMO'S GUIDELINES ON ISM IMPLEMENTATION

Whilst the IMO developed the ISM Code and, by doing so, established the international legal framework for the mandatory minimum safety standards for the maritime community, implementation of the IMO's Conventions into the domestic law of Flag States has always been the responsibility of each Flag State itself. The IMO has, however, produced 'Guidelines' to encourage a harmonised international implementation of IMO Conventions, albeit non-binding ones. With regards to the ISM Code, these are found in the IMO's Guidelines for Flag State Administrations on the Implementation of the ISM Code.[226]

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[221] 'Maritime safety: International Safety Management (ISM) Code' (*Europa*) <http://europa.eu/legislation_summaries/transport/waterborne_transport/l24062_en.htm> (accessed 29 October 2014).
[222] Resolution 1 of the Conference of Contracting Governments to the International Convention for the Safety of Life at Sea 1974 (adopted on 24 May 1994).
[223] Oil tankers, chemical tankers, gas carriers, bulk carriers and cargo high-speed craft.
[224] Flag State jurisdiction.
[225] Port State jurisdiction.
[226] Resolution A.788(19), Guidelines on Implementation of the International Safety Management (ISM) Code by Administrations, as amended by Resolutions A.913(22) and A.1022(26).

Although the language used in the preamble to these Guidelines evidences their non-legally-binding nature, it also stresses the need for uniform implementation of the ISM Code by Flag State Administrations. In the preamble, the IMO asserts that there is a need for uniform implementation of the ISM Code, and "urges" governments to adhere to the Guidelines when implementing the Code.[227] It further "requests" that governments inform the IMO of any difficulties experienced when attempting to follow these Guidelines.[228]

The Guidelines instruct Flag State Administrations in how to determine whether a ship company, and its fleet, are in compliance with the requirements of the ISM Code. 'Instructions' are provided by Paragraphs 2.1.3 and 2.1.4:

> **Paragraph 2.1.3**: Determining the conformity or non-conformity of safety management system elements with the requirements specified by the ISM Code may demand that criteria for assessment be developed. Administrations are recommended to limit the development of criteria in the form of prescriptive management system solutions. Criteria for assessment in the form of prescriptive requirements may have the effect that safety management in shipping results in Companies implementing solutions prepared by others, and it may then be difficult for a Company to develop the solutions which best suit that particular Company, operation or ship.
>
> **Paragraph 2.1.4**: Therefore, Administrations are recommended to ensure that these assessments are based on determining the effectiveness of the safety management system in meeting specified objectives, rather than conformity with detailed requirements in addition to those contained in the ISM Code, so as to reduce the need for developing criteria to facilitate assessment of the Companies' compliance with the Code.

Essentially, the Paragraphs instruct a Flag State to base all of its ISM surveys on the ship company's conformity with the requirements of the ISM Code itself, and not on any additional requirements prescribed by the Flag State. These two Paragraphs therefore serve to reiterate two of the key characteristics of the ISM Code, as discussed in the previous chapter: i) it is "based on general principles and objectives;"[229] and ii) it is "expressed in broad terms."[230]

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[227] Paragraph 2 of the Preamble to the Guidelines.
[228] Paragraph 3 of the Preamble to the Guidelines.
[229] Paragraph 4 of the Preamble to the ISM Code.
[230] Paragraph 5 of the Preamble to the ISM Code.

Like the ISM Code itself, the Guidelines provide detailed instructions in some areas, whilst in others remaining somewhat vague and ambiguous. Detailed instructions, however, are provided on the certification process[231] and on how to undertake ISM audits.[232] The UK followed these Guidelines fully when it incorporated the ISM Code into its domestic legislation. Furthermore, the UK's Flag State Administration, the MCA, continues to refer to the IMO's Guidelines in its own guidance and instructions to its ISM surveyors.[233]

In addition to providing detailed instructions on how ships are to comply with the ISM Code, the Appendix to the Guidelines also provides specific requirements and standards, which the audit team involved with the ISM certification should follow. One key standard is to be found in Paragraph 2.3 to the Appendix:

> **Paragraph 2.3**: Any organisation performing verification of compliance with the provisions of the ISM Code should ensure that there exists independence between the personnel providing consultancy services and those involved in the certification procedure.

This standard/requirement goes some way towards addressing the concerns of those maritime academics, such as Falkanger, who argue that the Flag State Administration should undertake the responsibility of ISM auditing and certification, rather than delegate the responsibility to organisations such as Classification Societies, in order to avoid any conflicts of interest, and also to avoid varied standards.[234] However, this concern is somewhat moot with regards to the UK due to the responsibility for ISM auditing and certification being retained by the Flag State Administration (the MCA). The point is also overvalued with regards to the EU due to the EU's 'Recognised Organisation' requirements. The issue of Classification Societies, and the apparent conflict that arises with their undertaking of ISM certification, is discussed in the following chapter, as well as in Chapter 7 of this thesis.

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[231] Paragraph 3.
[232] Paragraph 3.10.
[233] International Management Code for the Safe Operation of Ships and for Pollution Prevention - The ISM Code: Instructions for the Guidance of Surveyors (The Maritime & Coastguard Agency 2009) at p. 71.
[234] T Falkanger et al., *Scandinavian Maritime Law: The Norwegian Perspective* (2nd edn, Universitetsforlaget AS 2004) at p. 71.

2.3 KEY REQUIREMENTS OF THE ISM CODE

One of the key characteristics of the ISM Code is that which is stated in its preamble, whereby it is recognised that no two ship companies are the same, and that different ships operate in a wide range of varying conditions.[235] In order for a ship company to comply with the requirements laid down by the Code, it is necessary merely for the company to have in place an *effective* 'Safety Management System' (SMS). For the purposes of this thesis, a 'ship company' is understood as meaning that which is defined by the Code:

> **Paragraph 1.1.2:** the owner of a ship or any other organisation or person such as the manager, or the bareboat charterer, who has assumed the responsibility for operation of the ship from the shipowner and who, on assuming such responsibility, has agreed to take over all duties and responsibility imposed by the Code.

2.3.1 AN EFFECTIVE SAFETY MANAGEMENT SSYSTEM

By virtue of Paragraph 2, a ship company *should* (emphasis added) establish a policy to ensure that an *effective* (emphasis added) SMS is implemented.[236] This policy is fundamental to, and forms an integral part of, the company's SMS. Furthermore, the company *should* ensure that this policy is maintained at all levels of the company, both shore-based and ship-based.[237] This means that the company is responsible for ensuring that all relevant personnel at all levels of the company with responsibilities relevant to the company's SMS are aware of, and understand fully, the safety policy. For an ISM auditor/inspector, objective evidence of the company satisfying this Paragraph includes: interviews with relevant personnel to establish the level of awareness and understanding; records of internal and external audits; records of corrective and preventative actions and their evaluation; and maintenance plans and records of maintenance of the ship and its equipment.[238]

Under Paragraph 3, the company *should* define and document the responsibility, authority and interrelation of all personnel who manage, perform and verify work

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[235] P Anderson, 'Managing Safety at Sea' (DProf Thesis, Middlesex University 2002) at p. 8.
[236] Paragraph 2.1.
[237] Paragraph 2.2.
[238] *IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Cod*e (International Association of Classification Societies 2005) at p. 11.

relating to any facet of safety.[239] This includes: the person(s) with the highest authority for developing, implementing and maintaining the SMS; person(s) with the overall operational responsibility, and authority relevant to safety; and person(s) responsible for safety on a routine basis. Under this Paragraph, the company is to define the responsibility in key job descriptions for shore-based and ship-based positions that have duties related to the SMS.[240] Importantly, these descriptions are to include the level of knowledge required for the ship types that the company is operating. Objective evidence of the company satisfying this requirement includes: organisational charts; documented details of how the company exercises effective control of the responsibilities of its subcontractors involved in the SMS; documented verification that any subcontractor fully meets the requirements set out in the SMS; documented verification that on-board personnel are aware of who bears full responsibility and has authority relating to the SMS.[241]

Although the ISM Code does not stipulate what constitutes an *effective* SMS, when examining the Code in its entirety, it is clear that in order for a SMS to be *effective*, it must include, *inter alia*: the company's policies, describing the means of ensuring safety of life and providing for a safe working environment[242] (these policies must provide safeguards against all identified risks, and a process for the continuous improvement of the safety management skills of the personnel on board the ships and in the office ashore[243]); instructions and procedures for the safe operation of each ship;[244] procedures for reporting accidents and non-conformities with the SMS, as well as procedures for corrective action to be taken to prevent reoccurrence of such non-conformities;[245] and procedures for emergency situations (these procedures must be reviewed regularly and revised accordingly, and this review will include: the preparedness of the crew being tested regularly with drills and exercises organised by the company;[246] a review of the procedures for internal audits and management evaluations of the SMS[247]); clearly defined levels of authority for every employee who

[239] Paragraph 3.2.
[240] Though it could be argued that all positions have duties which relate to at least some extent the company's SMS.
[241] IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code at p. 12.
[242] As well as the means of ensuring the prevention of pollution and the protection of the marine environment.
[243] Paragraph 1.2.
[244] Paragraph 7.
[245] Paragraph 9.
[246] Paragraph 8.
[247] Paragraph 12.

could impact on issues of safety, which are regularly updated;[248] defined lines of communication between and amongst shore-based and ship-based personnel being reviewed.[249] These are discussed in turn below.

2.3.2 THE DESIGNATED PERSON ASHORE

One of the most important requirements of the Code is that contained within Paragraph 4, which states that the company *should* designate a person, or persons, ashore to have the authority and responsibility to monitor all aspects of the safe operation of the company's fleet, and to act as the link between the company ashore and shore-based personnel. The concept of a Designated Person Ashore (DPA) was somewhat of an "afterthought" with regards to the ISM Code. In the original drafts of the Code, there were no requirements for a DPA; the idea was introduced by the UK delegation to the IMO,[250] following lessons learned from learn the *Herald of Free Enterprise* disaster.[251] Anderson claims that behind the MCA's proposal for the establishment of a DPA was the apparent lack of accountability of the *Herald*'s owners, even though safety concerns had been brought to their attention on various occasions prior to the disaster.[252]

If the requirement for a DPA was, as Anderson claims, an "afterthought", this may be why Paragraph 4 is vague, even for the ISM Code; specifying neither the qualifications the DPA should have, nor the position they should occupy within the company's corporate structure. As a result, there exists a diversity of responses to Paragraph 4. Some DPAs "sit at the right hand of the shipowner", holding a very senior position in the company with many years of management experience at sea as well as ashore, and with the shipowner consulting them before making any major decisions. Within other ship companies, the DPA is often a recent graduate who has never been to sea and who has very little, if any, management experience.[253] Regardless of experience, in practice it has been observed that if the DPA is to satisfy Paragraph 4, and exercise any influence in the company's decision-making process when it comes to safety, they must be given clear authority to do so.

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[248] Paragraph 3.
[249] Paragraph 6.
[250] i.e. the MCA.
[251] P Anderson, 'The ISM Designated Person: Keystone or Scapegoat' *Maritime Risk International* (1 December 2006).
[252] As discussed in the review of the existing literature in the previous chapter.
[253] Anderson, 'The ISM Designated Person: Keystone or Scapegoat'.

Essential to the DPA's ability to satisfy the requirements of this Paragraph, is the direct access they must have to the highest levels of the company's senior management, if they are not themselves part of that senior management.[254] Evidence of this access to senior management may be found in organisational charts, job descriptions and other documents, which define authority and responsibility within the company. Evidence that the DPA has real and effective access to senior management includes: routine and *ad hoc* reports between the DPA and senior management; assorted correspondence; and minutes of management meetings in which the DPA participates.

With regards to the DPA monitoring and providing a link between the company and the fleet, this may include activities such as visits to ships, the review and analysis of reports of accidents and non-conformities, internal audit reports, inspection reports, the minutes of on-board safety and management meetings, and reports of drills and exercises.[255]

The International Association of Classification Societies (IACS) has observed that it is a common misunderstanding that the DPA must be made responsible for the entire administration of the SMS, and for the planning and conduct of internal audits, and that they must act as the "sole conduit" for all contact between ship-based personnel and the company. In practice, the role of DPA is often undertaken by the Technical Superintendent or Operations Manager, and it is more apt to view the DPA as having the responsibility for ensuring that the aforementioned processes are in place and operating as required; but not actually responsible for their practical implementation.[256] Objective evidence of this may include: descriptions of responsibilities, authorities and reporting lines; interviews which establish the awareness (of both shore-based and ship-based personnel) of the DPA's role and identity; the documented monitoring of the safety aspects of the operation of the fleet, such as a review of audit reports, accidents, hazardous occurrences and non-conformities etc.[257]

Thus the role of the DPA is to provide the link in responsibility between the ship and the highest level of management that was missing in many organisations prior to the

[254] For the purposes of this thesis, a ship's master constitutes 'senior management', as discussed in Chapter 6 of this thesis.
[255] IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code at p. 15.
[256] ibid at p. 15.
[257] ibid at p. 15.

adoption of the ISM Code.[258] This new role has been heralded by some as the "keystone" of safety management.[259]

2.3.3 THE MASTER

By virtue of Paragraph 5 of the ISM Code, the company must clearly define the role and responsibilities of each master with regards to: their implementation of the company's SMS;[260] their motivation of the crew in observation of that SMS;[261] and periodic review of the SMS, and the reporting of any deficiencies observed in relation to the SMS to shore-based management (i.e. the DPA).[262]

The master's implementation of the company's SMS may be verified by audits of the various departments on board, and examples of objective evidence may include: accident, near miss and non-conformity reports submitted to the company (via the DPA); a display of the SMS at common places on board; documented interviews with the officers and crew demonstrating their understanding of the SMS; and documentation from regular Safety Committee Meetings (both on board and ashore) and emergency drills and training relating to safety related matters.[263]

Although the master's role in motivating the crew under Paragraph 5, identified as a central theme of the ISM Code, is discussed in the previous chapter, it is apt to provide some further guidance here. Such guidance comes from the IACS, which recommends that the master's motivation of the crew can be achieved by, *inter alia*, the master explaining to the crew how they can *personally* (emphasis added) benefit from the implementation of the SMS, as well as encouraging their perception of ownership and contribution to safety. The IACS suggest that this can be evidenced by: documented regular Safety Committee Meetings, emergency drills, training on safety-related matters, and screening of films; documented safety debates, lectures, competitions, and presentation of safety awards and prizes etc.[264]

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[258] 'Designated Person: Insurance or not?' *The Intermediary* (1 March 2000).
[259] Anderson, 'The ISM Designated Person: Keystone or Scapegoat?'.
[260] Paragraph 5.1.1.
[261] Paragraph 5.1.2.
[262] Paragraph 5.1.5.
[263] IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code at p. 17.
[264] ibid at p. 17.

Furthermore, the company must ensure that the documented SMS on board each ship contains a clear statement, emphasising the master's authority, with particular emphasis on establishing that the master has the overriding responsibility on board to make decisions with regards to safety.[265] This statement establishes the master's duty to act as a 'fail-safe', and to take action considered necessary in the best interest of the safety of the ship, and its crew and passengers, the significance of which is further highlighted in an earlier IMO Resolution.[266] Objective evidence of the master satisfying this Paragraph includes: documentation that the master has exercised their "overriding authority" under the SMS; and documented verification that the master understands the meaning of their "overriding authority".[267]

2.3.4 RESOURCES AND PERSONNEL

Paragraph 6 is a relatively lengthy provision of the ISM Code, detailing the company's responsibilities with regards to resources and personnel. The key parts to this Paragraph are outlined in turn below.

A PROPERLY QUALIFIED MASTER

Paragraph 6.1.1 states that the company *should* ensure that the master of any of its ships is properly qualified for command. Guidance from the IACS recommends that the master's qualification for command, to be verified by the company before assignment to its ships, may be determined with reference to: relevant Flag State and STCW Convention[268] requirements; previous seagoing experience on the same class of ship; and performance reports, including those from previous employers. Objective evidence of this verification includes: the master's certificate of competence, endorsed in accordance with the STCW Convention; the master's CV, stating previous experience on the same class of ship; and the company's written minimum requirements for the master's qualification and experience.[269]

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[265] Paragraph 5.2.
[266] Resolution A.443(XI), Decisions of the Shipmaster with Regard to Maritime Safety and Marine Environment Protection.
[267] IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code at p. 20.
[268] International Convention on Standards of Training, Certification and Watchkeeping for Seafarers 1978, herein referred to as the 'STCW Convention'.
[269] IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code at p. 20.

A MASTER FULLY CONVERSANT WITH THE SMS

Paragraph 6.1.2 states that the company *should* ensure that the master is 'fully conversant with the company's SMS'. This essentially means that the master should be able to demonstrate familiarity with the SMS during on-board inspections and audits, objective evidence of which would include: copies of the master's appraisal records and records of them being monitored and evaluated by the company; records of regular briefings on the SMS at the shore-based office with the company's masters; copies of the master's periodical SMS review submitted to the company; verification, ascertained from interviews, of the company's SMS-related procedures.[270]

A SUPPORTED MASTER

By virtue of Paragraph 6.1.3, the company *should* ensure that the master is given the necessary support so that the master's duties can be safely performed. The DPA, acting as the link between the company and on-board personnel, is responsible for ensuring that this obligation is satisfied, by both the company and the company's masters. Objective evidence of this includes: written reviews and feedback on safety meetings from the company; and documented feedback from the company to the master regarding requests for technical support, spare parts, elimination of deficiencies, additional training requests, responses to emergencies etc.[271]

QUALIFIED AND CERTIFIED SEAFARERS

Paragraph 6.2 provides that the company *should* ensure that each ship is manned with qualified and certified seafarers[272] in accordance with national and international requirements.

With regards to the qualification of on-board personnel, the company should have in place a system for selecting crew, including details on how the selection process should be carried out in accordance with the STCW Convention. This system should also include a verification process for checking that any manning agents contracted by the

[270] ibid at p. 21.
[271] ibid at p. 21.
[272] And medically fit.

company also follow the company's selection policy. This is critical when dealing with multi-national crews.

Examples of objective evidence of compliance with Paragraph 6.2 includes: the company's written recruitment procedures and minimum certification requirements for the appointment of officers; the company's established and documented procedures for ensuring that certificates do not expire; copies of valid certificates held by on-board personnel in accordance with the requirements laid down by the Flag State Administration and the STCW Convention.[273]

PROPERLY FAMILIARISED CREW

Paragraph 6.3 stipulates that the company *should* establish procedures to ensure that new personnel, and personnel transferred to new assignments, are given *proper* (emphasis added) familiarisation with their duties *prior to sailing* (emphasis added). This means that the company is to provide, in accordance with the STCW Convention, written instructions to the master of each of the company's ships, outlining the policies and procedures to be followed in order to ensure that all seafarers, who are newly appointed on board, are given the reasonable opportunity to become familiar with the on-board equipment, operating procedures and other arrangements needed for the proper performance of their duties, *before* being assigned to those duties.[274] Although the ISM Code does not define the key terms used in this provision, their interpretation by the international maritime community can be drawn upon here in order to provide accepted (or acceptable) definitions.[275] These definitions are discussed in turn below.

The term 'new assignments' is understood to mean either a ship, job or position that is new to the individual seafarer.

The term 'essential instructions prior to sailing' is understood to mean those instructions that define the individual seafarer's role within the ship's organisation, and which ensure that they are fully prepared for their role *prior to* (emphasis added) taking up their duties on board. These instructions may include, for example, details of the

[273] IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code at p. 22.
[274] ibid at p. 23.
[275] See ibid at p. 23.

seafarer's responsibilities, their authority, and their interrelationship with other seafarers involved in the SMS.

The term 'familiarisation' is understood to mean the process that allows a seafarer embarking for the first time on board a ship, or being transferred to a new assignment, to become familiar with that ship, its machinery, systems, equipment and operations. This familiarisation may be accomplished, for example, by the seafarer: i) embarking as a supernumerary i.e. shadowing a seafarer who is already undertaking the on-board responsibilities that the seafarer is to undertake as part of their 'new assignment'; ii) receiving essential information and detailed instructions in a language and using terms that the seafarer understands; iii) attending relevant seminars (paid for by the company); iv) observing an on-board overlap whilst the ship is in port i.e. similar to embarking as a supernumerary, but with a phased overtaking of the relevant responsibilities by the seafarer going overlap, before leaving port; and v) being provided with visual aids such as videos, manuals and operating instructions.[276]

The company is responsible for identifying the level and detail of familiarisation required for each individual seafarer undertaking a 'new assignment', and it should devise and implement a system of familiarisation accordingly. Objective evidence of a company satisfying the obligation under Paragraph 6.3 includes: the company's documented training programme for the seafarer; records of the seafarer's attendance at seminars and training courses; the company's evaluation and appraisal reports of the seafarer; the seafarer's responses to interviews and observation of their behaviour during an inspection, demonstrating that they have an appropriate knowledge of the SMS and performing drills satisfactorily; and familiarisation checklists completed by the seafarer and their trainer.[277]

AN ADEQUATE UNDERSTANDING OF THE CREW

Paragraph 6.4 states that the company *should* ensure that all personnel involved in the company's SMS have an adequate understanding of relevant rules, regulations, codes and guidelines. This essentially means that the company should have a plan on how to provide all personnel that are involved with safety, both shore-based and ship-based,

[276] ibid at p. 23.
[277] ibid at p. 24.

with information on the mandatory requirements of the relevant Flag State Administrations, and any applicable regulations and guidelines. Objective evidence that the company has complied with this Paragraph includes: a regularly updated company library, either in hardcopy or electronic format, detailing the relevant rules, regulations, codes and guidelines; copies of this library placed on board each of the company's ships; the testing of all personnel in relation to this library through interviews and inspections.[278]

IDENTIFYING TRAINING NEEDS

By virtue of Paragraph 6.5, the company *should* establish and maintain procedures for identifying any training that may be required in support of the SMS, and ensure that such training is provided for all personnel. In order to identify relevant training the company should take into account factors such as: the previous training and experience of each employee, both shore-based and ship-based; the proficiency of each seafarer in operating ship equipment; the familiarisation of each seafarer with new equipment, and equipment new to them, when they are transferred to a different class of ship; and drills which employees have undertaken, and their individual performance during such drills. Objective evidence of the company satisfying this Paragraph includes: documented company and on-board training plans; records of shore-based and ship-based drills and training; and internal audits and reports.[279]

2.3.5 PLANS FOR SHIPBOARD OPERATIONS

Paragraph 7 states that a ship company *should* establish procedures for the preparation of plans and instructions, including checklists as appropriate, for key shipboard operations concerning the safety of the ship.[280] The various tasks involved should be defined and assigned to appropriately qualified personnel. This Paragraph has significant implications for ship companies, as illustrated in Chapter 4 of this thesis and, although short, there are several key terms within the Paragraph that need to be explained in order to understand its requirements fully. These are discussed in turn here, with reference to their interpretation by the international maritime community.[281]

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[278] ibid at p. 24.
[279] ibid at p. 25.
[280] As well as for pollution prevention, but this is beyond the scope of this thesis.
[281] See IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code at p. 26.

The term 'key shipboard operations' is understood as covering: all operations for which mandatory rules and regulations prescribe performance requirements or specific requirements for plans, procedures, instructions, records and checklists; those operations concerned with a particular ship type; those operations which safe practices in ship operations and a safe working environment have been recommended by the IMO, Flag State Administrations, Classification Societies and other industry bodies;[282] and those operations that the company considers may create hazardous situations if not governed by plans and instructions.

'Procedures for the preparation of plans and instructions' is understood to include, *inter alia*, measures to prevent those risks, which the company identified in accordance with Paragraphs 1.2.2.2 and 1.4.2 of the Code. When developing procedures, the company should take into account all applicable international and national rules and regulations, and any codes, guidelines and standards available for the class of ship to be covered, as well as those relating to relevant/regular operations that the ship is to be engaged in. The IACS recommend that for those companies that have the same on-board procedures for multiple ship classes, they take care to identify the specific procedures that are relevant for each specific ship class.[283]

The term 'qualified personnel' is a term used to denote those individuals who are qualified to identify key shipboard operations and undertake actions required by the company's plans, procedures and instructions. This is based on the individual's adequate technical and operational knowledge relevant to the shipboard operation that is being planned or undertaken. Objective evidence of this includes documented procedures for the preparation of plans, and instructions for key shipboard operations concerning the safety of the ship and its crew.

2.3.6 'SHOULD' OR 'MUST' A SHIP COMPANY COMPLY WITH THE ISM CODE?

The ISM Code's use of the word 'should' has been repeatedly referenced throughout this chapter, through the use of italics. However, it should be observed that, although the Code uses the word 'should' in all of its requirements, including those outlined above, due to the Code's legally-binding nature, it can be assumed that the provisions

[282] As per Paragraph 1.2.3.2 of the ISM Code.
[283] See IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code at p. 27.

and requirements contained within the Code are mandatory, and therefore they ought to be read as meaning 'must'.

2.4 MEASURING ISM COMPLIANCE

Part B of the ISM Code outlines how a SMS' compliance with the Code is to be measured and certified, including the two types of certification: i) Documents of Compliance; and ii) Safety Management Certificates.

2.4.1 DOCUMENTS OF COMPLIANCE

By virtue of Paragraph 13, following an audit, every company found to comply with the requirements of the ISM Code will be issued with a certificate known as a 'Document of Compliance' (DOC). This DOC is to be issued by the Flag State Administration, or by an organisation authorised by the Flag State Administration. In the case of the UK, this is the MCA. The purpose of a DOC is to evidence that the company is *capable of* (emphasis added) complying with the requirements of the Code; not necessarily that the company is in compliance with them.[284] This essentially means that the company has in place all procedures and documentation necessary to implement an effective, working SMS, as discussed above. This DOC, however, is subject to annual verification,[285] and will be withdrawn if either the annual verification does not take place, or if there is evidence of major non-conformity with the Code upon any subsequent inspection, such as a Port State inspection.[286]

2.4.2 SAFETY MANAGEMENT CERTIFICATES

Paragraph 13 goes on further to stipulate that not only should a company be audited and certified, but each of the company's ships should also be audited and certified. A 'Safety Management Certificate' (SMC) is issued to a ship, for a validity of no more than five years, when it is verified that the company, *and* its shipboard management, conduct their operations in accordance with the company's approved and certified SMS.

[284] See Paragraph 13.2.
[285] Paragraph 13.4.
[286] Paragraph 13.5.

The SMC therefore serves as evidence that the ship is in compliance with the requirements of the company's SMS, and therefore the ISM Code.[287]

The validity of each SMC is subject to at least one intermediate verification by the Flag State Administration, or by an organisation authorised by the Flag State Administration, and the SMC will be withdrawn if the intermediate verification does not take place, or if there is evidence of major non-conformity with the SMS upon subsequent inspection.[288] The process of withdrawing DOCs and SMCs is discussed below. Their withdrawal as a method of encouraging implementation of the ISM Code is discussed in greater detail in the following chapter.

2.4.3 INTERIM CERTIFICATION

Under Paragraph 14 of the Code, an interim DOC may be issued to a company that has no practical operational experience of implementing its SMS. This situation arises when the company is either newly established or is newly implementing its SMS (i.e. it has not operated its SMS within three months or longer); or when a company is adding a new ship type/class, which is not listed in its existing DOC. It should be observed that the first of these scenarios rarely arises now, owing to the length of time that the ISM Code has been in force. The interim DOC is issued for a period not exceeding 12 months.

Interim SMCs may also be issued, by virtue of Paragraph 14, to a ship that has no practical operational experience of the company's SMS (i.e. it has not operated under the company's SMS for three months or longer). This can be when either a ship is newly built or when a ship changes ownership from one operating company to another. The interim SMC is issued for a period not exceeding six months. However, this may be extended for a further six months in special circumstances, but only if the Flag State Administration approves such a request.[289]

Both interim DOCs and SMCs are issued by the Flag State Administration, or by an organisation authorised by the Flag State Administration. The issuing of interim DOCs for 12 months and interim SMCs for six months allows for an appropriate length of time

[287] See Paragraph 13.7.
[288] Paragraph 13.9.
[289] See Paragraph 14.3.

in which the company and the ship, respectively, can gain operational experience, sufficient enough to satisfy the requirements of the ISM audits, and therefore be issued with full certificates.

It should be observed, once again, that interim certificates are less commonly used since the ISM Code initially came into force in 1998 (Phase 1). This is because the ISM Code's requirement that all ship companies have in place an effective SMS has been mandatory for some time now, and so it is rare for ship companies not to have operational experience of their SMS (unless they are newly established).

2.4.4 OBSERVATIONS AND NON-CONFORMITIES

During the ISM audit of the ship, 'observations' are made and documented by the auditor, who will then review these observations in order to determine whether they constitute non-conformities, or even major non-conformities, with the approved and certified SMS,[290] or whether they do not amount to non-conformities at the time of the audit but if left uncorrected may lead to one in the future.

An 'observation' is defined by the ISM Code as:

> **Paragraph 1.1.8**: A statement of fact made during a safety management audit and substantiated by objective evidence.

A 'non-conformity' is a term used to describe a particular aspect or state of affairs, revealed during the audit, which constitutes a failure to observe the company's SMS, and is defined by the Code as:

> **Paragraph 1.1.9**: An observed situation where objective evidence indicates non-fulfilment of a specified requirement.

A 'major non-conformity' is defined by the Code as:

> **Paragraph 1.1.10**: An identifiable deviation that poses a serious threat to the safety of personnel or the ship […] that requires immediate corrective action or the lack of effective and systematic implementation of a requirement of the Code.

[290] Resolution A.913(22), Revised Guidelines on Implementation of the ISM Code by Administrations.

A considerable amount of documentary evidence will exist to give the auditor a clear picture as to the gravity of such a non-conformity. Such evidence will include previous corrective action reports and progress reports on the corrective action currently being taken.[291] The auditor will review this documentary evidence in light of their observations in order to determine and categorise the severity of the non-conformance.

Once a non-conformity has been discovered, whether major or minor, the ISM Code requires corrective action to be taken by the company in order to bring the ship back into conformity with the company's SMS, and therefore the ISM Code itself.[292] Contrast this situation with the statement made by Simon Kverndal QC, a prominent maritime lawyer in the UK, who claims that although non-conformities tend to be "numerous and common", only those that are major and/or repeatedly left uncorrected lead to action by the Flag State Administration. In any event, the auditor has the discretion to allow only a maximum time limit of three months from the date at which a minor non-conformity has been uncovered, for the completion of any corrective action. During the time period set, the ship is to be inspected once again to confirm that the corrective action has been implemented. If the non-conformity is not corrected by the date stipulated, then this will automatically generate a major non-conformity. Failure to rectify a major non-conformity, whether this was an initial major non-conformity, or a non-conformity that was 'upgraded' to a major non-conformity following failure to implement corrective action, will initiate the withdrawal process of the ship company's ISM certificates in the following manner.[293]

Firstly, the individual ship's SMC will be withdrawn and consequently it will not be permitted to sail until it is re-audited and a new SMC issued; confirming that it once again complies with the SMS.[294] The Port State Authority[295] is authorised by virtue of

[291] P Anderson, ISM Code: A Practical Guide to the Legal and Insurance Implications (2nd edn, Informa Law 2005) at p. 98.
[292] See Paragraphs 9.2 and 10.2.3 of the ISM Code.
[293] See MSC/Circ.1059/MEPC/Circ.401, Procedures Concerning Observed ISM Code Major Non-Conformities (The International Maritime Organisation 2002).
[294] ibid, per Paragraph 7.
[295] The Port State is the State where the ship is docked. Port State Control is the inspection of foreign ships in national ports to verify that the condition of the ship and its equipment comply with the requirements of international (and that State's national) regulations, and that the ship is manned and operated in compliance with these ('Port State Control' (*The International Maritime Organisation*) <http://www.imo.org/blast/mainframe.asp?topic_id=159> (accessed 26 May 2015)).

the IMO's Procedures Concerning Observed ISM Code Major Non-Conformities,[296] to detain the ship and/or revoke its operating permits, where necessary, to enforce this requirement.[297] It is often said that this process serves as the most significant deterrent for non-compliance with the Code, and is discussed in Chapters 3 and 7 of this thesis.

If the ship's company fails to rectify the ship's major non-conformity within the time period set by the Port State Authority, or the recognised organisation acting on its behalf, the company's DOC will be withdrawn. However, only the Flag State that issued the ship company's DOC may actually withdraw it,[298] and therefore the Port State Authority where the ship is being detained will need to request that the relevant Flag State Administration withdraw the DOC. Provided that there is clear evidence that the company has not complied with the instruction to rectify the ship's major non-conformity, the DOC will be withdrawn in accordance with Paragraph 13 of the Code.

As a consequence of the withdrawal of the company's DOC, all SMCs associated with that DOC will be automatically withdrawn[299] until: i) the DOC is reissued following a successful reassessment of the company's SMS; and ii) a representative sample of the company's ships (at least one ship of each class operated by the company) are also reassessed.[300] Thus if a ship is detained for major non-conformity with the SMS, and this is not rectified by the company effectively and promptly, the company will lose its DOC, and its fleet their SMCs, and therefore will essentially be inoperative. The company will not only incur the cost of rectifying the original major non-conformity, but it will also incur the additional cost of having its SMS and a sample of its ships re-assessed. This, whilst also being unable to operate its ships and thus losing income. These measures strike an appropriate balance in that they ensure that a company operates safe ships, it is given the chance to rectify any serious issues brought to its attention, whilst also being punished harshly, but appropriately, if it does not take safety seriously.

[296] MSC/Circ.1059/MEPC/Circ.401, Procedures Concerning Observed ISM Code Major Non-Conformities.
[297] ibid, per Article 7.
[298] By virtue of Paragraph 13.5 of the ISM Code and Article 3.1.8 of Resolution A.788(19).
[299] Article 5 of MSC/Circ.1059/MEPC/Circ.401, Procedures Concerning Observed ISM Code Major Non-Conformities.
[300] Paragraph 13.5 of the ISM Code and Article 3.1.8 of Resolution A.788(19).

The significant potential impact of these measures means, in reality, that DOCs and SMCs are rarely withdrawn for non-conformities unless they are severe in nature and are repeatedly ignored by the ship's company. This is because companies do not wish to pay the heavier cost of not bringing its ships into conformity at the first opportunity.[301] Thus it is far more cost-effective for ship companies to ensure that their ships are fully ISM-compliant; it would be less cost-effective to allow any non-conformities to remain uncorrected and thus develop into major non-conformities; and even less cost-effective to allow major non-conformities to remain uncorrected. Therefore, although the ISM Code has resulted in an increase in administrative costs, a ship company's full initial implementation of the ISM Code, and its adoption of a safety culture, could produce significant financial savings in the long term.

2.5 REGIONAL LEGAL FRAMEWORK: THE EUROPEAN UNION

Twenty three of the 28 European Union (EU) Member States are Port States, and therefore the implementation of international legislation, and instruments governing maritime affairs by the EU, can be seen as both justifiable and, indeed, sometimes necessary. The EU has always had the competency to undertake activities in three areas of maritime policy: transport, fisheries and energy production. Shipping, which forms part of the EU's Common Transport Policy, was enshrined by the 1957 Treaty Establishing the European Economic Community.[302]

Progress in the area was originally slow, however, with piecemeal proposals being adopted in response to international incidents, rather than as a result of a legislative agenda or policy.[303] This was due to Member States initially being unwilling to give up national control/sovereignty over transport-related issues. Although it has been argued that the European Court of Justice's judgment in the French Seafarers' case in 1974[304] "spotlighted" the Member States' shift in policy towards the EU acting in maritime

[301] S Kverndal, 'The ISM and ISPS Codes: Influence on the Evolution of Liabilities' in DR Thomas (ed), *Liability Regimes in Contemporary Maritime Law* (Informa Law 2007) at p. 153.
[302] Article 84(4) of the Treaty Establishing the European Economic Community. See now Article 100(2) of the Treaty on the Functioning of the European Union.
[303] See, for example, the EU's *Erika* Legislative Packages.
[304] *C-167/73 European Commission v France* [1974] ECR 359. The case was brought before the ECJ due to a French law requiring a certain proportion of a French-registered ship's crew to be of French nationality.

affairs,[305] this case was primarily concerned with the EU principle of free movement of persons, and not with the EU's maritime transport policy. The growing aspiration for the EU to act in the area of maritime affairs actually became apparent when the EU was enlarged by four prominent maritime States: the UK, Ireland and Denmark in 1973, and Greece in 1981.

It was not until the European Parliament successfully took the Council of Ministers to the European Court of Justice in 1983, for failing to implement its treaty obligations,[306] that the EU started to progressively, and actively, exercise its competence to take action in this field.[307] The substantial increase in EU legislative activity in the area of maritime safety coincided with the increase in the international regulation of maritime safety by the IMO, as discussed above.

2.5.1 THE TREATY ON THE FUNCTIONING OF THE EUROPEAN UNION

Since 2007, the EU's competence in legislating on maritime safety has been conferred by Title I of the 2007 Treaty on the Functioning of the European Union.[308] Article 4(2)(g) of the TFEU's Title I[309] expressly states that the EU shall share competence for the area of transport.

> **Article 4**
> (2) Shared competence between the Union and the Member States applies in the following principal areas: […]
> (g) transport.

'Shared competence' means that both the EU and its Member States are free to adopt legally-binding measures relating to transport, which would include maritime transport. However, once the EU has legislated in a particular area, this will then limit the Member States' ability to do so. This is because EU law takes precedence over any national law. In the case of the UK, this principle is enshrined in Section 2 of the European Communities Act 1972.

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[305] L Rudolph, 'The hitherto existing Maritime Policy of the European Union' in P Ehlers and R Lagoni (eds), *Enforcement of international and EU law in maritime affairs* (LIT 2008) at p. 188.
[306] C-13/83 European Parliament v Council of the European Communities [1985] ECR 1513.
[307] Review of the Balance of Competences between the United Kingdom and the European Union: Transport (HM Government 2012) at para 1.3.
[308] Herein referred to as the 'TFEU'.
[309] Title I: Categories and areas of Union competence.

Article 90 of the TFEU's Title VI[310] provides that the EU's objectives in transport matters shall be pursued within the framework of a 'common transport policy'. Whilst Article 100(1) states that the provisions of Title VI only apply to transport by rail, road, and inland waterways, Article 100(2) holds that the European Parliament and the Council, acting in accordance with the ordinary legislative procedure,[311] may also lay down appropriate provisions for sea transport. This includes provisions relating to the duty of Member States to implement the ISM Code into their domestic legislation, and the manner of such implementation.

2.5.2 REGULATION (EC) NO 336/2006

Although the IMO is responsible for creating the ISM Code, in order to ensure that all EU Member States fully comply with the Code's requirements, the EU adopted Regulation (EC) No 336/2006.[312] This Regulation is designed to ensure that the ISM Code is implemented correctly and uniformly in all EU Member States, in order to enhance safety management and the safe operation of ships throughout European waters.[313] Although, it could be questioned why the EU felt it necessary to adopt this Regulation when every EU Member State is already legally-bound by international law to fully implement the ISM Code (due to each EU Member State also being a member of the IMO and a signatory to SOLAS), it can be assumed that it is partly to ensure *harmonisation* throughout the EU.

2.5.3 THE EFFECTS OF REGULATION (EC) NO 336/2006

Although the ISM Code is mandatory throughout the international maritime community, there are some who argue that it falls under the category of 'soft law', because it is essentially unenforceable by the IMO.[314] Others argue that the Code falls under the category of 'hard law' because the concept of 'soft law' is logically flawed.[315]

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[310] Title VI: Transport.
[311] Under the ordinary legislative procedure the Commission proposes a new legal measure. It then only becomes law unless it is jointly adopted by the Council (Ministers from Each Member State) and the European Parliament. For the transport base under Title VI, the Council acts by Qualified Majority Voting where a specified majority of votes is required for the law to be agreed, meaning that a single Member State does not have the power of veto.
[312] Regulation (EC) No 336/2006 of the European Parliament and of the Council of 15 February 2006 on the implementation of the International Safety Management Code within the Community and repealing Council Regulation (EC) No 3051/95.
[313] 'Maritime safety: International Safety Management (ISM) Code'.
[314] Discussed in the following chapter.
[315] See the discussion below concerning legal positivists.

Although the concept of soft law remains controversial in the legal academy, especially when it comes to international law, the debate is worthy of consideration.

There are three schools of thought regarding hard/soft law, as identified by Shaffer and Pollack: i) the constructivist school; ii) the rational institutionalist school; and iii) the legal positivist school.[316]

THE CONSTRUCTIVIST SCHOOL

Constructivists focus on law as a part of a process of social interaction that can shape shared social understandings of appropriate behaviour.[317] For constructivists, the creation of soft law reflects the gradual accumulation and transformative effect of shared understandings and State practices over time.[318]

Tubek contends that soft law instruments serve to: i) generate knowledge through, *inter alia*, the use of benchmarking, setting of minimum standards and the exchange of good practices; ii) develop shared ideas; and iii) establish non-binding standards that can eventually harden into binding rules once uncertainties are reduced.[319] Tubek's argument definitely has merit with regards to the adoption of the ISM Code. As identified in the literature review in the previous chapter, the ISM Code is an attempt to codify accepted industry practice and nationally-adopted legislation throughout the international maritime community. It could therefore be argued that soft law and hard law complement each other.

THE RATIONAL INSTITUTIONALIST SCHOOL

Rational institutionalists are sceptical about the binding nature of international law; arguing that international instruments, at best, serve to signal States' commitments.[320] Abbott and Snidal aptly define the 'legalisation' of international law as varying across three dimensions: i) precision of rules; ii) obligation; and iii) delegation to a third-party decision-maker, such as a court. According to this school of thought, law is only hard if

[316] G Shaffer and MA Pollack, 'Hard and Soft Law: What Have We Learned?' in JL Dunoff and MA Pollack (eds), *International Law and International Relations: Insights from Interdisciplinary Scholarship* (Cambridge University Press 2012) at p. 2.
[317] ibid at p. 2.
[318] ibid at p. 2.
[319] See ibid at p. 10.
[320] ibid at p. 3.

it refers to legally-binding obligations that are precise, and delegates authority for interpreting and implementing the law. Accordingly, rational positivists argue that law is soft when legal arrangements are weak along one of the aforementioned dimensions. Therefore, if an international legal instrument does not delegate authority to a third party to monitor its implementation *and enforcement* (emphasis added), then the instrument would amount to soft law. Relevant to this thesis is if an instrument were to be formally 'binding', but its content vague/ambiguous so that it leaves almost complete discretion to States as to its implementation, rational institutionalists would term this soft law. As already identified in the literature review in the previous chapter, the ISM Code's provisions are vague/ambiguous and therefore rational institutionalists would claim that the ISM Code is soft law.

THE LEGAL POSITIVIST SCHOOL

The third and final school of thought comes from legal positivists. Legal positivists aptly adopt a simple binary binding/non-binding distinction between hard and soft law. This school of thought claims that international law is not really law, and therefore cannot be hard law, because it cannot be enforced[321] i.e. from the perspective of a judge or lawyer, law is, by definition, binding and therefore enforceable by the courts.[322]

Others from the same school, such as Snyder, remain open to the idea that non-binding agreements may retain some characteristics and effects of binding law, but generally agree that the fundamental distinction between hard and soft law is determined by its binding or non-binding nature.[323]

Shaffer and Pollack provide a useful definition that incorporates the various thoughts from the school:

> "We might conceive of soft law in [legal] positivist terms as a codified instrument that is publicised, issued through an institutionalised process, with the aim of exercising a form of authority or persuasion, even though the instrument is not formally legally-binding."[324]

[321] HH Koh, 'Why Do Nations Obey International Law?' (Faculty Scholarship Series, Yale Law School 1997).
[322] See J Klabbers, 'The Redundancy of Soft Law' (1996) 65 Nordic Journal of International Law 167.
[323] See Shaffer and Pollack, 'Hard and Soft Law: What Have We Learned?' at p. 2.
[324] ibid at p. 2.

Two other prominent legal positivists, Reinicke and Witte, are of the opinion that soft-law instruments "can and often do represent the first important element in an evolutionary process."[325] If this definition is to be considered in an ISM context, it could be argued that the Code was the first step towards the establishment of a safety culture.

There are also some legal positivists, such as Klabbers, who deny the concept of soft law because, they claim, all law must be hard law as, by its very definition, law is binding.[326]

Regardless as to whether on the international stage the ISM Code amounts to hard law or soft law, for EU Member States it is equivalent to hard law. This is because when the EU adopted Regulation (EC) No 336/2006, it incorporated the ISM Code into EU law, making it directly applicable[327] and legally-binding, and thus fully enforceable within and by the EU.[328] Therefore, by virtue of Regulation (EC) No 336/2006, the ISM Code is to be considered hard law for all EU Member States, i.e. it gives EU Member States actual legally-binding and enforceable responsibilities (and rights).

In concluding on this issue, for the reasons outlined above, and owing to this thesis being written from a UK-perspective, the ISM Code is to be taken as being 'hard law' for the purposes of this thesis.

2.5.4 GENERAL OBSERVATIONS ABOUT REGULATION (EC) NO 336/2006

Regulation (EC) No 336/2006 has wider scope than the ISM Code. Paragraph 3 of the Code does not apply to fishing vessels or cargo ships less than 500 GT. However, Article 1.3 of the Regulation states that the Code "may be applied to all ships". This means that the ISM Code may be applied to any ship registered within the EU, irrespective of whether it is required by the Code to comply.[329]

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[325] W Reinicke and JM Witte, 'Interdependence, Globalization and Sovereignty: The Role of Non-Binding International Legal Accords' in D Shelton (ed), *Commitment and Compliance: The Role of Non-Binding Norms in the International Legal System* (Oxford University Press 2000) at p. 76.
[326] See G Shaffer and MA Pollack, 'Hard vs. Soft Law: Alternatives, Complements, and Antagonists in International Governance' (2010) 94 Minnesota Law Review 706 at p. 713.
[327] Paragraph 8 of the Preamble to Regulation (EC) No 336/2006.
[328] Paragraph 9 of the Preamble to Regulation (EC) No 336/2006.
[329] International Management Code for the Safe Operation of Ships and for Pollution (The ISM Code): Instructions for the Guidance of Surveyors (The Maritime & Coastguard Agency 2015) at p. 29.

Key provisions of Regulation (EC) No 336/2006 include Articles 4, 5 and 6. Article 4 requires each Member State to ensure that all ships and ship companies operating within its jurisdiction, as defined by Article 3, comply fully with the Regulation; Article 5 states that ships, and the companies operating them, which the Regulation applies to, comply with Part A of the ISM Code; Article 6 states that Member States shall comply with Part B of the ISM Code for the purposes of certification and verification.

Article 10 of the Regulation outlines the reporting requirements for Member States, relating to the implementation of the Regulation (and derogation from it):

> **Article 10 Reporting**
> (1) Member States shall report to the Commission every two years on the implementation of this Regulation.
> (2) The Commission shall, in accordance with the procedure referred to in Article 12(2), establish a harmonised specimen form for such reports.
> (3) The Commission shall, with the assistance of the European Maritime Safety Agency and within six months of receiving the reports from Member States, prepare a consolidated report concerning the implementation of this Regulation, with any proposed measures, if appropriate. This report shall be addressed to the European Parliament and the Council.

Underpinning the wider scope of the Regulation, compared to the ISM Code, and significant for the following chapter, is Article 9 of the Regulation. This Article requires Member States to lay down 'effective, proportionate and dissuasive' penalties for non-compliance with the Code.

2.5.5 THE COMMISSION

The EU Commission plays a significant role in ensuring that Member States implement the ISM Code effectively (by virtue of Regulation (EC) No 336/2006). As outlined above, Article 10 requires each Member State to submit a report to the Commission every two years, on the Member State's implementation of the ISM Code into its domestic law. If, following this report, the Commission and the EMSA are concerned with a Member State's implementation of the Code, the Commission will submit an advisory report to the Member State, as well as to the European Parliament and to the Council. This report will include any suggested recommendations and mandatory measures to be taken by the Member State, in order for it to satisfy its implementation

requirements under Regulation (EC) No 336/2006. If the Member State then fails to implement the corrective measures that the Commission proposed, the Commission has the option to commence infringement proceedings against that Member State, in accordance with Article 258 of the TFEU:

> **Article 258**
> (1) If the Commission considers that a Member State has failed to fulfil an obligation under the Treaties, it shall deliver a reasoned opinion on the matter after giving the State concerned the opportunity to submit its observations.
> (2) If the State concerned does not comply with the opinion within the period laid down by the Commission, the latter may bring the matter before the Court of Justice of the European Union.

Commencement of enforcement proceedings will result in the issue being brought before the EU Court. If the EU Court then agrees with the Commission and rules against the Member State, the Member State will be ordered to implement the corrective measures that were initially proposed by the Commission. If the Member State then refuses, or fails, to implement the corrective measures within the timeframe set by the EU Court, the Commission can invoke Article 258(2) of the TFEU, bringing the matter back before the EU Court. This will result in the EU Court imposing financial penalties on the Member State.[330]

It should be observed, however, that in reality Article 258 infringement proceedings are rarely invoked by the Commission for a Member State's breach of EU law; diplomacy and negotiations between the Commission and the Member State concerned usually resolve the issue of non-compliance before the need to resort to EU Court proceedings. However, Article 258 does serve as an effective enforcement/deterrent measure.

2.5.6 THE EU AND THE IMO

It is estimated that the EU's share of the world's tonnage (i.e. ships flying the flag of an EU Member State) is around 25%, and almost 30% of the world's trade by sea has an EU port of origin or destination.[331] Despite the European maritime industry being a

[330] See *C-65/91 Commission v Greece* [1992] ECR I-5245 as an example of where a Member State delayed compliance with the measures proposed by the Commission, and the consequent actions taken by the EU Court.
[331] W de Ruiter, 'International Maritime Legislation - the EU and Enforcing Resolutions' (2006) 5 WMU Journal of Maritime Affairs 1 at p. 1.

significant part of the international maritime community, the EU is not a full-sitting member of the IMO; its request to be a full member continues to be rejected by the IMO. Instead, the EU has 'observer status', and is represented at the IMO by the Commission. The Commission continues to encourage EU Member States, all 28 of which are full members of the IMO, to ratify and accede to existing international safety conventions.[332]

The EU's request to join the IMO has been a long-running and controversial dispute, with very few EU Member States supporting the application; the majority actually "fiercely" oppose it.[333] Furthermore, the international maritime community itself is unsupportive of the EU's ambitions to represent EU Member States collectively at the IMO. The EU argues that if it held full-member status, and was therefore more actively involved within the IMO's decision-making process, the consistency between European and international standards would be strengthened and harmonised,[334] and this would further ensure the full implementation and compliance of IMO instruments and standards within European waters and ports, including the ISM Code. However, the IMO is strongly opposed to the EU becoming a full member of the IMO because, although the IMO acknowledges that the EU is a supranational power and has acquired shared competence from its Member States in maritime matters,[335] it sees the EU as merely a collection of States that holds no sovereignty. Furthermore, all EU Member States are already full-sitting members of the IMO, so there is no need for the EU to represent them collectively. It has also been argued that there are no ships sailing with an EU flag (the EU has failed to establish a common ship register),[336] and so it is questionable whether the EU would be justified in holding full-membership status in any event. Member States are in full agreement that the EU should not represent them collectively at the IMO, but instead should merely implement the IMO's decisions as a common maritime policy. Despite this, the Commission still pushes for EU membership of the IMO. This has resulted in Member States feeling that the

[332] Review of the Balance of Competences between the United Kingdom and the European Union: Transport at para 1.19.
[333] M Roe, 'Maritime governance and policy-making failure in the European Union' (2009) 1 International Journal of Shipping and Transport Logistics 1 at p. 9.
[334] L Nengye and F Maes, 'Legal Constraints to the European Union's Accession to the International Maritime Organization' (2012) 43 Journal of Maritime Law & Commerce 279 at p. 283.
[335] As discussed above.
[336] Ringbom, The EU Maritime Safety Policy and International Law at pp. 32-34.

Commission is attempting to "usurp" their authority by going against their express wishes, and also those of the international community.[337]

2.6 IMPLEMENTATION OF THE ISM CODE BY THE UNITED KINGDOM

The UK had already been moving towards implementing a defined safety culture within the maritime industry over a decade prior to the adoption of the ISM Code. A clear sign of this can be seen with the 1992 Carver Report,[338] in which Lord Carver called for a framework of primary safety goals to be regulated and enforced by the IMO, as a necessary first step towards reducing maritime disasters.[339] It was lobbying such as this, which led to the drafting of the ISM Code and its adoption by the international maritime community.[340]

The UK, as a "traditional maritime State" with an excellent reputation for operating safe ships,[341] and a founding lobbyer for the creation of the ISM Code, openly welcomed the IMO's attachment of the Code to the SOLAS Convention, as the initial first step towards adopting an enhanced safety culture within the international maritime community. The UK, as a member of both the IMO and the EU, is bound to implement the ISM Code by incorporating it into its domestic law. The ISM Code was initially incorporated into UK domestic law by means of a Statutory Instrument; the Merchant Shipping (International Safety Management (ISM) Code) Regulations 1998.[342] These 1998 ISM Regulations were amended in 2014, in response to, and with the aim of implementing, Regulation (EC) No 336/2006.[343]

[337] See Roe, 'Maritime governance and policy-making failure in the European Union' at p. 10.
[338] *Safety Aspects of Ship Design and Technology* (The House of Lords Select Committee on Science and Technology 1992).
[339] Lord Donaldson of Lymington. 'The ISM Code – The Road to Discovery?' (The Inaugural Memorial Lecture of Professor Cadwallader, London, March 1998) at p. 10.
[340] See the previous chapter.
[341] Donaldson, 'The ISM Code – The Road to Discovery?' at p. 5.
[342] Herein referred to as the '1998 ISM Regulations'.
[343] As discussed above.

2.6.1 THE MERCHANT SHIPPING (INTERNATIONAL SAFETY MANAGEMENT (ISM) CODE) REGULATIONS 2014

The sole purpose of redrafting the 1998 ISM Regulations was to fulfill the UK's obligations imposed by Regulation (EC) No 336/2006. This is evident from the 2014 ISM Regulations themselves,[344] which refer repeatedly to the EU Regulation.[345]

The 2014 ISM Regulations specifically ascribe responsibility and punishment to two categories of individuals within the company: i) the DPA; and ii) the master of each of the company's ships.

THE DPA

Regulation 4 requires companies, which operate ships falling under the scope of Regulation (EC) No 336/2006, to comply with Part A of the ISM Code i.e. the ISM Code's obligations relating to ISM certification.[346]

Regulation 8 of the 2014 ISM Regulations outlines the requirements for 'ISM companies'[347] (i.e. a ship company, in the context of this thesis) to designate a person to monitor the safe and efficient operation of each of the company's ships (a DPA). Regulation 8(1)(b) requires the company to ensure that this DPA is provided with the sufficient authority, resources, appropriate knowledge, and the sufficient experience of the operation of ships in order to discharge their responsibilities.

Regulation 8(2) outlines the duties of the DPA to: i) monitor the safe and efficient operation of the company's ships;[348] ii) ensure that the company complies with the SMS;[349] and iii) ensure that the company's ships are properly manned, equipped and maintained in accordance with the company's SMS.[350] Regulation 8 is equivalent to that of the ISM Code's Paragraph 4.

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[344] The Merchant Shipping (International Safety Management (ISM) Code) Regulations 2014, herein referred to as the '2014 ISM Regulations'.
[345] See, for example, Regulations 2(1), 4 and 5.
[346] Regulation 4(a) requires compliance with Article 5 of Regulation (EC) No 336/2006; Regulation 4(b) requires compliance with Regulation 6 of the 2014 ISM Regulations.
[347] Defined by Regulation 2(1) to mean 'where a person is not the owner of the ship has assumed responsibility for the operation of the ship and has agreed with the owner to take over all the duties and responsibilities imposed by the ISM Code, that person; or in all other cases, the owner of the ship.'
[348] Regulation 8(2)(a).
[349] Regulation 8(2)(b).
[350] Regulation 8(2)(c).

It should be observed that the 1998 ISM Regulations required the DPA to do more than this. They also required the DPA to ensure that the company's ships were operated in compliance with 'other statutory requirements', in addition to the ISM Code.[351] The reason why this additional requirement is absent from the 2014 ISM Regulations is owing to the reason for the redrafting of the Regulations itself. As a result of the EU adopting Regulation (EC) No 336/2006, the UK was bound to implement the ISM Code in the manner prescribed by Regulation (EC) No 336/2006, and therefore the Code and its terminology were 'mirrored' in the 2014 ISM Regulations. Thus, because the 2014 ISM Regulations were required to implement fully Part A of the ISM Code, there is little need for the Regulations to mention 'other statutory requirements'; these are covered under Part A of the Code by virtue of Paragraph 1.4.2. This Paragraph requires companies to develop, implement and maintain its SMS in compliance with relevant international and Flag State legislation.

THE MASTER

Regulation 7 requires the master of every one of the company's ships to operate their ship in accordance with the SMS on the basis of which the SMC was issued. This Regulation essentially mirrors Paragraph 5 of the ISM Code.

Guidance from the UK Government states that, with regards to Regulation 7, the responsibility for overseeing and implementing all relevant aspects of the company's SMS on board the ship rests with the master. The same guidance document states that the company should provide clear guidance to its masters concerning their responsibility on matters affecting the safety of the ship, including its passengers and crew.[352] It further stipulates that there *must* (emphasis added) be a clear and unequivocal statement in the SMS that the master has overriding authority with regards to deviating from the SMS in times of crisis.[353] Regulation 7, therefore, is essentially the UK's equivalent to Paragraph 5 of the ISM Code.

[351] Regulation 8(2)(b).
[352] International Management Code for the Safe Operation of Ships and for Pollution (The ISM Code): Instructions for the Guidance of Surveyors at p. 33.
[353] ibid at p. 34.

DETENTION OF SHIPS UNDER REGULATION 14

A key component of the 2014 ISM Regulations is Part 4, which attempts to satisfy the UK's duty under Article 9 of Regulation (EC) No 336/2006 to impose effective, proportionate and dissuasive penalties for non-compliance with the ISM Code. Regulation 14 deals with the detention of ships for non-compliance with the 2014 ISM Regulations.

> **Regulation 14 Detention**
> (1) Where an inspector has clear grounds for believing that, in relation to a ship to which these Regulations apply, there has been a failure to comply with regulation 4, 5, 7 or 8 or a breach of any term of an exemption granted under regulation 12 or a derogation from the ISM Code granted under Article 7 of the EU Regulation, or there will be if the ship puts to sea, the ship is liable to be detained.

Regulation 14(1) establishes an [MCA] inspector's authority to detain ships found to be contravening Regulation 4, 5, 7 or 8. The inspector may, by virtue of Regulation 14(2), permit a detained ship to sail for the purpose of proceeding to the nearest appropriate repair yard available. If the authority under Regulation 14(1) is exercised, then the inspector must serve the master of the ship a detention notice, stating the grounds for the detention and the terms of the notice to be complied with before the ship is to be released.[354]

Highlighting the severity of detaining a ship for non-compliance with the Regulations and, due to the Regulations' very nature, the ISM Code itself, is Regulation 14(7). Regulation 14(7) requires that when a ship is detained under Regulation 14(1), the Secretary of State[355] is to immediately inform the consul or diplomatic representative of the State where the ship is registered, or the appropriate maritime authority of that State.

Regulation 14(7) states that the inspector must release the ship at the request of the ship's master or its company if: proceedings for an offence under Regulation 15 have not been commenced within seven days; such proceedings have concluded and the

[354] Regulation 14(5).
[355] For the Department of Transport.

master or the company have been convicted; £30,000 has been paid by way of security;[356] or if the release of the ship is ordered by a court.

INDIVIDUAL LIABILITY AND PUNISHMENT UNDER REGULATION 15

A primary focus of the author's research and the thesis hypothesis is that of the potential of individual liability for corporate manslaughter to be used alongside the ISM Code to encourage the adoption of an enhanced safety culture. Whilst there is no such individual liability for corporate manslaughter under UK law at present, there is individual liability for breaching the 2014 ISM Regulations, as found within Regulation 15(2).

> **Regulation 15 Offences and penalties**
> (2) Any contravention of—
> (a) regulation 7; or
> (b) regulation 8(2),
> is an offence, punishable on summary conviction by a fine not exceeding the statutory maximum [i.e. £5,000], or on conviction on indictment by imprisonment for a term not exceeding two years, or a fine, or both.

The DPA and the master are specifically identified by Regulation 15 as being liable for punishment if they contravene the Regulations (i.e. Regulation 7 and 8(2) respectively). These two categories of individual have overall responsibility for safety on board the company's ships. The master, by virtue of Paragraph 5.2 of the ISM Code, also has the overriding authority and the responsibility to make decisions with respect to safety. It is therefore understandable why the 2014 ISM Regulations would single out these specific individuals in the way that it does.

The 2014 ISM Regulations, by virtue of Regulations 15(2)(a) and 15(2)(b), acknowledge the key role that these two categories of individual play in ensuring that a company's ships are operated safely. The possibility of being personally fined £5,000, a relatively significant amount for either of these individuals, as well as receiving a criminal conviction, for breaching the 2014 ISM Regulations, is a substantial deterrent for the individuals concerned. However, the prospect of receiving a sentence of two years imprisonment is an even more substantial deterrent and, although this sentence would only be imposed by the courts in very serious and exceptional circumstances, the

[356] Or an amount less than £30,000 if it is deemed acceptable by the Secretary of State.

prospect should encourage the individuals concerned to comply 'more fully' with their ISM duties, in order to avoid the possibility of imprisonment.

One weakness of the 2014 ISM Regulations, however, is that they do not identify any other category of individuals within the company that could be liable for non-compliance with the Regulations and the ISM Code. Individual liability for all the senior management should be included within the Regulations. This is discussed in Chapter 6 of this thesis, as part of the support for the thesis hypothesis.

'EFFECTIVE, PROPORTIONATE AND DISSUASIVE' PENALTIES

Although Regulations 14 and 15 introduce the concept of both corporate and individual liability and punishment into maritime safety legislation (i.e. for non-compliance with the 2014 ISM Regulations), they do so rather inadequately. As discussed above, Article 9 of Regulation (EC) No 336/2006 requires EU Member States to lay down penalties that are 'effective, proportionate and dissuasive.' It is the author's opinion that the fines, which can be imposed on ship companies for contravention of Regulation 14 and 15, are neither effective, proportionate, nor dissuasive, for large ship companies like those operating within the UK, with annual turnovers in the millions of pounds range.

In order for a criminal penalty to be 'effective, proportionate and dissuasive', it must serve as a deterrent from offending and re-offending.[357] The 2014 ISM Code Regulations' reference to the statutory maximum fine of £5,000 is not a significant enough amount to serve as an appropriate punishment for non-compliance with the ISM Code, and therefore it is not an effective deterrent. This is especially so when it is considered, for example, that the cost of bringing the ship (back) into compliance is often greater than the cost of the fine itself. As a result, companies often knowingly operate ships that are not in full compliance with ISM requirements and, by doing so, run the risk of them failing an inspection, so as to continue trading and generating profit.[358] Therefore, with regards to punishing the company for non-compliance with

[357] See MG Faure, 'Effective, Proportional and Dissuasive Penalties in the Implementation of the Environmental Crime and Ship-source Pollution Directives: Questions and Challenges' (2010) December European Energy and Environmental Law Review 256 at p. 259.

[358] This point is well illustrated by the case of the *Terry Siete* in 2012. In this case, the company continued to flout a prohibition notice because it was more financially beneficial to the company to keep the ship operating and to pay the fine, than to take the ship out of service immediately and spend the money to bring the ship into compliance with the Code. See 'UK: Shipping Company Pays Fines because of ISM Code Abuse' *World Maritime News* (14 March 2013)

the ISM Code, there is no true 'effective, proportionate and dissuasive' penalty currently imposed by UK domestic law.

With regards to punishing those key individuals responsible for safety within the ship company who fail to undertake their ISM duties accordingly (i.e. the DPA and the master), oon the face of it the 2014 ISM Regulations satisfy the UK's obligation to impose 'effective, proportionate and dissuasive' penalties under Article 9 of Regulation (EC) No 336/2006.

A somewhat more 'effective, proportionate and dissuasive' punishment for ship companies would be the possibility of individual senior managers of that company[359] receiving a custodial sentence for the company's breach of a relevant provision of the 2014 ISM Regulations (specifically Regulations 4, 5 or 8). This possibility of imprisonment would send a clear signal to ship companies, and the 'corporate individuals' within that company,[360] that the law takes seriously compliance with the ISM Code, and that failure to comply may result in a significant punishment for those individuals identified as liable for the company's breach. However, it often proves problematic for the law to identify such an individual liable within a large corporate structure such as the large ship companies operating from the UK today, and this is addressed in Chapter 6 of this thesis.

2.7 CONCLUDING REMARKS

It is clear that the ISM Code is needed in order to provide a minimum standard for the safe management and operation of the world's ships. So too is it clear that the IMO is needed in order to establish and regulate the international legal framework that the ISM Code is a part of. Although regional implementation of the ISM Code should not be necessary to ensure implementation of the ISM Code by Flag States, action taken by the EU has provided for harmonised implementation of the Code by its Member States. This can be seen with Regulation (EC) No 336/2006 and its effect on the UK's ISM Regulations, which incorporate the ISM Code into UK domestic legislation.

<https://worldmaritimenews.com/archives/78845/uk-shipping-company-pays-fines-because-of-ism-code-abuse/> (accessed 15 September 2017).

[359] Identified via the process discussed in Chapter 6, as part of the thesis hypothesis.

[360] i.e. members of the company's management who make decisions regarding the activities of the company (e.g. directors, executives and other senior managers).

The 2014 ISM Regulations fall short, however, when it comes to the UK's duty to lay down penalties that are 'effective, proportionate and dissuasive'. This means that there is no real punishment for non-implementation of the Code by ship companies and corporate individuals, and therefore no effective deterrent. It is therefore clear that more effective means of ensuring ISM compliance are needed.

CHAPTER 3
ENFORCING ISM IMPLEMENTATION

3.1 INTRODUCTION

This chapter outlines and analyses the different methods of enforcing the implementation of the ISM Code. It first examines the efforts of enforcing the Code's implementation, internationally by the International Maritime Organisation (IMO), and regionally through Port State Control regimes. The role of the Maritime and Coastguard Agency (MCA) in enforcing ISM implementation in the UK is considered, as well as the role of Classification Societies. The chapter also considers proposed alternative measures of enforcing/encouraging ISM implementation.

Throughout this chapter, two distinct types of enforcement are considered, namely those which come under the category of 'administrative enforcement' and those which come under the category of 'criminal enforcement'. The chapter concludes by providing a basic outline of the author's proposal for individual liability for corporate manslaughter, which forms the basis of the thesis hypothesis.

3.2 ENFORCEMENT OF ISM IMPLEMENTATION INTERNATIONALLY BY THE IMO

Although the IMO is the most significant and authoritative contributor to the international maritime legal framework, it is often seen as the 'weakest link' in enforcing the implementation of the legislation that it creates.[361] As noted in the previous chapter, the IMO was established to provide harmonisation of maritime safety governance through the creation of a well-structured hierarchy, with the IMO at the top and the national maritime administrations of each Member State connecting the IMO to the ship companies.[362] This was as a result of the international maritime community's realisation that the methods of governance that had previously been adopted by individual States acting unilaterally, and without co-ordination by a governing body,

[361] OF Knudsen and B Hassler, 'IMO legislation and its implementation: Accident risk, vessel deficiencies and national administrative practices' (2011) 35 Marine Policy 201 at p. 203.
[362] ibid at p. 203.

were not universally effective, and ultimately resulted in varying standards throughout the international maritime community.[363]

It remains the responsibility of individual Member States to implement IMO legislation, but the IMO acknowledges that some Member States lack the expertise, experience and resources to implement IMO legislation effectively.[364] In order to address this issue, the IMO set up the specialised 'Sub-Committee on Flag State Implementation' in 1992, to improve the harmonisation of the implementation of IMO legislation by its Member States. This sub-committee, later renamed the 'Sub-Committee on Implementation of IMO Instruments',[365] works under the following terms of reference:

> "Under the direct instructions of the Maritime Safety Committee and the Marine Environment Protection Committee, the FSI Sub-Committee, in addressing the effective and consistent global implementation and enforcement of IMO instruments concerning maritime safety and security and the protection of the marine environment, will consider matters related to the following subjects, including the development of any necessary amendments to relevant conventions and other mandatory and non-mandatory instruments, as well as the preparation of new mandatory and non-mandatory instruments, guidelines and recommendations, for consideration by the Committees, as appropriate:
>
> (1) comprehensive review of the rights and obligations of States emanating from the IMO treaty instruments;
> (2) assessment, monitoring and review the current level of implementation of IMO instruments by States in their capacity as flag, port and coastal States and countries training and certifying officers and crews, with a view to identifying areas where States may have difficulties in fully implementing them;
> (3) identification of the reasons for the difficulties identified in (2) above, taking into account any relevant information collected through, *inter alia*, the assessment of performance, the investigation of marine casualties and incidents and the in-depth analysis of port State control (PSC) activities, while paying particular attention to the perceived difficulties faced by developing countries;
> (4) consideration of proposals to assist States in implementing and complying with IMO instruments. Such proposals could be implemented by States or by the Organization in a harmonized and co-ordinated manner and could include the development of any necessary amendments to relevant conventions and other mandatory and non-mandatory instruments, as well as the preparation of new mandatory and non-mandatory instruments,

[363] K Mitroussi, 'Quality in shipping: IMO's role and problems of implementation' (2004) 13 Disaster Prevention and Management 50 at p. 51.
[364] 'Implementation of IMO instruments' (*The International Maritime Organisation*) <http://www.imo.org/en/OurWork/Safety/Implementation/Pages/ImplementationOfIMOInstruments.aspx > (accessed 21 April 2014).
[365] Herein referred to as the 'Implementation Sub-Committee'.

guidelines and recommendations, for consideration by the Committees, as appropriate;
(5) development and maintenance of a system for the analysis of investigations into marine casualties and incidents, with a view to putting in place an efficient and comprehensive knowledge-based mechanism to support the identification of trends and the IMO rule-making process;
(6) review of IMO standards on maritime safety and security and the protection of the marine environment, with a view to maintaining updated and harmonized guidance on survey and certification-related requirements;
(7) development and maintenance of a framework to promote the global harmonization and co-ordination of PSC activities; and
(8) consideration of and action on any recommendations or instructions from IMO bodies related to the work of the Sub-Committee."[366]

3.2.1 IMO GUIDELINES

A key responsibility of the Implementation Sub-Committee, as identified in the terms of reference above, is the creation of 'Guidelines' to assist Member States in their implementation of IMO legislation. The Implementation Sub-Committee created the 'Guidelines on the Implementation of the International Safety Management (ISM) Code by Administrations'[367] on 23 November 1995.[368] These have been revised numerous times, the latest version of which (at the time of publication of this thesis) is that adopted by IMO Resolution A.1071(28) on 4 December 2013, which came into effect on 1 July 2014.

These ISM Guidelines, though being in the form of an IMO Resolution, are not legally-binding. A distinctive feature of them, however, is that they are directed towards Flag State Administrations, whereas the ISM Code is primarily directed towards ship companies. They consist of an 'Introduction', which briefly sets out the background to the ISM Code, a synoptic statement of the Code's mandatory application, and a statement of the auditing and certification responsibilities of the Flag State Administration. Apart from this introduction, the ISM Guidelines consist of three sections,[369] which address the scope and application of the Guidelines, the verification of Code compliance, and the certification process.[370]

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[366] See Agenda Item 20 of the Maritime Safety Committee's 80th Session.
[367] Herein referred to as the 'ISM Guidelines'.
[368] Resolution A.788(19), Guidelines on Implementation of the International Safety Management (ISM) Code by Administrations.
[369] In the original version of the ISM Guidelines (Resolution A.788(19)) there were four sections: 1) Scope and Application, 2) Verifying Compliance with the ISM Code, 3) Issuance and Validity of DOC and SMC, 4) the Certification Process.
[370] PK Mukherjee, 'The ISM Code and the ISPS Code: A Critical Legal Analysis of Two SOLAS

For the purposes of this chapter, it is the section pertaining to the verification of Code compliance that is most relevant. This section states, *inter alia*, that Flag State Administrations 'should' verify compliance with the ISM Code by determining: the conformity of the company's SMS with the requirements of the ISM Code, and that the SMS ensures that the objectives outlined in Paragraph 1.2.3 of the ISM Code are met.[371] The Guidelines go on to state that in order to determine conformity, Flag State Administrations 'may' develop assessment criteria, but this criteria should not be in the form of prescriptive management system solutions, as this may have the undesired effect of ship companies implementing a SMS prepared by others, and not a one best suited for that particular company, or the operation of its ship.[372] It is suggested that these Guidelines do not offer any real or valuable guidance to Flag State Administrations, but simply paraphrases the requirements to be found in the ISM Code itself. Therefore, the value of these Guidelines is questionable, and would appear not to aid in the IMO's aim of obtaining harmonisation of ISM Code implementation.

3.2.2 THE HARMONISED SYSTEM OF SHIP SURVEY AND CERTIFICATION

The IMO, in recognising the importance of the harmonisation of the enforcement of maritime safety legislation, including the ISM Code, established a 'Harmonised System of Ship Survey and Certification',[373] which entered into force on 3 February 2000.[374] This Harmonised System covers those IMO shipping Codes and Conventions[375] that require the issuing of certificates to evidence that requirements have been met, and which can involve the ship being out of service for several days. This Harmonised System was established in order to alleviate the problems caused by the various surveys required, and the intervals between the surveys not coinciding, so that a ship would no longer have to go into a port or a repair yard for a survey required by one Convention, shortly after doing the same thing in connection with another.

Regimes' (2007) 6 WMU Journal of Maritime Affairs 147 at p. 154.

[371] Article 2.1.2 of Resolution A.1022(26), Guidelines on the Implementation of the International Safety Management (ISM) Code by Administrations.

[372] ibid, per Article 2.1.2.

[373] Herein referred to as the 'Harmonised System'.

[374] By virtue of Resolution A.883(21), Global and Uniform Implementation of the Harmonized System of Survey and Certification (HSSC).

[375] These are: the International Convention for the Safety of Life at Sea (SOLAS) 1974, the International Convention on Load Lines 1966, the International Convention for the Prevention of Pollution from Ships 1973 (as modified by the Protocol of 1978 relating thereto (MARPOL 73/78)), the International Code for the Construction and Equipment of Ships Carrying Dangerous Chemicals in Bulk 1985, and the International Code for the Construction and Equipment of Ships Carrying Liquefied Gases in Bulk 1985.

However, with regards to the ISM Code, specific requirements regarding the issuing, validity and expiration of DOC and SMC certificates are provided.[376] Furthermore, in practice, many Flag State Administrations and Classification Societies operate under a form of harmonised survey and certification. This is especially so with the UK, which has implemented a survey and certification system as part of a regional Port State Control (PSC) regime (discussed below).

3.2.3 THE IMO'S SURVEY ON ISM IMPLEMENTATION AND IMPACT (2005)

In 2005, the IMO conducted a survey to assess the impact and effectiveness of implementation of the ISM Code.[377] As part of this survey, a 'Group of Independent Experts', selected from administrations, organisations, academics and the shipping industry, were tasked to analyse the impact of the ISM Code and its effectiveness in the enhancement of safety of life at sea. The Group developed four questionnaires for ship-based personnel, shore-based personnel, ship companies and Flag State Administrations.

Although the survey was in-depth, and it provides statistical data relevant to the theme of this thesis, it was conducted in 2005; not long following the time when the ISM Code initially came into force. It is therefore out-of-date and this does not reflect present-day implementation and impact data. Therefore, only a brief summary of the findings is appropriate here.

Thirty two Flag State Administrations participated in the survey. The majority were fairly satisfied with the Code and felt that its objectives were being met. However, most wanted modifications to the Code itself.[378]

Thirty-nine ship companies participated, and stated that they continued to invest heavily in ISM (in terms of effort, human resources and money), but they too suggested that the Code and the concept of ISM needed re-thinking in terms of:

[376] Discussed in the previous chapter.
[377] MSC 81/17/1, Role of the Human Element: Assessment of the impact and effectiveness of implementation of the ISM Code (The International Maritime Organisation 2005).
[378] ibid at Annex p. 14.

1. reducing the amount of paper work
2. improving ISM training
3. increasing the involvement of seafarers in the preparation and development of the company's SMS
4. improving measures to encourage compliance/deter non-compliance.[379]

The majority of the 89 shore-based personnel were in favour of the ISM Code and felt that the company's SMS was working well but that there was some room for improvement. The three main areas of improvement identified were:

1. making the SMS simpler and easier to use
2. providing better ISM training
3. having all company personnel, especially seafarers, involved in the development of the SMS.[380]

It was also observed that companies were seeing a decrease in incidents/accidents on board their ships as a direct result of the ISM Code.[381]

The large majority of the 2702 seafarers who participated in the survey were of the opinion that the ISM Code had had a significant positive impact on the way in which operations were being conducted on board their ships, and that lives were considerably safer as a result of the ISM Code.[382]

Although the findings are somewhat out-of-date, even in 2005, it appears that there were calls for better implementation of the Code at the ship company and seafarer level, especially with regards to more involvement and better training, and even the suggestion of better measures of ensuring compliance. However, these issues, unlike the calls for the ISM Code itself to be amended, are issues to be dealt with at the Flag-State level (discussed below).

These findings are certainly indicative of the international maritime community's attitudes towards ISM during the early stages of the Code coming into force, and the findings are well supported by other sources of data. However, they do not, it is suggested, reflect the community's attitudes at the time of this thesis being published, for reasons discussed throughout this thesis. Nor do they reflect the increasing upward

[379] ibid at Annex p. 19.
[380] ibid at Annex p. 20.
[381] ibid at Annex p. 23.
[382] ibid at Annex p. 27.

trend of ISM complacency. It is surprising that the IMO has not repeated this survey (or a similar one) since, so as to compare and contrast the results, and thus capture a more accurate picture of the situation following the ISM Code's initial 'honeymoon period'. There is certainly the need for one.

3.3 ENFORCEMENT OF ISM IMPLEMENTATION REGIONALLY BY PSC REGIMES

Another way in which the IMO claims to enforce its legislation across its Member States is through PSC regimes. This is the regional coordination of the inspection of foreign ships in national ports, to verify that they comply with IMO legislation. Most of the IMO's Conventions contain provisions for ships to be inspected when they visit foreign ports, including the SOLAS Convention, of which the ISM Code is attached to.[383]

A PSC inspection of a ship is not pre-arranged; it is carried out on a selective basis. Some have argued that the ISM Code would be better enforced if ships undergoing PSC inspections were to be selected depending on their geographical area of navigation, because it is commonly accepted that there are locations where accidents most frequently take place (evidenced by total losses of ships). This point is well received, and so it is argued that these geographical areas should be listed as very high-risk areas, and ships operating in these areas selected for inspection at a higher rate than others.[384]

Because a ship that visits a port in one Member State usually goes on to visit a port in another Member State in the same region, the IMO encourages the establishment of regional PSC regimes, known as Memoranda of Understanding (MOU). Although some criticise regional PSC regimes for detracting from the harmonisation efforts of the IMO by implementing different standards,[385] they are considered by the IMO to be a 'safety net' to catch what Flag State Administrations often miss.[386] Criticism may also be directed towards regional PSC regimes for their ability to inspect only a "fraction" of

[383] See Part B of the SOLAS Convention.
[384] AM Goulielmos et al., 'The quest of marine accidents due to human error, 1998-2011' (2012) 1 International Journal of Emergency Services 39 at p. 56. Note that this is what one regional PSC regime has done since 2011, and this is discussed in detail below.
[385] Mitroussi, 'Quality in shipping: IMO's role and problems of implementation' at p. 57.
[386] Knudsen and Hassler, 'IMO legislation and its implementation: Accident risk, vessel deficiencies and national administrative practices' at p. 203.

ships visiting port.[387] Some MOUs have managed to overcome this criticism by successfully adopting inspection regimes designed to target substandard ships. An example of this can be seen with the Paris MOU, to which the UK is a participant.

3.3.1 THE PARIS MEMORANDUM OF UNDERSTANDING

The Paris MOU was the first regional PSC regime to be established, and covers Europe, parts of the Russian Federation and Canada.[388] Significantly, in May 2009, the Paris MOU adopted the 'New Inspection Regime' at its Committee meeting in Reykjavik, Iceland. The New Inspection Regime was developed by a 'task force' led by the EC, with factual leadership delegated to the European Maritime Safety Agency (EMSA), and came into force on 1 January 2011.[389] This task force was established because both organisations have close ties with each other, owing to 24 of the 28 participants of the Paris MOU being Members of the EU.[390] Furthermore, the EU had to take the New Inspection Regime into account when drafting its Directive on Port State Control.[391]

Prior to the New Inspection Regime, participating States to the Paris MOU were obligated to inspect a random sample of at least 25% of those foreign ships entering their ports each year.[392] However, with the introduction of the New Inspection Regime, the 25% quota for inspections to be performed by each individual Member State was abandoned. An alternative 'fair share' method is now adopted, whereby a Member State selects ships to inspect based on the ship's 'Ship Risk Profile'. These profiles categorise a ship as being either a 'High Risk Ship', a 'Standard Risk Ship', or a 'Low Risk Ship'.

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[387] ibid at p. 203.
[388] The current Member States of the Paris MOU are: Belgium, Bulgaria, Canada, Croatia, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Latvia, Lithuania, Malta, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, Slovenia, Spain, Sweden and the UK.
[389] 'New Inspection Regime (NIR) & Ship Risk Profile (SRP) Calculator' (*The European Maritime Safety Agency*) <www.emsa.europa.eu/psc-main/new-inspection-regime.html> (accessed 23 April 2014).
[390] Austria, the Czech Republic, Luxembourg and Slovakia are not members of the Paris MOU owing to them being landlocked States and having no ports.
[391] Directive 2009/16/EC of the European Parliament and of the Council of 23 April 2009 on port State control.
[392] MLP Groenleer et al., 'Regulatory governance through EU agencies? The implementation of transport directives' ((Re)Regulation in the Wake of Neoliberalism: Consequences of three decades of privatisation and market liberalisation, Utrecht, June 2008) at p. 11.

CALCULATION OF THE SHIP RISK PROFILE

The criteria that a PSC inspector will use in order to calculate a ship's risk profile are: i) the performance of the ship company, taking into consideration the reported deficiencies and detentions of the company's fleet within the previous 36 months;[393] ii) the class and age of the ship; iii) the number of reported deficiencies and detentions of that particular ship within the previous 36 months; iv) the performance of the Flag State Administration where the ship is flagged/registered; and v) the performance of the Recognised Organisation/Classification Society that has certified the ship. This information is obtained through the 'THETIS' database, which is managed, hosted and operated by the EMSA.[394]

Expanding on criterion 4 above, the Paris MOU categorise Flag State Administrations as belonging on a 'White List', a 'Grey List' or a 'Black List'. The White List represents Flag State Administrations whose ships have a consistently low record of detentions and a high standard of ISM implementation. Flag State Administrations with an average performance are placed on the Grey List, and those whose ships have a high record of detention are placed on the Black List. Some, such as Sagen, have heralded these types of lists as a positive contributed to a safety culture, but have also called for it to be developed further.[395]

TYPES OF INSPECTION

There are two types of inspection under the New Inspection Regime. These are periodic inspections and overriding inspections. The conduction of periodic inspections is determined by use of the table below. For Low Risk Ships and Standard Risk Ships, an 'Initial' inspection is undertaken, with a 'More Detailed' one being undertaken if 'clear grounds' are established for one.[396] For High Risk ships, an 'Expanded' inspection is undertaken.[397] Furthermore, bulk carriers, chemical carriers, gas carriers, oil tankers and passenger ships older than 12 years automatically undergo an expanded inspection.[398]

[393] Based on the IMO Company Number.
[394] See Article 24 of Directive 2009/16/EC.
[395] Discussed in Chapter 6 of this thesis.
[396] See Article 13 of Directive 2009/16/EC.
[397] See Article 14 of Directive 2009/16/EC.
[398] See Article 14 of Directive 2009/16/EC.

Ship Risk Profile	Inspection Frequency[399]
Low Risk Ships	24-36 months after last inspection
Standard Risk Ships	10-12 months after last inspection
High Risk Ships	5-6 months after last inspection

Table 3.1: Frequency of Periodic Inspections Under the New Inspection Regime

There are two priorities that override the normal timeframe for inspection. Priority I states that a ship 'will be inspected' when it has been involved in a collision, stranding or grounding *en route* to the port; its class has been withdrawn; or it has been operated in an unsafe manner.[400] Priority II states that a ship 'may be inspected' if it has been reported by a pilot or agent etc; its certificates were issued by a Recognised Organisation/Classification Society whom recognition has been withdrawn (discussed below); or its master has failed to comply with the reporting requirements outlined below.

REPORTING REQUIREMENTS

The master of a High Risk Ship (or bulk carriers, chemical carriers, gas carriers, oil tankers and passenger ships older than 12 years) must notify the PSC authority of the ship's intended arrival at the port or anchorage 72 hours in advance, or before its departure if the intended voyage is less than 72 hours. All other ships must provide an arrival notification at least 24 hours in advance, or on departure if the intended voyage is less than 24 hours.[401]

REFUSAL OF ACCESS

Member States are under a duty to refuse entry of any ship that falls into one of the following categories: it is registered in a country that is on the 'black list' and has been detained on two occasions in the previous 36 months; it is registered in a country which is on the 'grey list' and it has been detained in the past 24 months; it has not reported to

[399] See Article 11 of Directive 2009/16/EC.
[400] See Article 11 of Directive 2009/16/EC.
[401] See Article 9 of Directive 2009/16/EC.

the repair yard as ordered by a previous inspector; or it has previously jumped detention.[402]

A ban is lifted after three months, if it is the ship's first ban; after 12 months, if it is the ship's second ban; and after 24 months, if it is the ship's third ban. Following a third ban, a ship is permanently banned if, after 24 months, the ship is not: registered in a country that is on the 'white list'; certified by a recognised organisation that is approved by the EU; and managed by a high-performing ship company.

In order to monitor EU Member States' compliance with Paris MOU requirements, the EMSA undertake visits to inspect and assess the head offices of the national maritime authorities of Flag State Administrations. A methodology for these audits was defined and tested for the first time in 2004,[403] and an audit coordinator appointed in 2005.[404] The audits are performed by delegations comprising of at least three assessors, who are experts in the field of maritime safety, and who have often been previously employed by Flag State Administrations.[405] As part of this methodology, the permission of the Member State to be audited is not required; the Member State is merely informed by the EMSA of the intended visit.[406]

The delegation reports a summary of its findings on site to the Flag State Administration, immediately following the audit. Within 20 days, an official report on this audit is submitted to the EU Commission, and copied to the national maritime authority that was inspected. However, the final report of the audit, which also includes the Commission's assessment of that report, is often not published until up to two years later. On the basis of the EMSA's report, the Commission can decide to take corrective action and/or propose sanctions against the Member State if there is concern. It should be observed that when deciding on such action or sanctions, the Commission assesses whether the Member State has effectively applied the requirements; not whether the Member State has in place an effective inspection system. This approach can be criticised as there may exist a situation where a Member State has in place inspection

[402] See Article 16 of Directive 2009/16/EC.
[403] See *Annual Report 2004* (The European Maritime Safety Agency 2004) at p. 26.
[404] See *Annual Report 2005* (The European Maritime Safety Agency 2005) at p. 13.
[405] Groenleer, 'Regulatory governance through EU agencies? The implementation of transport directives' at p. 12.
[406] Article 3 of Regulation (EC) No 1406/2002 of the European Parliament and of the Council of 27 June 2002 establishing a European Maritime Safety Agency.

systems and procedures which are effective, or even more effective than those imposed by the EU and the Paris MOU, but because they are *different* from those imposed, the Commission requires the Member State to change its inspection systems and procedures so that they are in line with the EU's.[407] However, the implementation of the EU's rules is vital in ensuring the *harmonisation* (emphasis added) of Port State control amongst its Member States.

STATISTICS RELATING TO THE NEW INSPECTION REGIME

In the year 2012, there were 18,308 inspections undertaken by PSC inspectors from Paris MOU Member States, which was down by 4% from 2011, as a result of the New Inspection Regime.[408] Despite the number of detentions dropping from 688 in 2011 to 669 in 2012, however, the percentage of detentions rose from 3.61% to 3.65%. Furthermore, the number of ISM-related deficiencies recorded show an increase of 5.6% from 1,644 in 2011 to 1,736 in 2012.[409]

From these statistics, one of two inferences can be drawn: either the New Inspection Regime is working effectively at targeting more High Risk ships and detaining those that are dangerously unsafe, and which would previously have had a 75% chance of escaping inspection and detention under the old inspection regime (whereby a random 25% of ships entering port were inspected); or there has been a rise in the number of ships failing to comply with the ISM Code and other maritime safety legislation. If the latter is true, then it raises serious concerns about the implementation of the ISM Code, which would need to be addressed at the international level. However, statistics post-2012 support the first of these possible inferences, as discussed below.

[407] See Groenleer, 'Regulatory governance through EU agencies? The implementation of transport directives' at p. 13.
[408] Annual Report 2012: Port State Control - Taking Port State Control to the Next Level (The Paris Memorandum of Understanding 2012) at p. 18.
[409] ibid at p. 21.

3.4 ENFORCEMENT OF ISM IMPLEMENTATION BY THE UK

3.4.1 THE MARITIME AND COASTGUARD AGENCY

As discussed in the previous chapter, the Maritime and Coastguard Agency (MCA), as a specialised executive agency of the Department of Transport, acts as the Flag State Administration of the UK, implements the Government's maritime safety policy in the UK, and works to prevent the loss of life on the coast and at sea. The MCA's responsibilities include, *inter alia*, inspecting and surveying ships to ensure that they are meeting UK and international safety regulations, including the ISM Code.[410] Therefore, the MCA has two roles to play in enforcing implementation of the ISM Code: ISM auditing and certification of UK ship companies and UK-registered ships, in its role as the Flag State Administration; and the inspection of foreign ships that enter UK ports, in its role as the Port State Authority.

THE MCA ENFORCEMENT UNIT

In addition to acting as ISM auditors and certifiers, the MCA has a dedicated Enforcement Unit, tasked to investigate significant breaches of merchant shipping regulations, and to make recommendations for prosecution where warranted. These recommendations are then reviewed by the Head of Enforcement and by the Director of Strategy and Finance who, on behalf of the Secretary of State for Transport, decide whether criminal proceedings should be commenced.[411]

The Enforcement Unit, however, is very small and comprised of only one Principal Officer and three Enforcement Officers, as well as two support staff.[412] Therefore, in practice, all the MCA's surveyors that work out of the 18 Marine Officers around the UK, undertake responsibilities relating to enforcement.[413]

The role of 'Enforcement Officer' was created by the Merchant Shipping Act 1995. Section 256 of the Act outlines four categories of Enforcement Officer.

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[410] 'About Us' (*The Maritime & Coastguard Agency*) <www.dfta.gov.uk/mca/mcga07-home/aboutus> (accessed 21 April 2014).
[411] See 'Enforcement Policy' (*The Maritime & Coastguard Agency*) <www.dft.gov.uk/mca/mcga07-home/aboutus/mcga-aboutus-transparency/enforcement_policy.htm> (accessed 21 April 2014).
[412] See U Jurgens, 'Enforcement of UK Merchant Shipping Legislation' (PhD Thesis, University of Southampton 2009) at p. 10.
[413] See 'Marine Offices' (*The Maritime & Coastguard Agency*) <www.dft.gov.uk/mca/mcga07-home/aboutus/contact07/marineoffices.htm> (accessed 21 April 2014).

The first category, established by Section256(9)(a), is that of 'Departmental Inspector', whose purpose is to report to the Secretary of State for Transport:

Section 256(1)

(a) upon the nature and causes of any accident or damage which any ship has or is alleged to have sustained or caused;
(b) whether any requirements, restrictions or prohibitions imposed by or under this Act have been complied with or (as the case may be) contravened;
(c) whether the hull and machinery of a ship are sufficient and in good condition;
(d) what measures have been taken to prevent the escape of oil or mixtures containing oil.[414]

The Merchant Shipping Act gives Departmental Inspectors full discretion to board a ship at any reasonable time, provided that they believe that it is necessary for them to go on board.[415] By virtue of the Act, a Departmental Inspector:

Section 259(2)

(a) may at any reasonable time (or, in a situation which in his opinion is or may be dangerous, at any time)—
    (i) enter any premises, or
    (ii) board any ship,
    if he has reason to believe that it is necessary for him to do so;
[…]
(c) may make such examination and investigation as he considers necessary;
[…]
(e) may take such measurements and photographs and make such recordings as he considers necessary for the purpose of any examination or investigation under paragraph (c) above;
(f) may take samples of any articles or substances found in the premises or ship and of the atmosphere in or in the vicinity of the premises or ship;
(g) may, in the case of any article or substance which he finds in the premises or ship and which appears to him to have caused or to be likely to cause danger to health or safety, cause it to be dismantled or subjected to any process or test (but not so as to damage or destroy it unless that is in the circumstances necessary);
[…]
(i) may require any person who he has reasonable cause to believe is able to give any information relevant to any examination or investigation under paragraph (c) above—
    (i) to attend at a place and time specified by the inspector, and
    (ii) to answer (in the absence of persons other than any persons whom the inspector may allow to be present and a person nominated to be present by the person on whom the requirement is imposed) such questions as the inspector thinks fit to ask, and

[414] Section 256(1).
[415] Jurgens, 'Enforcement of UK Merchant Shipping Legislation' at p. 12.

(iii) to sign a declaration of the truth of his answers;

(j) may require the production of, and inspect and take copies of or of any entry in,
   (i) any books or documents which by virtue of any provision of this Act are required to be kept; and
   (ii) any other books or documents which he considers it necessary for him to see for the purposes of any examination or investigation under paragraph (c) above.

Section 256(6) establishes another category of Enforcement Officer, known as an 'Inspector appointed under Section 256(6)'. The purpose of these inspectors is to serve improvement or prohibition notices only.[416] These inspectors, therefore, are not accorded the same powers as a Departmental Inspector with regards to boarding a ship and inspecting it.

The category 'Surveyor of Ships'[417] is created by Section 256(9)(b). A Surveyor is empowered by virtue of Section 258 to inspect a ship in order to determine whether it complies with UK and international safety regulations. However, a Surveyor is distinct from a Departmental Inspector, in that a Surveyor does not hold the powers provided under Section 259(2) to inspect the premises of the ship company; they are restricted to inspecting only the ship and its equipment under Section 258(1).[418] Relevant to this thesis, is a Surveyor's power to audit a ship's compliance with the ISM Code, established by Regulation 14 of the 2014 ISM Regulations, and discussed in greater detail below.

Section 256(9)(c) uses the term 'Departmental Officer' in its reference to Enforcement Officers. However, this is a generic term used to refer to any Enforcement Officer appointed under Section 256, including Surveyors and Inspectors, as discussed above. By virtue of Section 257(1)(a), a Departmental Officer derives additional powers whenever they suspect that the ISM Code is not being complied with. These powers are:

[416] Under Sections 261-266.
[417] Herein referred to as a 'Surveyor'.
[418] Except by virtue of Section 258(4) where the Surveyor has reasonable grounds for believing that provisions and water are stored for use on board UK ships and these do not conform to safety regulations.

Section 257(1)(a)

(a) to require the owner, master, or any of the crew to produce any official log-books or other documents relating to the crew or any member of the crew in their possession or control;
(b) to require the master to produce a list of all persons on board his ship, and take copies of or extracts from the official log-books or other such documents;
(c) to muster the crew; and
(d) to require the master to appear and give any explanation concerning the ship or her crew or the official log-books or documents produced or required to be produced.

The purpose and powers of the Departmental Officer is dependent upon the original role of the Enforcement Officer.[419]

ENFORCEMENT OF THE ISM CODE

As discussed above, the MCA, as the UK's Flag State Administration, enforces maritime safety regulations, including the ISM Code, through its audits and inspections. Non-compliance of these regulations by the ship company or master may result in administrative or criminal sanctions. When an inspector boards a ship in port to conduct an ISM audit, they do so following the procedures set out in the Paris MOU's New Inspection Regime.

The MCA divide offences as relating to either: i) pollution; ii) collision regulations; iii) unsafe operations by the ship company; iv) conduct endangering by the master and crew; v) the carriage of dangerous goods; or vi) fraud (concerning seafarer documentation). The MCA has the option to impose administrative sanctions for non-compliance of the ISM Code, which include: for individual seafarers – notifications of concern, a caution, or an inquiry into the seafarer's fitness to hold a Certificate of Competency; for the ship company – follow up inspections, prohibition notices, improvement notices, notifications of concern, a caution, or more significantly, detention of the ship.[420]

[419] For a full discussion on the function and powers of Enforcement Officers see Jurgens, 'Enforcement of UK Merchant Shipping Legislation' at pp. 10-18.
[420] 'MCA Enforcement Policy Statement' (*The Maritime & Coastguard Agency*) <www.dft.gov.uk/mca/mcga07-home/aboutus/mcga-aboutus-transparency/enforcement_policy.htm> (accessed 21 April 2014).

3.4.2 DETENTION OF NON-COMPLIANT SHIPS

As discussed in the previous chapter, the MCA can withdraw a UK ship company's DOC if that company does not have in place an effective SMS, or a ship's SMC if the company's SMS is not being implemented on board. Although the MCA's withdrawal of a ship's SMC does not represent detention of the ship, owing to ships not being permitted to sail without a valid SMC by virtue of Regulation 6(1) of the 2014 ISM Regulations, the withdrawal of a SMC has an equivalent effect.

When looking at the number of prosecutions, especially in comparison to the number of detentions, it is clear that criminal prosecution is not used as a primary means of enforcing the ISM Code. This is in accordance with the MCA's policy not to prosecute individuals unless they are personally responsible for the breach of the ISM Code/Regulations.[421] However, it is suggested that criminal prosecutions should be used more regularly by the MCA as a means of enforcing the implementation of the ISM Code and other maritime safety legislation. If prosecutions/convictions were more common, then this would have a two-stage domino effect: ship companies would wish to avoid the hassle and negative publicity that comes with the company and/or one if its employees being prosecuted, and so it would take appropriate action to ensure that the SMS was being implemented fully; individual seafarers would have the threat of criminal prosecution at the fore of their minds when conducting their SMS-related duties on board, and so take better care to comply with their legal duties i.e. to implement the company's SMS fully. This increase in on-board ISM-implementation would result in a more enhanced safety culture within the UK maritime industry; reducing the number of unsafe acts/conditions, and therefore reducing the chance of there being an accident or fatality (Anderson's terminology). This is an issue that is discussed in more detail in Chapters 6 and 7 of this thesis.

3.5 THE ROLE OF CLASSIFICATION SOCIETIES

The ISM Code ushered in a new culture of safety and a "new principle of maritime responsibility,"[422] but its success is wholly dependent on the proper execution of its

[421] See Jurgens, 'Enforcement of UK Merchant Shipping Legislation' at p. 401.
[422] 'ISM Code brings change - and for the better' *Fairplay* (7 June 2001).

certification and auditing functions.[423] As discussed in the previous chapter, Articles 1 and 3 of the SOLAS Convention[424] place this responsibility on the Flag State Administration. However, the Flag State Administration is entitled under the SOLAS Convention to delegate the responsibility of auditing and certifying to a 'Recognised Organisation'.[425] These are usually the leading Classification Societies that comply fully with the minimum requirements laid down in the guidelines developed by the IMO,[426] specifically it's Guidelines for the Authorisation of Organisations Acting on Behalf of the Administration,[427] as well as its Specifications on the Survey and Certification Functions of Recognised Organisations Acting on Behalf of the Administration.[428] This is in recognition that many Flag State Administrations do not have the adequate technical experience, manpower, or global coverage to undertake all the necessary statutory inspections and surveys using its own staff.[429] The UK has, however, chosen to retain the responsibility for certification and auditing, and therefore conducts all ISM Code audits itself through its Flag State Administration; the MCA. However, Flag State retention of ISM certification responsibilities appears to be the exception to the norm, with most Flag States delegating ISM certification responsibilities to a Classification Society.

Whilst Classification Societies have always played an active role in the certifying and classification of ships, their role has developed as the international maritime community itself has developed. Originally formed by marine insurance underwriters to assess the integrity of ships, they later became responsible for certifying whether ships conformed to private classification standards and public regulations on safety at sea.[430] Their role as 'certifiers of safety' is a new "stratum of responsibility",[431] created solely as a result of the adoption of the Code. Some argue that this has resulted in an "upheaval"[432] within the maritime community. It is important to examine this criticism in order to

[423] S Kverndal, 'The ISM and ISPS Codes: Influence on the Evolution of Liabilities' in DR Thomas (ed), *Liability Regimes in Contemporary Maritime Law* (Informa Law 2007) at p. 159.
[424] As Chapter IX.
[425] By virtue of Regulation 6 of Part B to Chapter I of the SOLAS Convention.
[426] See Chapter XI-1 of the SOLAS Convention.
[427] Resolution A.739(18), Guidelines for the Authorization of Organizations Acting on Behalf of the Administrations.
[428] ibid.
[429] *IACS Recommendation No.41: Guidance for IACS Auditors to the ISM Code* (The International Association of Classification Societies 2005) at p. 14.
[430] P Boisson, 'Classification Societies and Safety at Sea' (1994) 18 Marine Policy 363 at p. 364.
[431] 'ISM Code brings change - and for the better' at p. 25.
[432] Boisson, 'Classification Societies and Safety at Sea' at p. 363.

assess whether Classification Societies are effective at improving maritime safety or not.

3.5.1 CLASSIFICATION SOCIETIES AS CERTIFIERS OF SAFETY

Classification Societies have long been criticised for the apparent conflict of interest that exists where the ship company being audited on behalf of the Flag State Administration is also a paying client of that Classification Society.[433] This encourages Classification Societies to be more lenient with their clients, and this can be seen with the reduction of standards and the granting of 'grace periods' within which necessary repairs are to be completed; rather than requiring them to undertake the repairs immediately with the afforded expense of the ship being out of operation.[434] Sagen, a leading maritime specialist and ISM inspector, has stated that Classification Societies have to "sell the ISM Code to their customers, so they are very lean in their auditing."[435] This is inherent due to Classification Societies being financed by, and therefore their activities influenced by, ship companies.[436] This point is well illustrated by the situation in South Korea, pre-2014, as discussed in Chapter 6 of this thesis.

Thus Classification Societies are often faced with the conflict of advising their clients who pay for the audit, or acting on behalf of the Flag State Administration that has delegated the statutory duty to it. Evidence of this is seen with reports of one leading Classification Society bowing to the pressures of its clients and reducing its attendance for intermediate verification audits to half a day, despite common accepted practice stating that a minimum of one whole day is needed.[437] Instead, a range of different areas are identified and a sample of procedures within those areas is audited. If the sample audit is satisfactory, it is assumed that the whole of the SMS is working satisfactorily.[438] Whilst this is worrying, what is more worrying is a situation where the same sample audits are conducted every time and so unsafe areas or procedures

[433] See Chapter 7 of this thesis for examples of such criticism.
[434] A Mandaraka-Sheppard, *Modern Maritime Law and Risk Management* (2nd edn, Cavendish Publishing 2007) at p. 283.
[435] Document with the author.
[436] P Anderson, *Cracking the Code* (The Nautical Institute 2003) at p. 17.
[437] P Anderson, 'The ISM and ISPS Codes: A Critical Analysis of Content, Philosophy and Legal Implications' in DR Thomas (ed), *Liability Regimes in Contemporary Maritime Law* (Informa Law 2007) at p. 177.
[438] P Anderson, 'ISM and ISPS Codes: Influence on the Evolution of Liabilities' (International Colloquium on Maritime Legal Liabilities, Swansea, September 2006) at p. 10.

continue to be unchecked.[439] It has been reported that often ship companies are aware of which sample of procedures tend to be inspected by certain Classification Societies/inspectors, and so they focus their attention only on ensuring that those procedures will pass the inspection. This allows for, and encourages, complacency to set in, and serves to undermine the community's safety culture.

A leading maritime academic, Falkanger, has added weight to this criticism; claiming that the line between public and private interests has been:

> "blurred by Classification Societies' undertaking of activities, which should fall within the public institutions remit."[440]

He argues that it should be solely the Flag State Administrations that undertake the responsibility of ISM audits and certification. This point is well received, and the author has encountered it many times during the course of this research project. See, for example, responses to the author's survey in Chapter 7 of this thesis.

It should be noted, however, that this concern may be moot, or at least its significance overvalued, with regards to the role of Classification Societies within the EU. This is owing to the stringent regulation of Classification Societies by the EU institutions, especially the Commission. As noted above, Flag State Administrations are permitted to delegate ISM inspection and certification of ships registered with its flag registry to Classification Societies.[441] The EU has more stringent requirements than the IMO, however. For example, EU Member States can only delegate the responsibility of ISM inspection and certification to a Classification Society that is 'recognised' by the EU. In order to be on the EU's list of approved/recognised organisations, the Classification Society must satisfy the minimum criteria set out in Annex 1 of the EU's Regulation on common rules and standards for ship inspection and survey organisations.[442] This serves to ensure that a high standard of performance, relating to the inspection of ships and the identification of non-compliance with the ISM Code, is met by the Classification Society.

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[439] ibid at p. 10.
[440] T Falkanger et al., *Scandinavian Maritime Law: The Norwegian Perspective* (2nd edn, Universitetsforlaget AS 2004) at p. 71.
[441] By virtue of Chapter XI-1 of the SOLAS Convention.
[442] Regulation (EC) No 391/2009 of the European Parliament and of the Council of 23 April 2009 on common rules and standards for ship inspection and survey organisation. Herein referred to as 'Regulation (EC) No 391/2009'.

If a Member State wishes to delegate ISM inspection and certification duties to a Classification Society not recognised by the EU, it must first submit a request to the Commission for it to be recognised, together with evidence that it fully complies with the Annex 1 minimum criteria.[443] The Commission will then undertake an assessment of that Classification Society[444] and grant recognition, provided that it complies fully with Annex 1.[445]

In order to ensure that a high benchmark is continuously maintained, all of the recognised Classification Societies are assessed, by both the Commission and the Member State which originally submitted the request for recognition, on a regular basis, but at least every two years as a minimum.[446] By virtue of its Article 7, if a Classification Society has failed to meet the obligations laid down in Regulation (EC) No 391/2009, and the standards contained in Annex 1, it may have its 'Recognised Organisation' status revoked, either temporarily or permanently. However, if the failure to meet these obligations is "repeated and serious", the Commission is required to withdraw its recognition permanently, following the procedure outlined here.[447]

Revocation of recognised organisation status is instigated by the Commission, following an assessment of the Classification Society that produced unsatisfactory results.[448] The Commission, by virtue of Article 7(3) of Regulation (EC) No 391/2009, submits to the Committee on Safe Seas and the Prevention of Pollution from Ships (COSS) its proposal to revoke the Classification Society's recognised organisation status. Members of the COSS then vote on the Commission's proposal to revoke and, if the majority accept the proposal, it is submitted to the Council for its adoption.[449] If the majority of the COSS do not agree with the Commission's proposal, it is submitted to the Council for its vote on the matter. If the (qualified) majority of the Council support the Commission's proposal, it will be adopted. In any event, if the proposal is adopted,

[443] Article 3(1).
[444] Article 3(2).
[445] Article 4.
[446] Article 8.
[447] Demonstrated by the use of the word 'shall' in Article 7(1).
[448] Outlined in Article 8.
[449] And the European Parliament informed.

the Classification Society will no longer be able to act on behalf of EU Member States for the purposes of ISM inspection and surveys.[450]

The EU's Regulation (EC) No 391/2009 provides a harmonised level of safety standards[451] for the inspection and certification services that Classification Societies undertake on behalf of Flag State Administrations throughout the EU. It aims to bring together, and complement, the standards established by the ISM Code and other measures, such as IMO Guidelines and Resolutions.[452]

3.5.2 AUDITING THE SHIP COMPANY

The actual process of auditing a company's SMS, and its ships' implementation of/compliance with that SMS, has long been criticised by mariners and academics. Anderson is of the opinion that these audits simply do not work, and the main reason he puts forward for this argument is that a Classification Society, as a result of commercial pressure (outlined above and discussed, to some extent, in Chapter 7 of this thesis), does not audit every aspect of the company's SMS, or the ship implementing it; but merely audits a small sample.[453] The sample audit of a ship usually lasts for one day at most, and is only performed once every two-and-a-half-years.[454] This length of time is insufficient to determine whether the crew on board a ship is complying with the approved SMS; an external audit requires the auditor to review the voluminous procedures and documents that make up the company's SMS, and assess the "myriad of historical and contemporary data […] concerning every aspect of the company's operations, including inspections, training, maintenance, manning, procedures, and drills"[455] in order to determine whether the SMS is being implemented effectively/complied with on board. One working day is an insufficient amount of time for an auditor to adequately review and assess all of the ship's documentary data, to interview the crew, and to assess the crew's performance of regular day-to-day procedures as well as emergency drills.

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[450] This procedure is outlined by Article 12(3) of Regulation (EC) No 391/2009 with reference to Articles 5 and 7 of Council Decision 1999/468/EC of 28 June 1999 laying down the procedures for the exercise of implementing powers conferred on the Commission.
[451] And environmental protection.
[452] See Paragraph 5 of the Preamble to Regulation (EC) No 391/2009.
[453] Anderson, 'The ISM and ISPS Codes: A Critical Analysis of Content, Philosophy and Legal Implications' at p. 177.
[454] ibid at p. 177.
[455] LC Sahatjian, 'The ISM Code: A Brief Overview' (1998) 29 Journal of Maritime Law and Commerce 405 at p. 407.

Further criticism is made by Lord Donaldson, a former Master of the Rolls, who accuses some Flag State Administrations of ignoring their responsibilities and pressuring Classification Societies, acting on their behalf, to issue ISM certificates without real verification, or despite there being evidence of major non-conformities.[456] The withdrawal of ISM certificates deprives the ship company of the use of the ship, which has financial costs and other commercial repercussions. Often Flag State Administrations do not wish to negatively affect trade, and/or lose ships to another Flag State's Ship Register, and so pressure is applied and ISM certificates are issued, sometimes without even an initial inspection.[457] Although this has long been acknowledged as the common practice of some less reputable Flag States,[458] the international maritime community has recently worked towards remedying the disparity that exists, and with some positive results, including the adoption of Port State Control Regimes, as discussed below.

3.6 THE PARIS MOU AND THE UK

The UK has been a participant of the Paris MOU since it first entered into operation on 1 July 1982. Since this time, the MCA has been undertaking PSC inspections in accordance with the Paris MOU's inspection regimes. Within the UK, PSC inspections are governed by the Merchant Shipping (Port State Control) Regulations 2011.[459]

During a PSC inspection at a UK port, the inspector will follow the procedures as outlined in the PSC Regulations, and so will first undertake an 'initial inspection'[460] i.e. they will check whether or not the ship company (of the ship under inspection) is in possession of a valid DOC, and the ship is in possession of a valid SMC. The inspector will then check that these certificates correspond with the true conditions on board the ship and that, overall, the ship complies with what is required by the company's SMS, as well as the ISM Code. This initial inspection is usually conducted by a walkthrough of the accommodation, over the deck and through the engine room, and will normally

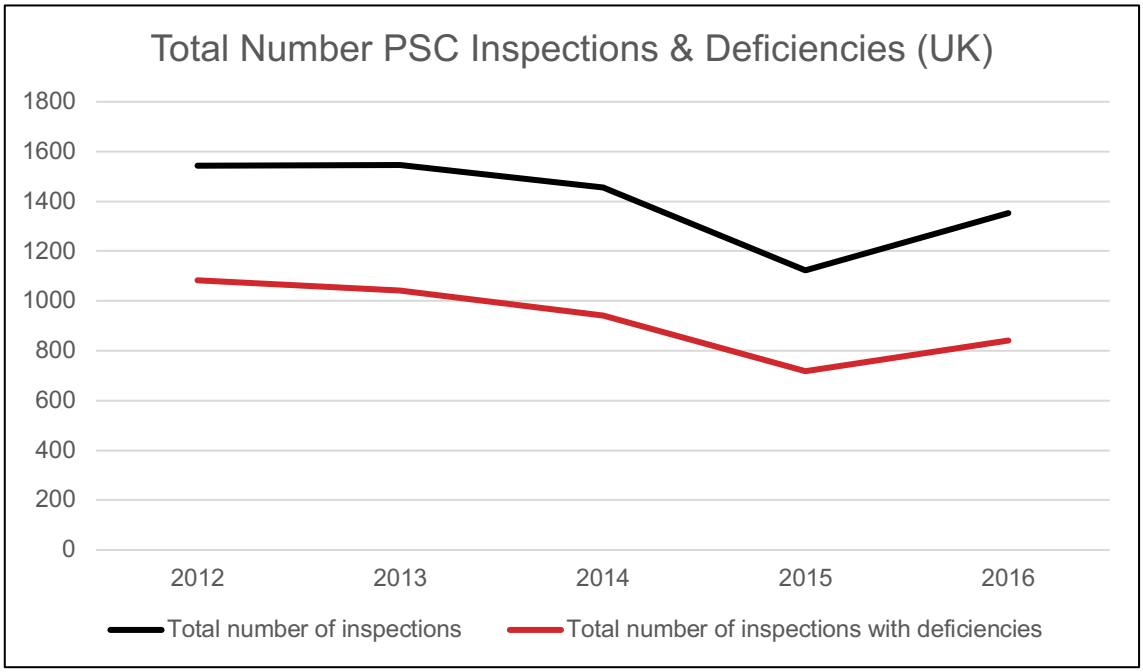
[456] Lord Donaldson of Lymington, 'The ISM Code – The Road to Discovery?' (The Inaugural Memorial Lecture of Professor Cadwallader, London, March 1998) at p 5.
[457] ibid at p. 5.
[458] ibid at p. 5.
[459] Herein referred to as the 'PSC Regulations'.
[460] By virtue of Regulation 5(1).

last around three hours. If 'clear grounds' are found during the initial inspection which suggests that the ship might not 'substantially meet' the requirements of the company's SMS and the ISM Code, a more thorough inspection will be conducted, known as a 'detailed inspection'.[461] This, on average, will increase the total inspection time to about six hours or more, depending on the number of defects found.[462]

RECENT FINDINGS

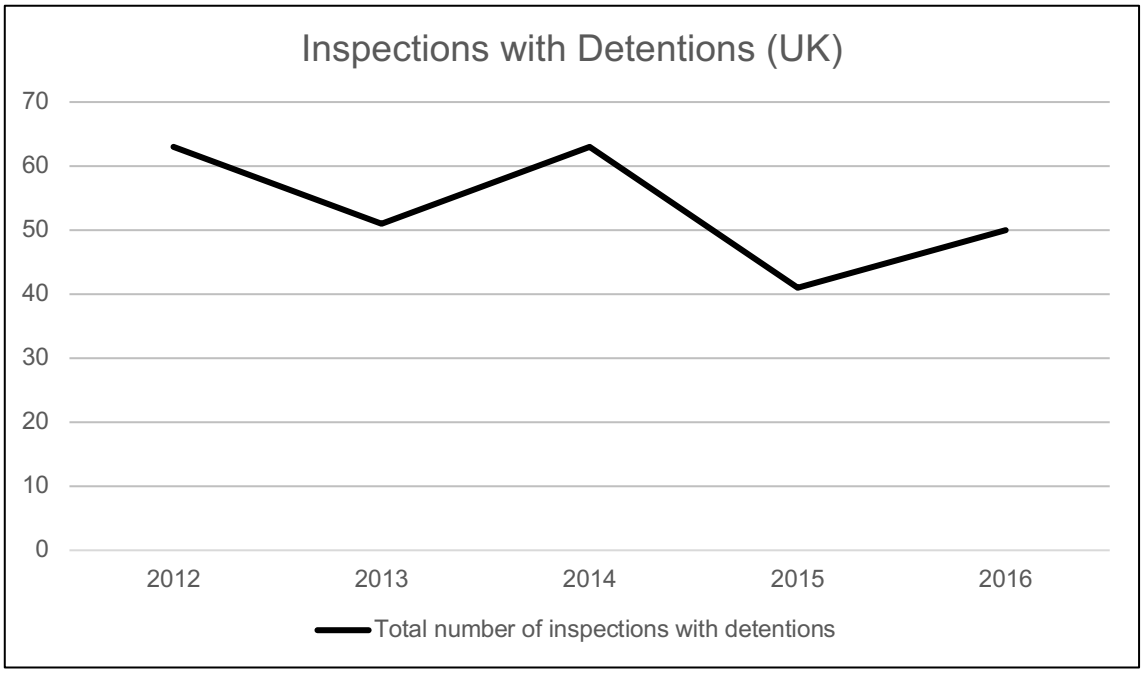
The author sourced data and statistics pertaining to the PSC inspections undertaken as part of the Paris MOU.[463] Although the Group of Independent Experts, who undertook the IMO's survey on ISM implementation and impact, stated that 'hard data' collected from PSC records has serious limitations in indicating any effects of ISM Code implementation,[464] the author has used this 'hard data' alongside other sources of data and, later in this thesis, experts' judgement on ISM implementation based on collectively-gathered subjective opinions from various levels of the international maritime community.[465] The data is therefore reliable, when read together, for identifying and supporting common trends and themes.

[461] By virtue of Regulation 5(3).
[462] Jurgens, 'Enforcement of UK Merchant Shipping Legislation' at p. 102.
[463] See Annual Report 2012: Port State Control - Taking Port State Control to the Next Level, Annual Report 2013: Port State Control – Consolidating Progress (The Paris Memorandum of Understanding 2013), Annual Report 2014: Port State Control – Adjusting Course (The Paris Memorandum of Understanding 2014), Annual Report 2015: Port State Control – Safer Entry of Enclosed Spaces (The Paris Memorandum of Understanding 2015), and Annual Report 2016: Port State Control – Seafarers Matter (The Paris Memorandum of Understanding 2016).
[464] MSC 81/17/1, Role of the Human Element: Assessment of the impact and effectiveness of implementation of the ISM Code at Annex p. 2.
[465] See Chapter 7 of this thesis.

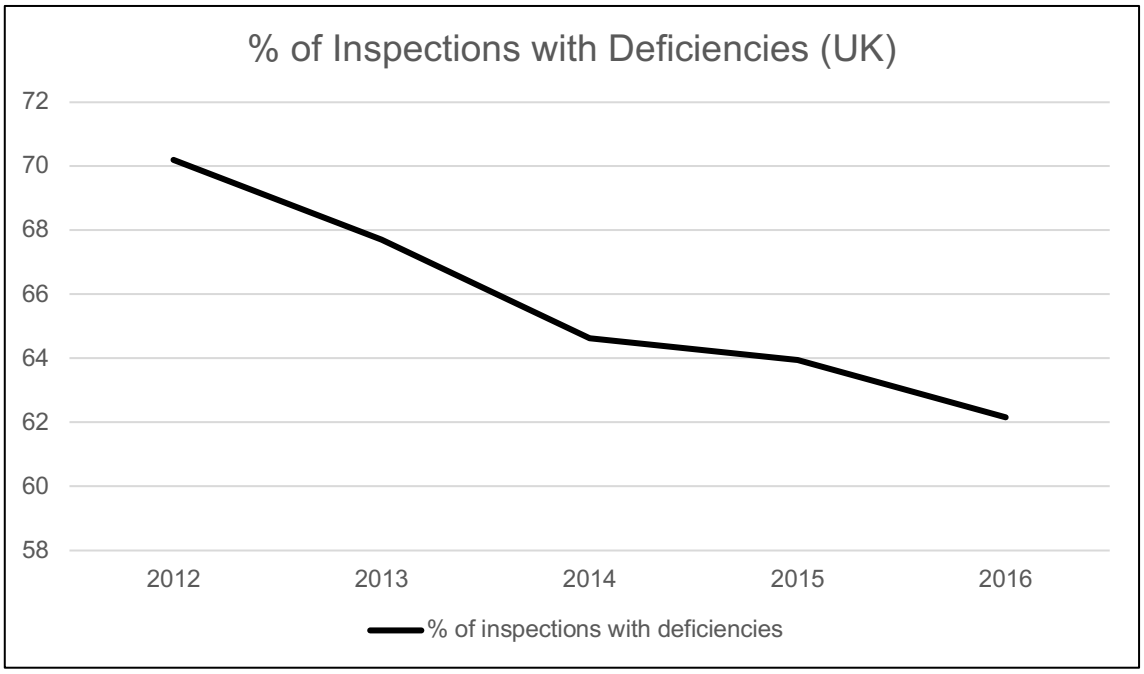


Graph 3.1: Total Number of PSC Inspections & Deficiencies

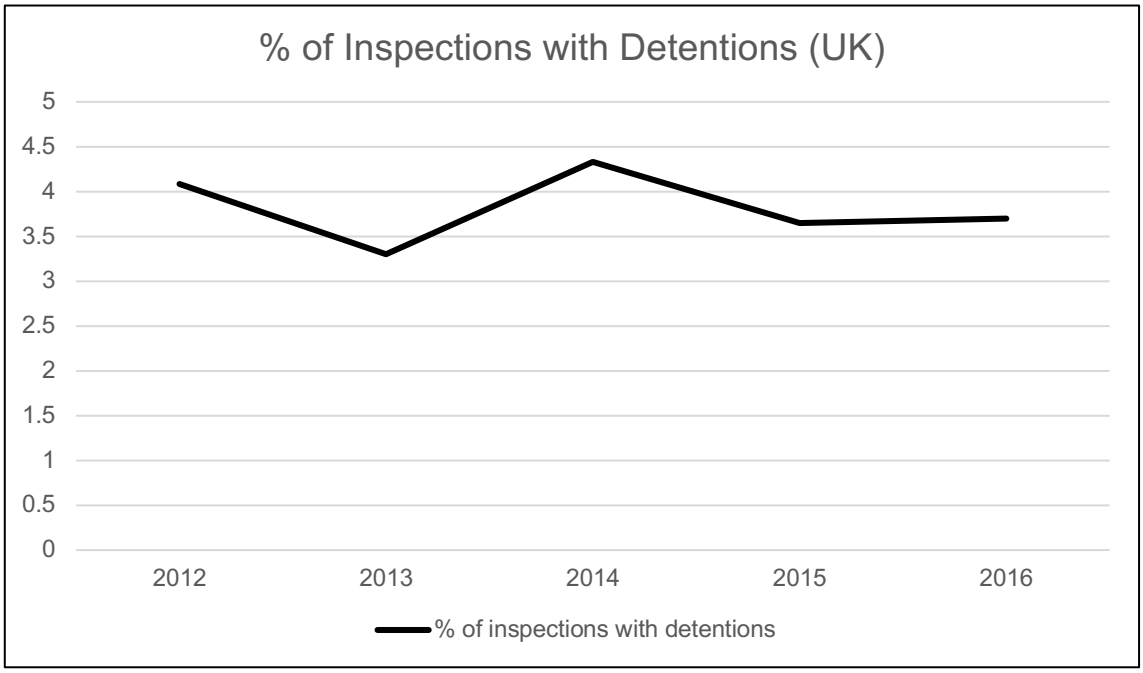
Whilst the New Inspection Regine 'targets' higher risk ships, and it would therefore be expected that, from 2012, the number of inspections with deficiencies would increase, statistics in fact show that the number of inspections with deficiencies decreased. This would appear to indicate that those companies operating (foreign) higher risk ships entering UK ports began implementing the ISM Code more effectively, as a result of the New Inspection Regime and the resulting increased risk of detention.



Graph 3.2: Total Number of Inspections with Detentions



Graph 3.3: Percentage of Inspections with Deficiencies



Graph 3.4: Percentage of Inspections with Detentions

However, this data pertains only to foreign ships entering UK ports, and not to UK-registered ships. From the perspective of the UK as a Paris MOU participant, these statistics would appear to suggest that ISM compliance and maritime safety are improving (for those foreign ships entering UK ports).[466] The contention that ISM is a learning curve (i.e. learning from experience in order to continuously develop the SMS and improve safety) is well supported by these statistics. They would also suggest that PSC inspection regimes are a success, especially the New Inspection Regime. Whilst the author would agree with this, it is also suggested that more could be done, beyond inspections, in order to reduce complacency with safety and to encourage ISM compliance.

3.7 ADMINISTRATIVE V CRIMINAL ENFORCEMENT

As demonstrated by this chapter, there are two primary methods of enforcing maritime safety regulations: the administrative method of detaining ships, and the criminal method of prosecuting the ship company or culpable individuals. With specific regards to the enforcement of the ISM Code, there is, however, a large disparity between the two different methods of enforcement.

[466] This observation was made by a participant to the author's survey, and is discussed in Chapter 7 of this thesis.

It is clear from the data sourced from the MCA, as well as personal communications between the author and the MCA,[467] that more breaches of the ISM Code are dealt with by detaining the ship, rather than by criminal prosecutions. In his research into the enforcement of UK maritime legislation, Ulrich Jurgens, a MCA Surveyor, claims that the reason why prosecutions are rare for non-compliance with the Code is that the MCA is reluctant to use the criminal law to enforce it,[468] due to the maritime industry's concerns regarding the increasing criminalisation of seafarers.[469] It is suggested that this is not the sole reason, or even the primary reason, for the low number of prosecutions. Rather it is due to the criminal law's inability to effectively prosecute an individual for failing to comply with the ISM Code i.e. for not implementing the SMS fully on board in accordance with Paragraphs 2 and 5 of the Code. In any event, the relatively unchanged number of prosecutions since the 2014 ISM Regulations came into force evidences that the threat of prosecution under the Regulations is not an effective tool for encouraging ISM implementation, or an effective deterrent for ISM complacency. This is a theme that is discussed in Chapter 7 of this thesis.

When a prosecution is brought for a breach of the ISM Code, it is usually against the ship company and not any individual, despite this being an option under the 2014 ISM Regulations. The focus of this thesis, however, is on the consideration of using individual liability for corporate manslaughter, alongside the ISM Code, to effectively punish those who fail to comply with the Code and death occurs as a result; and to serve as an effective deterrent for ISM complacency/non-implementation. In essence, for the author, legislative and policy efforts should be directed towards ensuring ISM implementation by the individual, so as to affect the overall implementation by the ship company, and which, in turn, would ensure that an enhanced safety culture is adopted by the international maritime community.

[467] Document with the author.
[468] As well as other UK maritime safety legislation.
[469] Jurgens, 'Enforcement of UK Merchant Shipping Legislation' at p. 401.

3.8 ALTERNATIVE METHODS OF ENFORCEMENT

3.8.1 REGIONAL V GLOBAL PSC REGIMES

With nine regional PSC regimes in operation,[470] there are concerns that there are varying standards of inspectors and inspection, and this has resulted in a lack of uniformity with regards to enforcing the implementation of the ISM Code.[471] Some argue that PSC regimes are not operational, and that these varying standards, and the high cost associated with PSC inspections, cannot be used as a tool to rectify 'Flag State weakness'.[472] Others believe that PSC would be more effective if governed by the IMO, and so have called for the establishment of an internationally-uniform standard of competence of inspectors, to be set and governed by the IMO.[473] It is suggested that the governance of a uniform standard by the IMO may not resolve the issue of varying standards, because any uniform standard would still be subject to different interpretations by the individual Member States and administrations implementing it.[474] However, IMO governance would certainly improve standards to a certain degree.

Regional PSC regimes are successful, and the statistics certainly evidence the Paris MOU's success.[475] Furthermore, it could be argued that there already exists a uniform standard, to be found in the IMO conventions and resolutions. What is needed, however, is for the IMO to take a more active role in the auditing of the various PSC regimes to ensure that they are working effectively and harmoniously. This suggestion receives support from leading maritime specialists and practitioners, such as Sagen.[476]

3.8.2 PROPOSALS FOR IMO AUDITORS

Another proposal which is worthy of consideration, is that of replacing PSC inspection with IMO inspection. This would be achieved through a two-pillar system:

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[470] The Paris MOU (Europe and the north Atlantic), the Tokyo MOU (Asia and the Pacific), the Acuerdo de Viña del Mar (Latin America), the Caribbean MOU (the Caribbean), the Abuka MOU (West and Central Africa), the Black Sea MOU (the Black Sea region), the Mediterranean MOU (the Mediterranean), the Indian Ocean MOU (the Indian Ocean), and the Riyadh MOU (the Gulf region).
[471] Goulielmos, 'The quest of marine accidents due to human error, 1998-2011' at p. 54.
[472] Mitroussi, 'Quality in shipping: IMO's role and problems of implementation' at p. 57.
[473] See, for example, responses included as part of the data analysis in Chapter 7 of this thesis.
[474] See L Chen, 'Legal and practical consequences of not complying with ISM code' (2000) 27 Marine Policy & Management 219 at p. 227.
[475] ibid at p. 227.
[476] Document with the author.

1. The establishment of a body of IMO inspectors who would undertake the inspection of ships at the ports of IMO Member States. These inspectors would be trained, certified and stringently supervised by the IMO, with regular spot checks to ensure that they are performing in accordance with what is expected of them. IMO inspectors would work impartially, independently and wholly in the interest of the IMO and the maritime community.
2. The IMO would produce prescriptive checklists, outlining and describing, in detail, what the IMO inspector is to look for during their inspections, rather than random sample inspections.

This would remove the responsibility of the Flag State Administration, such as the MCA, from the inspection process. It is the author's opinion that this suggestion, if implemented, would not necessarily improve the standard/quality of inspections in cases such as the UK (due to the MCA having an exceptional reputation with regards to its inspection standards), but it would improve the overall standard of inspection across the international maritime community, in much the same way that the Code itself improved the overall standards relating to safety. Furthermore, although the Flag State Administrator would no longer be responsible for PSC inspections, it would be those inspectors normally employed by the Flag State Administrator who would be employed as IMO inspectors. However, to reiterate the author's earlier point, the issue is not necessarily with inspection, but rather with the methods of enforcing implementation.

3.8.3 CORPORATE MANSLAUGHTER

Although ship companies and seafarers tend to disagree with introducing more legislation that increases the 'criminalisation of seafarers',[477] it is right that those whose actions are culpable should be punished appropriately. This thesis does not examine all areas of this increasing criminalisation of seafarers, but examines one particular proposal relating to the introduction of individual liability for corporate manslaughter, and its potential to encourage implementation of the ISM Code. Although Chapter 5 of this thesis discusses corporate manslaughter in detail, it is appropriate to briefly introduce here, the concept of corporate manslaughter as an enforcement tool.

Since 6 April 2008, the Corporate Manslaughter and Corporate Homicide Act 2007[478] has been in force in the UK. This Act makes it an offence if the way in which the

[477] See Chapter 6 of this thesis.
[478] Herein referred to as the 'Corporate Manslaughter Act'.

activities of an organisation were managed or organised amounted to a gross breach of a relevant duty of care and caused the death of the person to whom this duty of care was owed.

Although it has been argued that "there is nothing in the ISM Code itself that could be interpreted as imposing criminal liabilities,"[479] in the UK, breach of the 2014 ISM Regulations can constitute a criminal offence.[480] Therefore, the argument that the ISM Code does not impose criminal liabilities is somewhat moot from a UK perspective. In addition, the Corporate Manslaughter Act considers standards and benchmarks to determine a company's culpability, and the ISM Code provides this benchmark when determining whether a ship company has acted 'recklessly' or with disregard to maritime safety.[481]

However, the Corporate Manslaughter Act has failed to incorporate individual liability for the offence, and therefore individuals within the company cannot be convicted of corporate manslaughter alongside the company. The remainder of this thesis considers the proposal to: develop the Corporate Manslaughter and Corporate Homicide Act, so as to include individual/secondary liability; use this developed liability as a tool within the maritime industry to target and punish those culpable individuals (alongside the ship company) where death has resulted from non-compliance of the ISM Code; and use the possibility of receiving a conviction for such an offence as a tool to ensure implementation of the ISM Code, and therefore improve maritime safety and reduce the number of accidents and fatalities.

3.9 CONCLUDING REMARKS

Although implementation of the ISM Code by some Flag States is inadequate, and this needs to be addressed by the IMO, most Flag States have followed the IMO's Guidelines on the Implementation of the International Safety Management (ISM) Code by Administrations, so implementation is not a concern. This is even less of a concern with States that are parties to Port State Control regimes, such as the Paris MOU.

[479] P Anderson, ISM Code: A Practical Guide to the Legal and Insurance Implications (2nd edn, Informa Law 2005) at p. 155.
[480] Discussed above.
[481] Discussed in Chapter 6 of this thesis.

Not only do PSC regimes encourage better implementation of the Code by participant States, but they provide for coordinated and harmonised inspection regimes. Furthermore, statistics would suggest that PSC regimes are effectively encouraging better ISM implementation by those ship companies whose ships enter the ports of participant States. However, the effect of PSC inspections has reached its limit, and more needs to be done to ensure that ship companies and individuals implement the ISM Code fully and effectively.

The author has briefly considered various alternative and complementary administrative and criminal methods of enforcing/encouraging ISM implementation. The focus of this research project, however, is on the consideration of using corporate manslaughter legislation to punish both the ship company and its corporate individuals when there has been a death at sea, to serve as an effective deterrent for non-implementation of the ISM Code, and thus provide for an enhanced safety culture within the international maritime community.

CHAPTER 4
POST-ISM CASE STUDIES

4.1 INTRODUCTION

This chapter uses case studies to demonstrate the need for better implementation of the ISM Code by analysing two post-ISM maritime disasters. These disasters show that, despite the ISM Code being in force and the international maritime community being engaged in a process of enhancing maritime safety, some members of the community, including Flag State Administrations and ship companies, are being complacent and failing to implement effective safety management systems.

The differences between the two case studies should be observed. One post-ISM disaster concerns the Republic of Korea[482] ferry *Sewol*, which capsized on 16 April 2014, as a result of poor helmsmanship coupled with the overloading and improper stowing of its cargo. Although the *Sewol* was not bound by the ISM Code due to it not engaging in international voyages, South Korea did have in place a basic system for overseeing the safety management of its domestic ships,[483] which the *Sewol* was bound by. However, this system was corrupt and ineffective, and has since been replaced with something akin to an 'ISM-Code-style' system of safety management for domestic ships. This is a significant example of a Flag State recognising the need for the effective safety management of all its ships, whether they are engaged in international voyages or domestic ones, which can only be achieved through the adoption of an effective safety culture.

The second post-ISM disaster concerns the Italian cruise ship *Costa Concordia*, which capsized on 13 January 2012, as a result of an incompetent First Officer navigating the ship with an incompetent Helmsman at the wheel. This case study is significant to the thesis because it is indicative of how some key players in the international maritime community are being complacent with safety; failing to implement the ISM Code, which results in an ineffective safety culture being adopted, and with disastrous consequences. As the *Costa Concordia* was Italian-registered, it was bound by the ISM

[482] Herein referred to as 'South Korea'.
[483] i.e. ships that are engaged purely in domestic voyages.

Code because of Italy's membership of the IMO[484] and its membership of the EU.[485] Because of this, and because of the wider range of materials available to the author, as we as for the reasons outlined in Chapter 1 of this thesis, the *Costa Concordia* disaster is examined in greater detail, using Reason's theory of organisational accidents.

4.2 POST-ISM CASE STUDY I: THE *SEWOL* (2014)

As noted in Chapter 2 of this thesis, the ISM Code is only mandatory for ships engaged in international voyages; the regulation of safety standards of domestic ships is left to each individual Flag State (though a Flag State is free to adopt the same standards as the ISM Code for its domestic ships). In the case of South Korea, there was, at the time of the *Sewol* disaster, a system in place to regulate the safety standards of domestic ships. However, this system was wholly ineffective and allowed for a corrupt and collusive link between the shipping industry and government regulators. This encouraged the adoption of a negative safety culture, which ultimately led to the *Sewol* disaster.[486] The analysis here examines the combination of the causes of the *Sewol* disaster, and the reform package measures implemented by the South Korean Government to replace the ineffective system, with what is essentially a national ISM Code.

4.2.1 SUMMARY OF THE DISASTER: 16 APRIL 2014

On 15 April 2014, the South Korean ferry *Sewol*, departed Incheon for Jeju, under the command of Captain Lee Joon-seok. It had 443 passengers, 33 crew members and a total of 3,608 tons of cargo on board.[487] During the morning of 16 April, the *Sewol* was sailing too fast in the Maenggol Channel when its helmsman turned too sharply. As a result of the *Sewol* having been illegally modified, and it being overloaded with improperly-lashed cargo and vehicles, when the *Sewol* heeled, cargo and vehicles shifted and the ship listed, and it could not be righted. As the ship was listing, passengers were ordered to stay in their cabins, even whilst the Captain and crew were abandoning ship. The *Sewol* soon capsized and 304 people (mostly high school students) lost their lives. In addition, the Korea Coast Guard (South Korea's Coast

[484] As a result of Italy's membership of the IMO, it is a signatory to the SOLAS Convention.
[485] As a result of Italy's membership of the EU, it is bound by Regulation (EC) No. 336/2006.
[486] SK Kim, 'The *Sewol* Ferry Disaster in Korea and Maritime Safety Management' (2015) 46 Ocean Development & International Law 345 at p. 355.
[487] This total included the weight of the vehicles that were on board.

Guard authority) were negligent in their rescue efforts, and this contributed to the disaster's high death toll.

The capsizing of the *Sewol* was South Korea's worst-ever maritime disaster, and many criticised the ship's operating company, its Captain and crew, the Korea Coast Guard, and the South Korean Government, for contributing, in some way, to the 304 deaths. Such was the public outrage over the Government's handling of the disaster, that the country's Prime Minister resigned, its Coast Guard was disbanded by the country's President, and the system of supervising and regulating safety of South Korea's domestic ships completely reformed.

4.2.2 ANALYSING THE CAUSES OF THE DISASTER AND ATTRIBUTING BLAME

There are five parties that were identified as significantly contributing towards the *Sewol* disaster and the subsequent loss of life, all of which were identified by the Korean Maritime Safety Tribunal's inquiry into the disaster; the Government agency that investigated the causes of the *Sewol* disaster.[488] The analysis here outlines the actions of each party that contributed to the disaster, in order of that party's level of contribution.

CHONGHAEJIN MARINE COMPANY

On 8 October 2012, Chonghaejin Marine Company[489] bought the Japanese ferry *Sewol*, formerly known as the *Ferry Naminoue*. It was 18 years old and in a run-down state.[490] Between 12 October 2012 and 12 February 2013, it underwent significant modifications, which were revealed by the investigation into the disaster to have been based on illegal redesigns. The company modified the *Sewol* to expand its cargo space and to create additional passenger space, on the third, fourth and fifth decks at the aft of the ship. This was done in order to accommodate an additional 114 passengers (for a total of 956 people, including crew), as well as an art gallery. As a result of this redesign, the *Sewol* had its gross tonnage increased by 239 tons to 6,825 tons, the ship's

[488] The prosecution of some of these parties is discussed in Chapter 6 of this thesis.
[489] Herein referred to as 'Chonghaejin Marine'.
[490] It was registered on the Korean Register of Shipping on 22 October 2012.

centre of gravity was raised by 51cm as a result of it being top-heavy, and with a port-starboard imbalance.

The *Sewol* passed safety inspections carried out by the Korean Register of Shipping (KR), with the proviso that the ship had to carry less cargo and more ballast water so as to offset the increased weight from the additional passenger space created at the top of the ship. The exact stability limits set by KR were a maximum cargo of 987 tons with a minimum of 2,030 tons of ballast water. When the *Sewol* capsized on 16 April 2014, it had 3,608 tons of cargo on board (266% more than the maximum limit set) and 580 tons of ballast (28.6% of the minimum of requirement).[491]

Chonghaejin Marine's only concern was with regards to maximising profit. Not only did the company have a total disregard towards safety when it illegally modified the *Sewol*, but it adopted a negative safety culture, which encouraged a dangerous working environment throughout the company. This was never more apparent than when it was discovered during the investigation that the company had spent only ₩541,000 (approximately £400) in 2013 on training its staff,[492] and only around £1.50 in 2014 on safety training for the *Sewol*'s crew members.[493] Furthermore, the *Sewol*'s regular master, Captain Shin, warned Chonghaejin Marine about the ship's decrease in stability following its modifications. He also requested a repair for the malfunctioning steering gear on 1 April 2014. The company responded by threatening to dismiss Captain Shin if he continued with his complaints.

The attitude and behaviour adopted by the company meant that the *Sewol* went to sea in a dangerous state; dangerously modified, poorly maintained, overly-loaded with improperly-secured cargo, and with incompetent and untrained crew. As a direct consequence of the unsafe culture adopted, 304 people lost their lives on the morning of 16 April 2014.

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[491] 'South Korea Sewol ferry: What we know' *BBC News* (16 May 2014) <http://www.bbc.co.uk/news/world-asia-27342967> (accessed 21 May 2014).
[492] S Mundy and J-A Song, 'Sewol ferry disaster exposes South Korea safety shortcomings' *The Financial Times* (29 April 2014) <https://www.ft.com/content/6fee9790-cebb-11e3-8e62-00144feabdc0> (accessed 18 June 2015).
[493] S-H Choe et al., 'In Ferry Deaths, a South Korean Tycoon's Downfall' *The New York Times* (26 July 2014) <https://www.nytimes.com/2014/07/27/world/asia/in-ferry-deaths-a-south-korean-tycoons-downfall.html> (accessed 1 February 2015).

KOREAN SHIPPING ASSOCIATION

At the time of the *Sewol* disaster, safety standards for domestic ships engaged in South Korean waters were regulated by the country's 2009 Maritime Transport Act. This Act delegated the Flag State Administration's[494] responsibilities for managing the safe operation of domestic ships to the Korean Shipping Association (KSA);[495] a mutual association of private Korean ship companies.

Most importantly, the KSA was to monitor that passenger ships were not overcrowded or overloaded.[496] It was known to the KSA that the *Sewol* was being regularly overloaded with cargo; the ship exceeded its cargo limit on 246 trips (nearly every voyage that it made in which it reported cargo to the KSA) in the 13 months that it was operated by Chonghaejin Marine.[497] Ignoring the *Sewol*'s repeated overloading, and thus permitting it to sail in an unsafe condition, put the ship and the lives of those on board in considerable danger. This was clearly a breach of the KSA's legal obligations, and supports the argument that the KSA should never have been responsible for monitoring safety[498] due to the clear conflict of interest that exists where the body tasked with enforcing the regulations was funded by ferry and cargo ship operators, and which doubles as a lobbying group for the industry.[499] This conflict is similar to the one discussed in the previous chapter regarding Classification Societies.

HELMSMAN CHO JOON-KI

On the morning of 16 April 2017, Third Officer Park Han-kyul was the Officer of the Watch, with Helmsman Cho Joon-ki steering the ship. At 08:20, the *Sewol* was sailing at a speed of 20 knots and approaching the Maenggol Channel. At this point, the Third Officer gave the order to change the steering from automatic to manual, which is standard procedure when sailing through hazardous areas such as the Maenggol Channel. Following the disaster, some media outlets directed criticism towards the Third Officer for being inexperienced and unfamiliar with the Channel, and claimed that her orders caused the *Sewol* to collide with a reef, which tilted the ship and caused it to

[494] South Korea's Ministry of Oceans and Fisheries.
[495] By virtue of Articles 21 and 22.
[496] Kim, 'The *Sewol* Ferry Disaster in Korea and Maritime Safety Management' at p. 353.
[497] 'South Korea ferry was overloaded on 246 trips in months before sinking, documents show' *Fox News* (4 May 2014) <http://www.foxnews.com/world/2014/05/04/south-korea-ferry-that-sank-was-regularly-overloaded-never-caught-for-13-months.html> (accessed 8 June 2014).
[498] Kim, 'The *Sewol* Ferry Disaster in Korea and Maritime Safety Management' at p. 353.
[499] Mundy and Song, 'Sewol ferry disaster exposes South Korea safety shortcomings'.

heel.[500] However, this was discredited by the Joint Police-Prosecution Investigation Team;[501] Park Han-kyul had sailed through the Channel on multiple occasions on another ship and, although the outskirts of the Channel contain hazardous rocks in shallow waters, the *Sewol*'s path did not get close to these. Therefore, Third Officer Park's experience and competency were not a factor in the *Sewol*'s disaster.

At 08:48, the *Sewol* was travelling at a speed of 18 knots and with a heading of 135 degrees, and the Third Officer ordered the Helmsman to alter course to 140 degrees, then to 145 degrees. There are two conflicting accounts as to what happened following this order; one account from the Helmsman and one account from the Third Officer. The latter account is the one that is supported by the testimony of other members of the *Sewol*'s crew, as well as the ship's Automatic Identification System (AIS), and is the account that has been accepted by the Joint Investigation Team as being the most accurate. It is therefore this version of events that are assumed for the analysis here.

According to the accepted version of events, when the Third Officer ordered the ship to turn from 135 degrees to 140, Helmsman Cho mistakenly turned the *Sewol* back to 130 degrees from 135. Then, in order to correct his mistake, he turned sharply to 145 degrees (from 130). This sharp 15-degree turn, combined with the strong underwater currents of the Maenggol Channel, resulted in the ship heeling heavily to port by 20 degrees, its bow turning to starboard, and the poorly-lashed cargo and vehicles shifting to the port side of the ship. When the cargo fell/shifted to the port side, the *Sewol* lost its restoring force (i.e. it could not right itself) and this allowed water to flow into the ship from the port-side cargo-bay door at the ship's stern. Although the *Sewol*'s regular master had advised the company that sudden turns greater than five degrees should not be attempted due to the ship's instability, this vital information was not relayed to Captain Lee or his crew. Had the *Sewol*'s crew been advised of this stability issue, the Helmsman may not have turned the ship as sharply as he did.[502]

The Joint Investigation Team concluded that Helmsman Cho's negligent actions i.e. his "unreasonable sudden turn" to starboard, was the primary cause of the *Sewol*'s capsizing (coupled with the overloading of the cargo).

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[500] M Park, 'What went wrong on Sewol?' *CNN* (15 May 2014) <http://edition.cnn.com/2014/05/15/world/asia/sewol-problems/> (accessed 4 June 2014).
[501] Herein referred to as the 'Joint Investigation Team'.
[502] Kim, 'The *Sewol* Ferry Disaster in Korea and Maritime Safety Management' at p. 347.

CAPTAIN LEE JOON-SEOK

Whilst Captain Lee was not the *Sewol*'s regular master, he had over 40 years of seagoing experience and had travelled the Incheon-Jeju route on numerous occasions. In any event, he was not in command of the bridge when the Helmsman turned the ship too sharply. However, it could be argued that Captain Lee contributed to the *Sewol*'s instability and its capsizing in two ways.

Firstly, the *Sewol* was illegally and dangerously overloaded with cargo. Although Captain Lee was under commercial pressure from Chonghaejin Marine to overload the *Sewol*,[503] he was the ship's master, and therefore ultimately responsible for the safety of the ship and the safety of the lives on board. He set sail knowing that the *Sewol* was overloaded, and he must bear the responsibility for that (alongside Chonghaejin Marine and its corporate individuals).

Secondly, the cargo was improperly secured in the cargo bay. Even though the *Sewol* was overloaded, had the cargo been stowed securely, the ship would not have lost stability when the Helmsman turned too sharply. As the ship's master, Captain Lee was responsible for supervising and ensuring the safe loading and stowing of cargo on board.[504] At the very least, he should have checked that the cargo was secure before leaving port, especially considering that the *Sewol* was delayed in port for several hours due to adverse weather conditions. If proper supervision had taken place, or if a final check before departure had been made, Captain Lee would have discovered that the cargo was improperly lashed and therefore, it is assumed, would have ordered it to be safely secured before leaving Incheon Port. Captain Lee, therefore, bears the blame for the unsafe stowing of the cargo (along with those members of crew who failed to stow it safely) as the *Sewol*'s front-line manager, responsible for the overall safety of the ship.

Although Captain Lee's poor management of the overloading and stowing of cargo ultimately contributed to the *Sewol*'s capsizing, it is more his appalling management of

[503] It was revealed during the investigation that the overloading of the *Sewol* had been common practice, as stated above, and that the ship was redesigned in order for it to be able to carry more cargo, with overloading as a means of addressing the company's dire financial situation. See ibid at p. 346.
[504] This is part of ensuring that the ship is 'seaworthy', but the specific topic of 'seaworthiness' is beyond the scope of this thesis.

the ship's evacuation that he has received criticism and condemnation for.[505] It is a significant factor in the cause of the death for those who died in the disaster, and therefore it is important to consider it here.

At 08:50, the *Sewol* was leaning 30 degrees to port, Captain Lee reported to the bridge and the Chief Engineer stopped the engines. With its engines off, the *Sewol* became unable to change direction so began drifting sideways. At 08:52, and as the *Sewol* was sinking, Communication Officer Kang-seong made an announcement over the ship's public-address system, ordering passengers to stay in their cabins. Captain Lee approved and maintained this order up until the moment that the ship capsized.

The first call to the emergency services was not made by Captain Lee or a member of his crew, but by Choi Duk-ha, a high-school student who was on board and in his cabin. At 08:54, he was connected to the Mokpo Coast Guard station and four minutes later Patrol Vessel *No. 123* was dispatched to the scene.[506] At 09:07, the Coast Guard was contacted and advised that the *Sewol* was capsizing and assistance was requested. Contact was made once more at 09:14, to advise that the *Sewol*'s angle of list meant that abandoning ship by use of the ship's lifeboats was not possible.

At 09:23, whilst passengers were still in their cabins, the Jeju Vessel Traffic Service (VTS) ordered the crew to instruct passengers to don lifejackets.[507] At 09:25, Jeju VTS requested that Captain Lee make an immediate decision whether to abandon the ship at this time, as it had not been provided with sufficient information to make the decision itself. As part of this conversation, Captain Lee was advised that ships were due on the scene in 10 minutes. However, Captain Lee decided against giving the order to abandon (or to prepare for abandoning) the *Sewol* until the ships had arrived, and so still continued to order passengers to remain in their cabins.

Despite the *Sewol*'s increasingly dangerous situation (listing at over 50 degrees at this point), the order to abandon ship was not given until 09:30. However, due to the public-

[505] The criminal prosecution of Captain Lee is discussed in Chapter 6 of this thesis.
[506] At 09:01, a crew member contacted the Incheon branch of Chonghaejin Marine to report on the *Sewol*'s situation.
[507] When the crew replied that the ship's public-address system was no longer working, Jeju VTS ordered the crew to personally/physically go and order the passengers to put on their lifejackets.

address system being inoperable, this order was not relayed to all passengers; most remained in their cabins.

Once Jeju VTS confirmed that ships had arrived at the scene to provide assistance with the evacuation/rescue operations, it ordered the ships to drop their lifeboats so that the *Sewol*'s passengers could jump overboard and be rescued. This order was given at 09:33; five minutes before all communications between Jeju VTS and the *Sewol* ceased (due to the ship losing power), and eight minutes before 150-160 people jumped overboard.

Inexcusably, Captain Lee, the First and Third Officers, and the Chief Engineer were amongst the first people to abandon ship and be rescued (at around 09:46), whilst most of the passengers still remained in their cabins as instructed. As the *Sewol* fully capsized, passengers, including most of the high-school students that were on board, continued to follow the Captain's instructions to stay put.

KOREA COAST GUARD

As discussed above, the causes of the *Sewol* disaster are attributable to a combination of factors, including illegal modifications to the ship in order to increase its cargo capacity, cargo overloading, and 'poor helmsmanship.'[508] Furthermore, the appalling evacuation efforts by Captain Lee and his crew have been identified as a major factor behind the high death toll.[509] However, much fewer people would have died had the rescue response of Korea Coast Guard not been slow, uncoordinated and unfocused.[510] It is therefore appropriate that blame has been attributed to those responsible within the organisation, especially the master of Korea Coast Guard's Patrol Vessel *No. 123*, Captain Kim Kyung-il, who was in charge of rescue operations at the scene.

In accordance with Korea Coast Guard's Search and Rescue Procedures, and the country's 2008 Rescue and Aid at Sea and in the River Act,[511] Captain Kim was designated the commander of the rescue operation at the scene; charged with assessing

[508] 'Punishment for Coast Guard over Sewol Disaster' *The Maritime Executive* (10 October 2014) <http://www.maritime-executive.com/article/Punishment-for-Coast-Guard-over-Sewol-Disaster-2014-10-10> (accessed 4 November 2014).
[509] Mundy and Song, 'Sewol ferry disaster exposes South Korea safety shortcomings'.
[510] 'South Korea coast guard captain jailed over Sewol ferry rescue bid' *BBC News* (11 February 2015) <http://www.bbc.co.uk/news/world-asia-31412680> (accessed 18 July 2015).
[511] At the time of the publication of this thesis, the latest version of this Act is the 2014 version.

the scene and *swiftly* (emphasis added) rescuing passengers and crew. Captain Kim was slow to arrive on the scene and, when he did arrive, he failed to broadcast an evacuation order through his ship's loud speakers. Furthermore, he made no effort to encourage passengers to abandon ship,[512] despite knowing that the *Sewol*'s internal public-address system was inoperable and therefore not all passengers had received the instruction to abandon ship. Captain Kim merely ordered his crew, and those on board the other ships that had been in the area and had come to assist in the rescue operation, to rescue those who were already in the water, or who were already visible on the hull of the *Sewol*, attempting to jump overboard.[513]

In essence, Captain Kim acted negligently and incompetently by failing to take proper measures at the scene.[514] His coordination of the *Sewol*'s evacuation amounted to a "botched rescue effort"[515] that wasted valuable time and cost lives.[516] It is therefore appropriate that blame has been attributed to Captain Kim for his contribution to the disaster's high death toll on 16 April 204.[517]

It should be observed, however, that within Korea Coast Guard, blame was not only placed with Captain Kim. Many officials within the organisation were found to have been corrupt; acting negligently and irresponsibly with their duties.[518] In response to the "*Sewol* fiasco", on 18 May 2014, President Park Geun-hye disbanded Korea Coast Guard; its investigation and information responsibilities were transferred to South Korea National Police, whilst the rescue and salvage operations, and ocean security responsibilities, were transferred to a newly-established government body, the 'Ministry of Public Safety',[519] by virtue of the 2015 Framework Act on the Management of Disasters and Safety.[520]

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[512] KJ Kwon and T Hume, 'South Korean coast guard captain jailed for 4 years over botched Sewol rescue' *CNN* (12 February 2015) <http://edition.cnn.com/2015/02/12/world/korea-sewol-coast-guard-jailed/index.html> (accessed 18 July 2015).
[513] W Laursen, 'Coast Guard Captain Sentenced over Sewol' *The Maritime Executive* (11 February 2015) <http://maritime-executive.com/article/coast-guard-captain-sentenced-over-sewol> (accessed 18 March 2015).
[514] ibid.
[515] 'South Korea coast guard captain jailed over Sewol ferry rescue bid'.
[516] He also lied to reporters; claiming that he had broadcast the order to abandon ship over *No. 123*'s loud speakers. See ibid.
[517] Captain Kim was sentenced to four years in prison for professional negligence contributing to death. See Laursen, 'Coast Guard Captain Sentenced over Sewol'.
[518] For example, 13 Coast Guard Officers at the Jeju VTS Centre were convicted of negligence and the forgery of communication records. See Kim, 'The *Sewol* Ferry Disaster in Korea and Maritime Safety Management' at p. 348.
[519] KJ Kwon et al., 'South Korean president dismantles coast guard after ferry disaster' *CNN* (19 May

4.2.3 IMPLEMENTING AN EFFECTIVE SYSTEM OF SAFETY MANAGEMENT: POST-*SEWOL*

Following the *Sewol* disaster, it became apparent that South Korea's system for managing the safe operation of its domestic ships was dangerously ineffective and, recognising that a cause of the disaster was the collusive relationship that existed between the maritime industry and those tasked with managing its safety (both within the Government and the KSA),[521] the South Korean Government engaged in reforming the corrupt system and replacing it with a comprehensive package of measures. These measures were designed to enhance maritime safety and to instil a safety culture within the South Korean maritime industry.[522] They were introduced in 2015, with the reform of three primary pieces of maritime legislation: the Maritime Safety Act; the Seafarers Act; and the Ship Safety Act. When read together with the 2009 Maritime Transport Act, these laws constitute a system of safety management for domestic ships. The key parts of this new system are discussed accordingly.

CREATING A SAFETY CULTURE

With the amendments to the Maritime Safety Act, the Ministry of Oceans and Fisheries,[523] as South Korea's Flag State Administration, has been given more responsibility and more powers with regards to governing maritime safety. One key responsibility is that it must formulate and implement a five-year 'National Plan for Maritime Safety' (referred to as the 'master plan').[524] As part of this plan, the Ministry is to set out its aims for modernising the passenger ship industry and for promoting maritime safety. The Ministry has used its authority under the Maritime Safety Act to lower the maximum age allowed for domestic passenger ships from 30 years to 25 years. Furthermore, ships that are older than 20 years must pass a new strict inspection, conducted by the Korea Ship Safety Technology Administration (KSSTA), every year. In practical terms, if this new inspection requirement is not satisfied, a ship company will lose the licence for that ship to operate,[525] which is what ultimately happened to

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2014) <http://edition.cnn.com/2014/05/18/world/asia/south-korea-coast-guard/index.html> (accessed 18 July 2015).

[520] Also known as the 'Disaster Management Act'.

[521] See Mundy and Song, 'Sewol ferry disaster exposes South Korea safety shortcomings'.

[522] Kim, 'The *Sewol* Ferry Disaster in Korea and Maritime Safety Management' at p. 356.

[523] Herein referred to as the 'Ministry'.

[524] Articles 6 and 7 of the 2015 Maritime Safety Act.

[525] Article 4 of the 2015 Maritime Safety Act, in order for a ship company to operate transport services, it

Chonghaejin Marine.[526] Although this is a good move towards improving safety and instilling a safety culture in the industry, it should be observed that the *Sewol* would not have been 'caught' by this new restriction as it was only 20 years old at the time of the disaster.

In recognising that there is a clear need for a safety culture in the maritime industry, something that was lacking before the Government implemented its package of reform measures, the Ministry has been given the option to create a 'Maritime Safety Charter',[527] as well as the option of establishing a 'Maritime Safety Day'.[528] These two measures are designed to facilitate and encourage the discussion around, and the increased awareness of, the need for a safety culture in the maritime industry. However, the Ministry has yet to use its powers conferred by these provisions to promote safety through the establishment of either a Maritime Safety Charter or a Maritime Safety Day.[529]

REPLACING THE KOREAN SHIPPING ASSOCIATION AS THE DESIGNATED AUTHORITY

The Government recognised that there was a clear and dangerous conflict of interest where the KSA was responsible for overseeing the safe operation of domestic ships. By virtue of the 2015 reforms to the Ship Safety Act, this designated responsibility and authority has been transferred to a newly-established agency of the Ministry, acting as the *de-facto* Flag State Administration; the KSSTA.[530] This, therefore, means that the KSSTA is now overall responsible for managing the safe operation of domestic ships, including approving their modifications, inspecting and certifying their compliance with maritime safety regulations, and approving their arrangements/limits relating to the loading and stowing of cargo.

Therefore, ship companies are now prohibited from modifying their ships without submitting designs and having them approved by the KSSTA.[531] This new requirement

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needs a licence for each route, granted by the Ministry of Land, Transport and Maritime Affairs.
[526] Discussed in Chapter 6 of this thesis.
[527] Article 97-2 of the 2015 Maritime Safety Act.
[528] Article 97-3 of the 2015 Maritime Safety Act.
[529] At the time of the publication of this thesis.
[530] Chapter VII of the 2015 Ship Safety Act.
[531] Articles 13 and 46 of the 2015 Ship Safety Act.

is intended to prevent situations where ships are illegally and dangerously modified, as was the case with the *Sewol*.

THE MASTER'S DUTIES AND RESPONSIBILITIES

With the 2015 reforms to the Seafarers Act, the South Korean Government effectively incorporated Paragraphs 5 and 8 of the ISM Code into the country's legislation for domestic ships. Chapter II of the Act outlines the duties of a ship's master. These include, most notably with regards to learning lessons from the *Sewol* disaster: i) the master's responsibility for inspecting cargo;[532] ii) the master's duty to command the bridge during specific times/events;[533] iii) the master's duty to stay on board the ship;[534] iv) measures to be taken by the master in emergency situations, including drills to prepare for such situations.[535]

1. DUTY TO INSPECT THE SHIP

> **Article 7 (Responsibilities for Inspection and Reporting before Departure from Port, etc.)**:
> (1) A captain shall conduct an inspection or check-up regarding each of the following matters (hereinafter referred to as "inspection, etc.") before departure from a port, as prescribed by Ordinance of the Ministry of Oceans and Fisheries:
> […]
> (2) Whether cargo is loaded properly;
> […]
> (2) A captain shall report the results of an inspection, etc. referred to in paragraph (1) to a shipowner, etc.
> (3) Where a captain deems any problem exists, as a result of an inspection, etc. referred to in paragraph (1), he/she shall, without delay, ask the shipowner to take appropriate countermeasures.
> (4) The shipowner in receipt of a request for countermeasures under paragraph (3) shall take necessary measures for the ship and the safe operation of the ship.

This provision supports the Ministry's requirement as of October 2014, that a ship's cargo be booked and ticketed electronically through 'Bolero', an electronic Bill of Lading platform. Once the loading capacity has reached the ship's limit, as determined and certified by the KSSTA, the ticketing automatically stops and thus no more cargo

[532] Article 7.
[533] Article 9.
[534] Article 10.
[535] Articles 11, 12 and 15.

can be booked or loaded on board the ship.[536] Both of these requirements work together to prevent ships from going to sea in an unsafe condition as a result of overloaded cargo and/or improperly secured cargo, like the *Sewol* was permitted to do on 15 April 2014.

Within the ISM Code, there is no direct equivalent to the Ship Safety Act's Article 7 requirement that the master inspect the ship's cargo before leaving port. However, the duty to inspect cargo would certainly be included as part of any effective SMS; contained within the established procedures for shipboard operations, as per the requirements of Paragraph 7 of the Code.

2. DUTY TO COMMAND THE BRIDGE

> **Article 9 (Direct Command of Captain)**:
> (1) In any of the following cases, the captain shall take direct command of steering the ship:
> (1) When the ship enters or leaves port;
> (2) When the ship passes through a narrow waterway;
> (3) When the ship passes through a sea area prone to marine accidents, such as collision and sinking;
> (4) When a ship is otherwise exposed to a potential danger. […]

Article 9 is a significant move towards improving maritime safety in South Korea. Paragraphs (1)(3) and (1)(4) were not in the previous versions of the Seafarers Act. It is surmised that they were added to Article 9, not in response to the *Sewol* disaster, but in response to the *Costa Concordia* disaster that occurred in 2012. This disaster could have been avoided had the ship's master been in command of the bridge during the critical stages of its navigation, and not the inexperienced and incompetent First Officer that was.[537] With specific regards to the *Sewol*, if this provision had been in force at the time the *Sewol* was being operated, then Captain Lee would have been in command on the bridge when the *Sewol* was sailing through the Maenggol Channel, instead of his Third Officer. The disaster *may* (emphasis added) have been avoided had Captain Lee ordered navigation through the Channel at a speed below 18 knots; if the speed of 18 knots was maintained, as was the case with the Third Officer, the Helmsman's errors would still have led to the ship's heeling, its instability, its listing and its eventual capsize.

[536] X Zeng, 'KR to lose Korean class monopoly' *Fairplay* (9 November 2015).
[537] Discussed below.

Again, for ships where the ISM Code applies, this Article 9 duty would come under the Code's requirement under Paragraph 7 for the establishment of procedures, plans and instructions for shipboard operations. However, this duty is not a necessity under Paragraph 7; a ship's officer who is qualified for command *should* (emphasis added) be competent enough to navigate the ship through hazardous areas, though it is accepted that Second and Third Officers, for example, may initially need supervision from the master until they have more experience.[538] It should be observed that the South Korean Government have gone beyond the minimum standard with this provision, in an attempt to address the industry's poor safety culture, and learning lessons from not only its *Sewol* disaster, but also Italy's *Costa Concordia* disaster.

3. DUTY TO STAY ON BOARD

Whilst there is no international law specifically requiring a ship's master to be the last person to leave his ship in the event of its emergency evacuation, South Korea is an exception to the norm. By virtue of Article 10 of the Seafarers Act, it is a criminal offence for the master to depart the ship before all of the passengers have left:

> **Article 10 (Duty to Stay On Board the Ship)**: A captain shall not leave his/her ship from the time the cargo is loaded and passengers start boarding until the time all the cargo is unloaded from his/her ship and all passengers have disembarked.

This provision thus serves to remind masters of their obligation to remain on board and to oversee the evacuation of their ship during times of emergency; abandoning ship before passengers have been safely evacuated is illegal and unacceptable. Whilst this Article was unchanged by the 2015 amendments, its essence has been strengthened by the Act's amended Article 11.

4. DUTIES IN EMERGENCY SITUATIONS

> **Article 11 (Measures to be Taken when Ship is in Danger)**:
> (1) Where a ship is in critical danger, the captain shall take all measures necessary to save human lives, the ship and cargo.
> (2) The captain shall not leave the ship before completing all measures necessary to save the human lives referred to in paragraph (1).

[538] First Officers certainly should not need this level of supervision; they should be competent and experienced enough to be in command of the bridge.

(3) Paragraphs (1) and (2) shall apply mutatis mutandis to seamen.

Article 12 (Measures to be Taken in Case of Collision of Ships): When ships collide with each other, the captain of each ship shall take all measures necessary to save human lives and the ship, and inform the other party of the name of his/her ship, the shipowner, a port of registry, the port of departure and the port of arrival.

Article 15 (Emergency Organization Chart, Drills, etc.):
(1) The captain […] shall post up the emergency organization chart describing duties of seamen to be performed in case of emergency in a conspicuous place inside a ship, and conduct drills with those aboard the ship in preparation for emergency, such as fire drills, lifeboat drills, etc. In such cases, seamen shall participate in the drills, performing their duties described in the emergency organization chart.
(2) In order to assist all passengers on board to be prepared for an emergency, the captain of a passenger ship shall indicate inside the ship the location of emergency signals and gathering place and the location where life preservers are placed, display guidelines on an evacuation method, etc. in a conspicuous place inside the ship, and educate the passengers on the method of using life preservers, evacuation procedures, and other matters that they must remember in preparation for an emergency.

Paragraphs (2) and (3) were added to Article 11 by the 2015 amendments to the Act. Reading Articles 11 and 12 together, the master is under a legal obligation to take all measures necessary during emergency situations in order to save lives.[539] Furthermore, he is not to leave the ship before these measures have been completed i.e. before he has made every attempt to rescue all those on board. This both clarifies and expands upon the Article 10 provision that was already in force, by specifically addressing the master's duties during emergency situations. This was in response to the appalling circumstances in which Captain Lee and his crew abandoned the *Sewol*, whilst hundreds of passengers remained in their cabins under the Captain's orders.[540]

In ensuring that the master follows appropriate procedures in emergency situations, Article 15 requires him to ensure that he and his crew are familiar with their duties, which include, *inter alia*, instructing passengers where to muster and how to use their lifejackets. This familiarisation is to be tested by the use of drills. Again, with reference to the *Sewol* disaster, the amendments to Article 15 complement Article 11(2) and, together, are intended to prevent masters from being unprepared and acting

[539] As well as the ship and its cargo, though human life should be the primary concern.
[540] Discussed above.

incompetently during emergency situations, and from hampering the evacuation and rescue efforts, as was the case with Captain Lee and his crew on 16 April 2014.

For those ships that are bound to comply with the ISM Code, the Code's provisions that are equivalent to the Seafarers Act's Articles 11, 12 and 15 would be the Code's Paragraph 8, which requires companies to identify and prepare the crew for emergency situations.

4.2.4 COMMENTS AND CONCLUDING REMARKS

Whilst the South Korean Government is to be commended for reforming and strengthening the system for supervising and regulating safety in the domestic maritime industry, it is questioned whether the new system could not be more efficient and more effective, especially considering its similarity with the ISM Code. The author's main criticisms are outlined accordingly.

Firstly, it is suggested that it would be more prudent to compile the laws relating to the safety of domestic ships into one Act, in the same way as the ISM Code was incorporated into the county's domestic legislation by virtue of the Maritime Safety Act. This would mean that the various rules and regulations relating to the safety of domestic ships would be codified into one piece of legislation, and therefore would be more concise, easier to understand and thus easier to comply with.

The author's second criticism relates to the implementation of these laws in practical terms. Where the ISM Code requires a ship company to create a SMS, outlining the responsibilities, duties and procedures for everyone within the company to follow with regards to safety, this is not a requirement for domestic ships in South Korea. Having a SMS and/or manuals on board would be more effective in that it would be easier for masters and crews to understand, and also more likely to be read by them.

The final criticism relates to the Government's failure to effectively tackle the complacency that some ship companies, like Chonhaejin Marine, have with safety. The Government should have outlined more specifically the ship company's responsibilities and duties with regards to safety, instead of focusing mainly on the ship's master.

South Korea had, up until the *Sewol* disaster, a relatively good safety record and a modern maritime infrastructure.[541] However, the system that was in place to regulate the safety standards of the country's domestic ships was ineffective, and this resulted in the *Sewol* disaster; a disaster which had a profound social and political impact in South Korea. In 2015, the South Korean Government reformed this system through its reform package measures on maritime safety. This new system replaced a corrupt body with a newly-formed agency of the Ministry of Oceans and Fisheries, to supervise and regulate the safety standards of the country's domestic ships. It prevents companies from illegally and dangerously modifying their ships, and it prescribes specific duties for the master and his crew with regards to navigation and emergency situations. On top of this, the Government disbanded Korea Coast Guard due to its incompetence and corruption. Although it is the author's opinion that this new system could be more efficient and more effective, the significant steps that the Government has made towards improving maritime safety and encouraging the adoption of a safety culture, looks promising, but only time will tell as to whether it will prove effective.

4.3 POST-ISM CASE STUDY II: THE *COSTA CONCORDIA* (2012)

During the early stages of this research project, a maritime disaster occurred off the coast of Giglio Island near Tuscany, Italy, which had a significant impact on the direction and focus of the author's research, and the development of the thesis hypothesis. This disaster is significant because it involved a state-of-the-art luxury cruise ship colliding with a rock and grounding, as well as poor handling of the ship's evacuation, due to important safety barriers being breached and a poor safety culture being promulgated by the ship's operating company. Not only is the disaster itself significant due to it occurring after the entry into force of the ISM Code, but so too are the subsequent investigations and criminal trials, the latter of which are discussed in detail in Chapter 6 of this thesis. Because of this disaster's significant contribution to the author's research, and for the purposes of this chapter, it is analysed from an ISM-Code perspective, using Reason's theory of organisational accidents (discussed below).

[541] Kim, 'The *Sewol* Ferry Disaster in Korea and Maritime Safety Management' at p. 345.

4.3.1 SUMMARY OF THE DISASTER: 13 JANUARY 2012

The cruise ship *Costa Concordia* left the port of Civitavecchia, Italy, in the late afternoon of 13 January 2012, initially following its standard and agreed route to Savona, Italy.[542] However, during the voyage, the ship's master, Captain Francesco Schettino, deviated from the original route between Giglio Island and the mainland, for touristic purposes.[543] The safety margin for this deviation was misunderstood by the Officers of the Watch and, as a consequence, was set in error, which meant that the *Costa Concordia* sailed too close to the shore. The danger was not realised until it was too late and, as a result, the *Costa Concordia* collided with a rock off the shore of Giglio Island in the Tyrrhenian Sea. The ship drifted back towards Giglio Island, where it grounded 500 metres from the village Giglio Porto, resting on its starboard side in shallow waters, with most of its starboard side under water.

Despite the *Costa Concordia*'s gradual sinking, its complete loss of power, and its close proximity to the shore in calm waters, an order to abandon ship was not given until half an hour after it collided with the rock. This has led to heavy criticism being directed towards the evacuation efforts of Captain Schettino and his crew (discussed below). Because of the poor handling of the evacuation, 32 of the 3,229 passengers and 1,023 crew (known to be on board) died.[544]

Although it could be argued that the number of deaths is relatively low for a maritime 'disaster', especially when considering the total number of people that were on board the ship, the *Costa Concordia* is one of the largest ships ever to be abandoned and the disaster dominated international media. It illustrates a significant problem with the implementation of the ISM Code, and its mandatory safety culture, by ship companies, seafarers *and* Flag State Administrations, despite there being in place clear international and regional legal frameworks.[545]

[542] Herein referred to as the 'original route'.
[543] See Appendix 3 for a chart displaying both the original and the deviated routes.
[544] As well as one member of the salvage team on 1 February 2012.
[545] These legal frameworks are outlined in Chapter 2 of this thesis.

4.3.2 AN ISM ANALYSIS OF THE DISASTER USING REASON'S MODEL OF ORGANISATIONAL ACCIDENTS

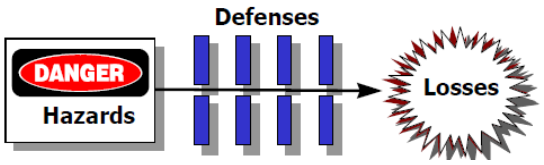

Diagram 4.5: Reason's Simplified Illustrative Model of Organisational Accidents[546]

The author has chosen to use Reason's model of organisational accidents to analyse the disaster from an ISM-Code perspective, using information from the official report into the *Costa Concordia* disaster[547] and an ISM-analysis provided by Arne Sagen of the Skagerrak Safety Foundation.[548] Reason hypothesises that an organisational accident that results in the loss of people and/or property, which the *Costa Concordia* disaster would come under, is caused by the breaching of those safety defences/barriers that would normally prevent hazards from manifesting into accidents/disasters.

DEVIATING FROM THE ORIGINAL ROUTE

In line with Reason's model, the first breaching of a safety barrier/defence in the case of the *Costa Concordia* came when Captain Schettino decided to change the original voyage plan without the prior agreement of Costa Crociere (the owners of the *Costa Concordia*) and the local port authorities. Italy's Automated Search and Rescue System (ARES) states that notification of a change to the planned route needs to be made to the port authorities if the new route deviates from the planned one by more than 15 nautical miles.[549] As the *Costa Concordia*'s deviation was less than this, it did not need to be notified to, or approved by, the port authorities and therefore, strictly speaking, Captain Schettino was not in error by not notifying of the deviation. However, a former master of the *Costa Concordia*, who was also Captain Schettino's mentor, has suggested that the deviation should have been submitted for approval, in which case it would have been approved with a safety margin of 1 nautical mile being stipulated, and with a

[546] This image is taken from A Di Lieto, *Costa Concordia Anatomy of an organisational accident* (Australian Maritime College 2012) at p. 3. A more detailed version of Reason's illustrative model of organisational accidents is provided in Chapter 1 of this thesis.
[547] Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation (Ministry of Infrastructures and Transports: Marine Casualties Investigative Body (Italy) 2013).
[548] Document with the author.
[549] See Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 44.

further stipulation that the *Costa Concordia* was not to exceed 5 knots when close to the island.[550]

> **Paragraph 7** of the ISM Code: The Company should establish procedures, plans and instructions, including checklist as appropriate, for key shipboard operations concerning the safety of the personnel, ship and protection of the environment. The various tasks should be defined and assigned to qualified personnel.
>
> **Section 4.3.10** of Costa Crociere's SMS: situations that may pose a hazard to navigation require the adoption of additional measures, including adjusting the speed so as to allow for a safe margin of manoeuvre, even in the case of the failure of the main engine and of the rudder.[551]

Despite best common practice stating that the maximum speed of the *Costa Concordia* should not have exceeded 5 knots on its approach to Giglio Island, it was travelling at a speed of 15.5 knots when it collided with the rock. At 15.5 knots, the *Costa Concordia* would have required 0.7 nautical miles in order to stop its momentum, and therefore the 0.5 limit set by Captain Schettino was too low in terms of satisfying Section 4.3.10 of the SMS. However, at 15.5 knots, the ship would have still been able to avoid collision, had it turned at the 0.5 nautical mile point, but the First Officer took it beyond this point (discussed below).

INSUFFICIENT NAVIGATIONAL CHARTS

The second breaching of a safety barrier also relates to the voyage planning; namely, that the route of the planned deviation was not drawn on any paper navigational chart. As a matter of international law,[552] the route of the *Costa Concordia* was to be plotted and recorded on paper charts, including any deviations from the original route. This legal requirement was incorporated into the company's SMS:

> **Section 4.1.4.2** of Costa Crociere's SMS: the officer in charge of navigation publications is to prepare and present, on paper charts, detailed plans to be approved by the Master of the ship.[553]

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[550] Di Lieto, Costa Concordia Anatomy of an organisational accident at p. 7.
[551] P.14 MAN 01 SMS PROCEDURES FOR THE BRIDGE. See Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 48.
[552] Resolution A.893(21), Guidelines for Voyage Planning.
[553] P.14 MAN 01 SMS "PROCEDURES FOR THE BRIDGE". See Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 43.

> **Section 4.7.1** of Costa Crociere's SMS: the charts and nautical publications to be used for navigation are the traditional paper charts published by the Admiralty.[554]

On 13 January 2012, only the original route was drawn on a paper chart (with a scale of 1:100,000).[555] The chart was used to plan the deviation, but the deviation was not actually plotted on the chart. Instead, the planned deviation was uploaded to the ship's automated navigation system (the Integrated Navigation System (INS)), which, according to Resolution A.893(21), could only be used as an aid to navigation; not the primary means. The nautical charts that would have been satisfactory for the planning of and plotting of the deviation's progress would have been those with scales of 1:20,000 or 1:5,000.[556] However, the *Costa Concordia* did not have these charts on board for Giglio Island because the area was not part of any scheduled route. However, it could be argued that Costa Crociere should have placed these charts on board because the company knew, or ought to have known, that the *Costa Concordia* regularly performed such touristic sail-pasts/deviations, as revealed during the investigation.[557]

The failure to plan and plot the deviation using the correct paper navigational chart(s) of 1:20,000 or 1:5,000 scale, meant that the rock formation, which the *Costa Concordia* ultimately collided with, was not discovered as a navigational hazard by the bridge crew.

AUTOMATIC NAVIGATION INSTEAD OF MANUAL MANOEUVRING

The third safety breach relates to the navigation and monitoring of the route by the bridge team.

> **Sections 4.3.9** and **4.3.10** of Costa Crociere's SMS: the operation of the ship in dangerous conditions must be by manual manoeuvers, and supported by look-out and radar.[558]

On the night of 13 January 2012, the bridge team was comprised of First Officer Ciro Ambrosio (the Senior Officer of the Watch), Third Officer Silvia Coronica (the Junior

[554] ibid at p. 46.
[555] See Appendix 4.
[556] See Appendices 5 and 6.
[557] Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 46.
[558] ibid at p. 48.

Officer of the Watch), a helmsman (Jacob Rusli Bin), and a deck cadet with look-out duties. First Officer Ambrosio oversaw navigation, with Third Officer Coronica assisting him in terms of fixing the *Costa Concordia*'s position/progress on the paper charts. However, as previously stated, the INS was being used to navigate the *Costa Concordia* automatically (using the route uploaded by the First and Third Officers); the (insufficient) paper chart was being used merely to record the ship's progress along this route, and the radar was not being used at all. Therefore, on approach to Giglio Island, the ship was being manoeuvred automatically; not manually by the Helmsman, as required by the SMS.[559]

INCORRECT USE OF THE INTEGRATED NAVIGATION SYSTEM

The fourth breach in safety relates to the erroneous use of the INS.

> **Paragraph 1.2.3.1** of the ISM Code: The safety management system should ensure compliance with mandatory rules and regulations.
>
> **Paragraph 6.4** of the ISM Code: The Company should ensure that all personnel involved in the Company's SMS have an adequate understanding of relevant rules, regulations, codes and guidelines.
>
> **Paragraph 6.5** of the ISM Code: The Company should establish and maintain procedures for identifying any training which may be required in support of the SMS and ensure that such training is provided for all personnel concerned.

As discussed above, it was confirmed by the investigation that Captain Schettino stipulated a safety margin of 0.5 nautical miles. This is understood by the maritime community as meaning a safety contour of 0.5 nautical miles from the 10-metre bathymetric line (i.e. the point from the shore where the water is 10 metres deep); not 0.5 nautical miles from the shore itself. However, the First and Third Officers mistakenly set the safety margin from a fixed point from the island's shore, which resulted in the *Costa Concordia* sailing too close to the island.

In addition to this mistake, the First Officer erroneously deactivated the alarm system on the INS, which resulted in the two navigational hazards that were undetectable by the ship's radar,[560] being unknown to the bridge crew. The STCW Convention requires all

[559] This was corrected by Captain Schettino when he later entered the bridge (see below).
[560] An underwater rock with a shallowest depth of 7.3 metres and a small rock approximately 1 metre

those operating the INS to undergo specific training.[561] This requirement was introduced by the 2010 Manila Amendments and entered into force on 1 January 2012 (12 days before the *Costa Concordia* disaster). However, Costa Crociere was unaware of the requirement and so it failed to provide the legally-required training.[562] Not only was this a breach of the STCW Convention, but it was also a breach of Paragraphs 1.2.3.1, 6.4 and 6.5 of the ISM Code. This lack of training is what led to the INS being used incorrectly and with devastating consequences.

Therefore, it can be said with some degree of certainty, that had the correct paper chart(s) been used to plan and plot the route of the deviation and to track the ship's progress along this route, and had the INS been used correctly as an aid to navigation, then the two rocks that presented a navigational hazard to the ship would have been known to the bridge crew, and a route would have been plotted to avoid them accordingly.

From the above analysis, it is clear that either the First and Third Officers were unfamiliar with the SMS, or they were complacent with, or ignorant of, the implementation of the SMS. If it is the former, then Costa Crociere was at fault; if it is the latter, then the fault lies with the First and Third Officers themselves. None of this, however, was Captain Schettino's error (although it could be argued that he should have overseen the planning/plotting of the deviation more thoroughly, especially considering the concerns that he had regarding the First Officer's experience and ability (discussed below)). The blame for this must surely be placed with Costa Crociere.

BRIDGE MANAGEMENT

The fifth and final safety barrier that was breached, and which resulted in the loss of the ship,[563] relates to the situation on the bridge immediately leading up to the *Costa Concordia*'s collision with the rock. The investigation into the accident revealed that the organisation of the bridge on the night of the disaster was poor; crew training and familiarisation was lacking, and this prevented certain duties being performed

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above sea level.
[561] Regulation A-II/1 of the STCW Convention (Manila Amendments).
[562] Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 46.
[563] But not necessarily the loss of life (see below).

correctly.[564] Captain Schettino entered the bridge at 21:34, with the ship's Hotel Director, Manrico Giampedroni,[565] as the ship was approaching Giglio Island. At this point, Captain Schettino was on the bridge merely as an observer; his First Officer was still in command. Captain Schettino noticed the use of the INS being used as the primary means of navigation and openly (and rhetorically) asked, "Don't we normally use paper charts and manual manoeuvring when we are this close to shore?" It was at this point that the inexperienced and incompetent First Officer[566] switched to paper charts and manual manoeuvring.

At 21:39, Captain Schettino declared "I take the conn." Four seconds later, the First Officer confirmed "Master has the conn." At this time, Captain Schettino was in command, but unaware that the *Costa Concordia* had passed the turning point for keeping the ship on a safety contour of 0.5 nautical miles from the shore[567] whilst under the First Officer's command (at this point the *Costa Concordia* was 0.6 miles from the shore). At 21:40, Captain Schettino gave the order to turn slowly to starboard at a course of 310 degrees, which suggests that he believed the ship to be still following the planned deviation.

Best common practice regarding the changing of command on the bridge stipulates that the person being relieved of command should state, to the person taking command, relevant information relating to the ship's course and speed, and its position in relation to the planned voyage. In this instance, the First Officer failed to do this. Whilst this evidences the First Officer's incompetence and/or lack of training, it was also Captain Schettino's responsibility to ensure that he was aware of the *Costa Concordia*'s situation, and he should have therefore made sure that he was furnished with this information before continuing with command.

At 21:43, Captain Schettino, noticing the white foam of the waves in the distance breaking against the rocks, and realising the immediate danger that the ship was in, gave the order to turn to starboard to 350 degrees, but the Helmsman did not understand,[568]

[564] Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 159.
[565] The criminal trial of Mr Giampedroni is discussed in Chapter 6 of this thesis.
[566] First Officer Ambrosio had only served twice before as a 'first mate' before he was hired to serve on the *Costa Concordia* and Captain Schettino had raised concerns over his lack of experience.
[567] Also known as the wheel-over point.
[568] Due to his inability to fully understand Italian (the working language of the bridge) or English. It

and said back, "340 degrees". Both Captain Schettino and the First Officer shouted "350 degrees" and at this point the Third Officer left her post to assist the Helmsman in his duties. Captain Schettino then remarked "If we are not grounding!" From the ship's 'black box' recording, the bridge crew are heard laughing; unaware of the dangerous situation that the *Costa Concordia* was in.

The Helmsman exacerbated an already dangerous situation by not responding to Captain Schettino's orders correctly and in a timely manner.

> **Paragraph 6.6** of the ISM Code: The Company should establish procedures by which the ship's personnel receive relevant information on the SMS in a working language or languages understood by them.
>
> **Paragraph 6.7** of the ISM Code: The Company should ensure that the ship's personnel are able to communicate effectively in the execution of their duties related to the safety management system.
>
> **Section 5.5.3** of Costa Crociere's SMS: The working language on board is the Italian language.[569]

Guidance from the International Chamber of Shipping and the International Shipping Federation on this point states that the ability of personnel to communicate effectively with other crew members should be reviewed at recruitment stage.[570]

Costa Crociere was obligated to appoint a Helmsman with an understanding of the Italian language sufficient enough to enable him to carry out his duties on board effectively and safely. Captain Schettino was responsible for ensuring that this requirement was satisfied in practice. He had previously been concerned about whether the Helmsman was qualified for the position due to his language barrier, and had asked the Second Captain to check on this. However, the checking of this by the Second Captain was insufficient as he merely examined the Helmsman's certificates and did not perform any oral tests in order to determine the helmsman's understanding of the Italian (or English) language. In fact, when the Helmsman gave a statement to the authorities

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should be observed that Captain Schettino's orders were all given in English when he took command from 21:39 due to the helmsman's language barrier. The international law relating to this is discussed in Chapter 6 of this thesis.

[569] MAN 01SMS "MANAGEMENT SYSTEM COMPANY MANUAL" See Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 41.

[570] *Guidelines on the Application of the IMO International Safety Management (ISM) Code*, (4th edn, International Chamber of Shipping and the International Shipping Federation 2010) at p. 22.

following the disaster, he needed an interpreter because he did not sufficiently understand English or Italian.[571] It could therefore be argued that with regards to the Helmsman being insufficient for his role on board the *Costa Concordia*, both the company and Captain Schettino should bear responsibility.[572]

> **Paragraph 6.2** of the ISM Code: The Company should ensure that each ship is manned with qualified, certified and medically fit seafarers in accordance with national and international requirements.

At 21:44, the *Costa Concordia*'s bow was less than 150 metres from the rocks, and it was off course by 809 metres.[573] At 21:45, Captain Schettino then gave the order to turn "hard to port". The First Officer then cried out, "hard to starboard!"; countermanding Captain Schettino's order, believing him to be turning the ship back towards the island. Captain Schettino then twice shouted, "hard to port!" This order was given in order to clear the aft of the ship from the rocks.

At a critical moment leading up to the collision with the rocks, the First Officer wrongly intervened after Captain Schettino had assumed command of the ship. When considering this error with that above regarding the First Officer's inappropriate and erroneous use of the INS, it is clear that First Officer Ambrosio lacked both competence and sufficient training for his role and his duties on board the *Costa Concordia*. The responsibility for this lies with Costa Crociere.[574]

As a result of the Helmsman's misunderstanding, the First Officer's countermanding of orders, and the Helmsman's delay in turning the ship due to this confusing state on the bridge, the *Costa Concordia* hit the rocks at 21:45, which tore a 53-metre gash in its port side. In line with Reason's model, this was the final safety barrier that could have prevented the *Costa Concordia* disaster.

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[571] Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 75.
[572] However, Costa Crociere have escaped liability for this (see Chapter 6 of this thesis).
[573] Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 28.
[574] Though it is the master's responsibility for evaluating this competence through drills and observations etc.

In line with Reason's definition of an organisational accident,[575] the bridge crew were insufficiently trained for, and insufficiently familiarised with, their duties on board the *Costa Concordia* as a result of a poor safety culture being promulgated by Costa Crociere ('latent/organisational conditions'). This resulted in the First and Third Officers' improper planning and navigating of the ship's deviation on the night of 13 January 2012. There were also 'active failures' present on the bridge in the form of distractions, errors and violations, primarily by the First Officer and the Helmsman. When the safety barriers/defences discussed above were breached, the latent/organisational conditions combined with the active failures to cause the disaster.

THE EVACUATION

Although following the breaching of the five safety barriers discussed above, the loss of the *Costa Concordia* was unavoidable, the loss of life was still avoidable at this point. The final breach in safety, which resulted in the loss of the 32 lives, came with the poor handling of the evacuation of the *Costa Concordia*. It is therefore important to analyse the stages of the evacuation in detail.

Paragraph 8 of the ISM Code:

8.1 The Company should identify potential emergency shipboard situations, and establish procedures to respond to them.

8.2 The Company should establish programmes for drills and exercises to prepare for emergency actions.

8.3 The SMS should provide for measures ensuring that the Company's organisation can respond at any time to hazards, accidents and emergency situations involving its ships.

Costa Crociere's **Crisis Management Preparedness Plan** following a collision that results in a breach:[576]

1. The Second Master (or the Officer on Duty) is to verify the damage sustained.

2. When the damage has been ascertained, the affected compartments must be identified.

3. The collision must be notified to the competent MRSC and to the Company's Fleet Crisis Coordinator.

4. The situation must be assessed and evaluated using the 'Damage Control Plan'.

5. The team responsible for verifying the damage are to investigate the part of the ship that has been breached.

[575] See Chapter 1 of this thesis.

[576] P15.6 IO 01 SMS "CRISIS MANAGEMENT PREPAREDNESS PLAN - OPERATIONAL & REPORTING PROCEDURE". See Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 71.

6. The Master is to take appropriate measures, such as the sealing of watertight doors, activating bilge pumps etc.
7. The Company's Technical Advisor must be kept informed of the situation as it develops.
8. If these measures are insufficient, the Master is to request assistance from nearby ships and the MRSC.
9. The General Emergency Signal must be given, and passengers and crew advised to go to designated areas/muster stations.
10. If remaining on board is dangerous, procedures for abandoning ship must be taken. The abandoning of the ship is to be monitored until the ship has been fully evacuated.

Despite these procedures being a part of the SMS, and used during drills in the past, they were not followed on 13 January 2012.[577] Immediately following the collision with the rock, all the ship's Officers reported to the bridge. At 21:57, Captain Schettino contacted Robert Ferrarino, Costa Crociere's DPA who acted in the capacity of Fleet Crisis Coordinator, and advised him that the *Costa Concordia* had collided with a rock and was being assessed for damage, and that it was experiencing a black-out due to water entering its stern.[578]

With regards to step 3 of the procedures, only partial information was provided to the Maritime Rescue Sub Centre (MRSC). Furthermore, despite the seriousness of the situation being known on the bridge by 22:01, first contact with the MRSC (i.e. Captain Gregorio Maria De Falco, of the Italian Coast Guard and the Port of Livorno's Harbour Master) was not made until 22:14. At this time, an (unidentified) officer advised that the ship had been suffering from a "black out" for approximately 20 minutes but that the situation was under control.[579] There was no mention of a collision or a gash in the ship's side.

Steps 4 and 5 of the procedures were not followed either; the 'Damage Control Plan' was not used to put in place a Damage Control Team in order to evaluate the damage and to determine what actions could be taken to stabilise the ship and thus reduce the danger. As a result, the extent of the damage to the ship was not known straight away, which delayed its evacuation.

[577] It should be observed that these procedures pointed out that the Master should follow them as closely as possible, but has the discretion to apply other suitable measures in accordance with the scenario and the Master's own experience.
[578] Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at p. 30.
[579] ibid at p. 16.

When it was realised that the ship had lost propulsion and assistance was needed, step 8 of the procedures was satisfied, albeit partially. At 22:26, Captain Schettino advised the DPA that the ship was taking on water through an opening in its port side, which was causing a gradual list. However, he did not provide Captain De Falco with this information until 22:38; 12 minutes after advising the DPA of the situation and 53 minutes after the ship collided with the rock.[580] It was also at this point that Captain Schettino requested a tug boat to assist the *Costa Concordia*'s manoeuvring into port.

With regards to steps 9 and 10 of the procedures, at 22:30, the Chief Engineer advised Captain Schettino to broadcast the General Emergency Signal[581] and to give the order to abandon ship. The General Emergency Signal was broadcast at 22:35 but the emergency procedures relating to the mustering of passengers and crew were not followed. For example, following the broadcast of the General Emergency Signal, the Hotel Director sent passengers away from muster stations and requested them to return to the ship's lounges. The official report into the disaster heavily criticised this part of the evacuation. It was revealed by the investigation that Costa Crociere was aware that during an 'abandon ship' drill, performed on board the *Costa Concordia* as part of an internal ISM audit in July 2011, members of crew were unfamiliar with their duties regarding mustering and evacuating the ship. This was further realised when, following a drill organised by Captain Schettino on 15 October 2011, he warned the company that the standard of his crew's performance had decreased since the last drill, and had proved dangerous at times. This was also confirmed by the Safety Trainer for the ship. However, Costa Crociere failed to implement any corrective action in accordance with Paragraphs 6.5 and 9 of the ISM Code.[582] This failure definitely contributed to the causes of death for the 32 people that lost their lives.

Despite the General Emergency Signal being broadcast at 22:35, the order to abandon ship was not given until 22:54, and the first lifeboats were not lowered until 22:55. Captain Schettino left the bridge at 23:19, and by 00:36, he had left the *Costa*

[580] ibid at p. 72.
[581] The signal is composed of seven or more short blasts followed by one long blast on the ship's whistle and internal alarm system.
[582] Cruise Ship COSTA CONCORDIA Marine Casualty on January 13, 2012: Report on the safety technical investigation at pp. 78-79.

Concordia altogether.[583] However, there are two versions of how and why Captain Schettino left the ship, and it is appropriate to consider them both.

THE ITALIAN COAST GUARD'S VERSION OF EVENTS

Captain De Falco coordinated the rescue efforts of those abandoning the *Costa Concordia*. He was in Livorno, 140 kilometres away from Giglio Island, and he was not in possession of all the facts relating to the *Costa Concordia*'s condition or the progress of its evacuation. This can be seen when, at 22:16, Captain De Falco ordered the customs patrol boat *G.104*, which was in the area, to the scene to observe and report on the situation, and to provide assistance with the evacuation efforts. *G.104* reached the *Costa Concordia* at 22:39. It was captained by a lawyer, and not a person experienced with search and rescue operations. This inexperience was probably the reason why he failed to advise Captain De Falco that the *Costa Concordia* had grounded on its starboard side. As a result, Captain De Falco mistakenly believed the *Costa Concordia* to be grounded upright, albeit with a slight list. Captain De Falco, believing Captain Schettino to have wilfully abandoned ship and leaving many passengers and crew on board, ordered him to get back on board and oversee the evacuation from the ship.

In a tape recording released to the media, Captain Schettino can be heard attempting to advise that the Costa Concordia had grounded on its side and that he was still coordinating the evacuation from a lifeboat at the scene. However, Captain De Falco dismissed and ignored this information, and repeatedly ordered Captain Schettino back on board. Captain Schettino refused this order and maintained that he was unable to get back on board the *Costa Concordia* due to its position in the water. This tape recording has been taken out of context, encouraged by Captain De Falco, and so has significantly and unfairly affected the treatment of Captain Schettino by the media and the courts.[584]

CAPTAIN SCHETTINO'S VERSION OF EVENTS

Captain Schettino maintains that he did not abandon the command of the *Costa Concordia* voluntarily. He claims that he was overseeing the evacuation of passengers on the starboard side, and he could not get to the port side due to the heavy and

[583] The exact time is unknown.
[584] This is discussed in Chapter 6 of this thesis.

increased listing. The last lifeboat on the starboard side was trapped below the *Costa Concordia* by the extended telescopic davits, penetrating the lifeboat's roof, and the lifeboat's pilot was in a state of panic; fearing that the lifeboat would be pushed underneath the *Costa Concordia*. Captain Schettino attempted to unhook the lifeboat, but when the ship listed further (between 40 and 70 degrees), he lost his footing on the deck and fell on to the roof of the lifeboat. It was at this point that Captain Schettino was able to free the lifeboat from its perilous situation, and thereby saved the lives of those on board it.

From this lifeboat, Captain Schettino continued to coordinate evacuation efforts and command the lifeboats. He stayed close by to the *Costa Concordia* as it continued to list; he did not safely flee as Captain De Falco has suggested in the media.[585] It is clear from photographic and diagrammatic evidence provided to the author by Sagen, that Captain Schettino could not get back on board the *Costa Concordia* from the port side, as Captain De Falco was ordering; the ladder was not accessible from any lifeboat.[586] Furthermore, the situation on the port side of the ship when Captain Schettino was ordered to go back on board, was such that the only way to get back on board was to climb up the ladder where the passengers were climbing down. As images clearly show, any attempt to climb up the ladder would have had fatal consequences for the passengers trying to climb down it.[587]

Based on the statements of Captain Schettino, and corroborating evidence and analysis provided to the author, it is clear Captain Schettino had no choice but to enter the lifeboat on the starboard side when he did, and he was unable get back on board from either side of the ship. He, therefore, had no choice but to coordinate the evacuation of the *Costa Concordia* from the lifeboat.

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[585] N Squires, 'Cruise disaster: word by angry word - coastguard accuses Concordia captain of abandoning passengers' *The Telegraph* (18 January 2012) <http://www.telegraph.co.uk/news/worldnews/europe/italy/9021456/Cruise-disaster-word-by-angry-word-coastguard-accuses-Concordia-captain-of-abandoning-passengers.html> (accessed 4 March 2015).
[586] To better illustrate this point, the author has included these images, with appropriate commentary, in Appendices 7, 8, 9, 10 and 11.
[587] See Appendix 10.

4.3.3 ATTRIBUTING BLAME

From the above analysis, six parties can be identified as significantly contributing to the causes of the disaster and the resulting loss of life.

Costa Crociere, as the ship company, should bear most of the blame for the failures that led to the *Costa Concordia* disaster and its poor evacuation. The company adopted a SMS that it did not always follow in practice: it failed to appoint a competent Helmsman; it failed to train the bridge crew in the correct use of the INS; and it failed to provide effective training on how to safely evacuate the ship in emergency situations, despite being informed and warned on previous occasions that this presented a serious danger to the lives of those on board. The company's failure to follow its own SMS requirements, and to implement corrective action, resulted in a poor safety culture being adopted and encouraged from the top, and this cascaded down through the company.

Ciro Ambrosio was not qualified for the position of First Officer of the *Costa Concordia*. He was inexperienced and incompetent, though this was partly Costa Crociere's fault for not ensuring that he was sufficiently familiarised with the company's SMS, and for not identifying and providing necessary training for, *inter alia*, correct use of the INS and the proper handing-over of command. His inexperience and incompetency meant that he did not carry out Captain Schettino's orders correctly, and this put the *Costa Concordia* in considerable danger.

Jacob Rusli Bin was not qualified for the position of Helmsman on board the *Costa Concordia*. He did not understand the Italian and/or English languages, and therefore struggled to understand orders given on the bridge. This proved critical on 13 January 2012, when immediate action needed to be taken but Mr Bin's misunderstanding and confusion prevented him from acting swiftly, thus leading to the *Costa Concordia* turning too late and ultimately colliding with the rock.

Although Captain Schettino has essentially received all the blame for the *Costa Concordia* disaster and the loss of the 32 lives,[588] it is the author's opinion that he is not to blame for the ship's collision. Furthermore, he is only partly to blame for its poor evacuation. Although Captain Schettino did sail the *Costa Concordia* too fast at 15.5

[588] Discussed in Chapter 6 of this thesis.

knots, the ship would have avoided collision had the First and Third Officers implemented fully Captain Schettino's orders regarding the deviation, and if the Helmsman performed his duties correctly. It could be argued that Captain Schettino should also have actively supervised and reviewed the planning and progress of the deviation, though a First Officer of such a ship should not need this level of supervision.

Although Captain Schettino had discretion with regards to the following the company's outlined procedures for evacuating the ship following a collision, and chose not to, he should have followed them in this instance. The discretion related to substituting the procedures for suitable ones fitting the scenario. Captain Schettino's actions in evacuating the *Costa Concordia* did not satisfy this; his delay in broadcasting the General Emergency Signal, and in giving the order to abandon ship, significantly hampered the evacuation efforts, which most certainly contributed to the cause of death of the 32 people who lost their lives. However, understandably Captain Schettino was in shock and, furthermore, he was not solely to blame for the poor evacuation.

During previous drills, Hotel Director Manrico Giampedroni had proven that he was aware of his duties during the evacuation of the ship, and was competent in carrying them out. However, during the evacuation on 13 January 2012, he failed to carry out these duties. In this instance, Costa Crociere was not to blame, but Mr Giampedroni was, for his wilful actions.[589]

Robert Ferrarino, the DPA and Fleet Crisis Coordinator, failed to sufficiently act as the link between Costa Crociere, the *Costa Concordia* and the MRSC. He was continuously advised and warned about the developments of the scenario and its increased danger, but he failed to encourage Captain Schettino to promptly abandon ship. Furthermore, he failed to provide support and information in a timely manner to Captain De Falco.[590]

Of these six partiers, the five individuals were successfully prosecuted for their roles in the disaster. However, some have claimed that Captain Schettino has been used as a scapegoat by Costa Crociere and unfairly treated and punished by the Italian courts.

[589] The Italian courts have reprimanded Mr Giampedroni for this willful action, and this is discussed in Chapter 6 of this thesis.
[590] Again, the Italian courts accepted that this failure amounted to a criminal act and punished Mr Ferrarino accordingly, as discussed in Chapter 6 of this thesis.

Furthermore, Costa Crociere has shockingly escaped all liability. The punishment of the five individuals, and the lack of punishment of Costa Crociere is discussed in detail in Chapter 6 of this thesis.

4.4 CONCLUDING REMARKS

Although the ISM Code was not applicable to the *Sewol*, South Korea has since recognised the need for *all* (emphasis added) ships to be governed and regulated by a system of safety management, as well as the need for a safety culture within the country's maritime industry. Whilst the ISM Code was applicable to the *Costa Concordia*, the ship's operating company failed to implement the Code fully and so failed to embrace a safety culture. This complacency with safety resulted in the company appointing inexperienced and incompetent officers and crew, which ultimately led to the *Costa Concordia* being operated dangerously, with devastating consequences.

The two maritime disasters demonstrate the need for the ISM Code (or a national equivalent for domestic ships). Both disasters occurred as a result of the ship company being complacent with safety, and therefore highlight the importance of Flag State Administrations ensuring that the Code is being implemented fully and effectively on board the ships to which it has jurisdiction over.

CHAPTER 5
CORPORATE MANSLAUGHTER

5.1 INTRODUCTION

This chapter begins by analysing the origins of the common law offence of corporate manslaughter, including the various failed attempts by the judiciary to make the offence work. The process of the Corporate Manslaughter and Corporate Homicide Act 2007's development and enactment is examined, and the few cases that have been heard under the Act are discussed. Throughout this chapter, it is made clear that the Act is incapable of securing a conviction against a large company and, despite the number of corporate manslaughter prosecutions increasing, due to the Act's specific exclusion of secondary/individual liability, the Act is not achieving the success it was originally created to achieve. The trends that are identified in this chapter are a foundation of the author's theories and the thesis hypothesis, as discussed in the following chapter.

5.2 BACKGROUND TO THE OFFENCE OF CORPORATE MANSLAUGHTER

Often the impetus for law reform lies in those events that have had a significant impact upon society. This claim is made by Gobert, in his article examining the development of the Corporate Manslaughter and Corporate Homicide Act 2007, and appraising its value to the criminal law.[591] At the time that the court summonses were issued against P&O, and the seven individuals, for the *Herald of Free Enterprise* disaster, Wells made the observation that there had been an increase in the number of incidents of corporate manslaughter,[592] and a marked increase in the tendency towards blaming companies and collective industries, such as the maritime/shipping industry, rather than individuals for the deaths that had occurred.[593] Griffin claims that it is this public perception, driven by the media's coverage of major disasters, which led the Government to initiate a long road to reform of the law of corporate manslaughter.[594]

[591] J Gobert, 'The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?' (2008) 71 The Modern Law Review 413.
[592] Instances where a company's culpable conduct has led to a person's death.
[593] C Wells, 'Corporate Manslaughter: A Cultural and Legal Form' (1995) 6 Criminal Law Forum 45.
[594] S Griffin, 'Corporate Manslaughter: A Radical Reform?' (2007) 71 Journal of Criminal Law 141.

It is appropriate at this point to examine first the origins of corporate criminal liability, and the development of the various doctrines used by the courts in England and Wales to attribute such liability for the offence of corporate killing/manslaughter (in its common law form).

5.2.1 THE ORIGINS OF THE IDENTIFICATION DOCTRINE: THE ALTER EGO THEORY

Prior to the entry into force of the Corporate Manslaughter and Corporate Homicide Act 2007, the identification doctrine was the legal method used by the courts, by which companies were held accountable for those common law offences that required proof of *actus reus* and *mens* rea. This was achieved by merging the individual(s) within the company with the company itself, and was first proffered as a method of attributing liability to companies in the civil case of *Lennard's Carrying Co Ltd v Asiatic Petroleum Co Ltd*.[595] In this case, Asiatic Petroleum Co sued Lennard's Carrying Co under the Merchant Shipping Act 1894 for the negligence of the company's managing director, Mr Lennard, in allowing the ship carrying the petroleum to go to sea in a state of unseaworthiness, which resulted in it sinking and the cargo being lost. It was held by the House of Lords in this case, that an act of a managing director, or 'controlling officer'[596], constituted (for the law of torts[597]) an act of the company itself. Viscount Haldane, the Lord Chancellor (as he then was), when delivering the leading judgment, stated that:

> "A corporation is an abstraction. It has no mind of its own any more than it has a body of its own. Its active and directing will must consequently be sought in the person of somebody […] who is really the directing mind and will of the corporation, the *alter ego* [(emphasis added)], and centre of the personality of the corporation."[598]

Viscount Haldane went on to justify his 'alter ego' theory as a method of attributing liability to companies, by stating that a company should be liable for the acts of such a

[595] [1915] AC 705.
[596] ibid at 713.
[597] Only the civil liability of corporations was discussed in this case.
[598] ibid at 713.

person because "his action [was] the very action of the company itself."[599] This argument, it is submitted, is a just and reasonable one in a modern commercial society.

In a subsequent shipping case, concerning the fatal collision between the steamships *Charlotte* and *Theory*,[600] Mr Justice Hill provided clear and logical interpretation of the alter ego theory, stating that: i) the owners of a ship are a company; ii) the ship is controlled by the managers of that company; iii) the company acts by the managers, and; iv) there is actual fault of the company if there is actual fault of the management.[601]

Viscount Haldane's 'alter ego' theory was then used to attribute liability to companies in two criminal cases in 1944,[602] but no clear guidance was offered in either case as to which individuals' actions could be identified as those actions of the company. These cases were missed opportunities by the judiciary to provide much-needed development of the law in this area.

5.2.2 THE DIRECTING MIND AND WILL THEORY

In 1957, the identification doctrine was developed by the Court of Appeal in the civil case of *HL Bolton (Engineering) Co Ltd v TJ Graham & Sons Ltd*,[603] where Lord Justice Denning (as he then was) sought to establish the 'directing mind and will' test as the main basis for both civil and criminal liability of companies. In his judgment, Lord Denning used an anthropologic metaphor to describe companies, stating that:

> "They may in many ways be likened to a human body. They have a brain and nerve centre which controls what it does [… and] directors and managers represent the directing mind and will of the company, and control what it does. The state of mind of these managers is the state of mind of the company and is treated by the law as such."[604]

Under Lord Denning's 'directing mind and will' theory/approach to the identification doctrine, it was necessary to establish, *inter alia*, that: i) an officer, who could be regarded as the 'controlling mind' of the company, was responsible for an act or

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[599] ibid at 714.
[600] *'Charlotte' v 'Theory'* [1921] 9 Lloyd's Rep 341.
[601] ibid at 342.
[602] DPP v Kent and Sussex Contractors [1944] KB 146 and R v ICR Haulage Ltd [1944] KB 551.
[603] [1957] 1 QB 159.
[604] ibid at 172.

omission that led to the death; and ii) in addition to committing the *actus reus* of the offence, the officer also had the *mens rea* i.e. that an ordinary prudent person in the officer's position would have realised that there was an obvious and serious risk of injury in the same circumstances. Therefore, Lord Denning proposed that the means of determining the mind of the company should be to identify its actual human controllers.

Many have criticised Lord Denning's directing mind and will theory, including Mujih, who argues that finding an individual who would satisfy Lord Denning's two criteria outlined above would be difficult, especially in large companies with complex management structures.[605]

5.2.4 THE *NATTRASS* IDENTIFICATION DOCTRINE

Both Viscount Haldane's 'alter ego' theory and Lord Denning's 'directing mind and will' theory were considered by the House of Lords in the case of *Tesco Supermarkets Ltd v Nattrass*.[606] Further guidance was provided when the Court adopted Lord Denning's directing mind and will test in determining the basis upon which the acts of an individual could be attributed to the company. However, they expanded upon Lord Denning's test and placed a qualification upon it, by holding that only the acts of a 'controlling officer', such as the board of directors or the managing director, for example,[607] could be identified as those of the corporation. In Lord Reid's judgment, he stated that once a controlling officer was identified, it could be said that:

> "He is acting as the company and his mind which directs his acts is the mind of the company [… and] If it is a guilty mind then that guilt is the guilt of the company."[608]

According to Clough, this qualification appears to fuse Viscount Haldane's test with that of Lord Denning's, and would appear to solve the problem that had been associated with the two distinct identification doctrine theories; it established the class of individuals who could be regarded/identified as a 'controlling officer' of the company i.e. those with the capacity to exercise decision-making authority on matters of

[605] E Mujih, 'Reform of the law on corporate killing: a toughening or softening of the law?' (2008) 29 Company Lawyer 76.
[606] [1972] AC 153
[607] ibid at 171.
[608] ibid at 170.

company policy rather than merely giving effect to such policies on an operational level.[609]

The legal effect, therefore, of the *Nattrass* decision on the identification doctrine was to impose criminal liability upon a company for the *actus reus* and *mens rea* of those controlling officers who could be said to be the embodiment of the company. *Nattrass*, however, has been widely criticised by the academic community. Haigh, for example, aptly asserts that:

> "the identification model of fault embraced by the House of Lords in *Nattrass* can be criticised for the narrowness of its horizons and for its failure to capture the complexity of the modern company."[610]

Hsaio reinforces this opinion and asserts that for the larger company with a more complex management structure, the more difficult it is to identify whose mind within the company can be attributed to the company.[611]

This can be contrasted with the view taken by Png, who argues that despite the *Nattrass* test being narrow, the decision itself was still significant as: i) it upheld and affirmed the directing mind and will theory, as proffered by Lord Denning; ii) it recognised the need to construe relevant legislation in order to attribute criminal liability to a company; and iii) it narrowed the class of individuals who could be regarded as constituting the company's directing mind to those who were empowered to exercise its will.[612]

As Haigh observes further, the *Nattrass* decision had the legal effect of establishing immunity from criminal prosecution for those larger companies, which are comprised of complex management structures with many tiers of responsibility. This is a view also held by Parsons, who claims that the identification doctrine, as articulated by the House of Lords in *Nattrass*, prevented larger companies from being held responsible for corporate offences by operating as a legal barrier to potential corporate liability.

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[609] J Clough, 'Bridging the theoretical gap: the search for a realistic model of corporate criminal liability' (2007) 18 Criminal Law Forum 267.
[610] BE Haigh, 'An analysis of the Corporate Manslaughter and Corporate Homicide Act (2007): A Badly Flawed Reform?' (MJur Thesis, Durham University 2011).
[611] MWH Hsaio, 'Abandonment of the doctrine of attribution in favour of gross negligence test in the Corporate Manslaughter and Corporate Homicide Act 2007' (2009) 30 Company Lawyer 110.
[612] C-A Png, Corporate Liability: A Study in Principles of Attribution (Kluwer Law International 2001).

Clarkson expands upon this criticism by arguing that in large companies, decision making is usually delegated to various employees and so identifying anyone senior enough to be regarded as the directing mind, with the required *actus reus* and *mens rea*, would be "almost impossible".[613] Clarkson's criticism receives support from Png, who argues that a weakness of the *Nattrass* identification doctrine is that, owing to the use of the expression "directing mind and will", the impression conveyed by the House of Lords was that only the conduct or state of mind of those individuals who are in positions of management *and control* (emphasis added) could be said to have been those of the company, and this requirement to show control amounted to a restriction and proved problematic.

Therefore, it can be questioned whether the *Nattrass* approach did in fact solve the problem of the previous identification doctrine theories and, although this was not a corporate manslaughter case, it nonetheless illustrates the difficulties of finding a single individual in a large company, who satisfies both the *mens rea* and *actus reus* criteria, and it resulted in a number of subsequent failed prosecutions for corporate manslaughter.

5.3 FAILED CORPORATE MANSLAUGHTER PROSECUTIONS

To understand fully the application and effect of the identification doctrine on the offence of corporate manslaughter, it is first necessary to examine the common law offence of involuntary manslaughter,[614] and specifically gross negligence manslaughter. This offence has been developed many times over the years, but two significant developments should be noted.

The first development is to be found in the case of *R v Caldwell*.[615] In this House of Lords case, Lord Justice Diplock established that a person was *Caldwell*-type reckless if the identified risk was obvious, and either that the person had not given any thought to

[613] Clarkson CMV, 'Corporate Manslaughter: Need for a Special Offence?' in Clarkson CMV and Cunningham S (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate Publishing Group 2008).
[614] The separate area of common law manslaughter known as 'voluntary manslaughter' is not relevant to this thesis.
[615] [1982] AC 341.

the possibility of there being any such risk, or that the person had acknowledged that there was some risk present but had carried on with their conduct regardless.[616]

The second important development came when the law on involuntary manslaughter was re-stated following the House of Lords decision in *R v Adomako*,[617] now the leading authority in this area of law. Lord Justice Mackay (as he then was), providing the leading judgment, stated that in order to find the defendant guilty of involuntary manslaughter by gross negligence, it must be proven that: i) the defendant owed a duty of care to the victim; ii) the defendant breached that duty; iii) the death of the victim occurred as a result of the breach of that duty; and iv) the nature of the breach was so gross,[618] that it would substantiate a criminal conviction.

However, the law was unable to successfully combine the identification doctrine with the *Adomako* reckless test, and apply them to companies for the offence of corporate manslaughter. The reasons for this failure can be seen with the following failed prosecution cases.

5.3.1 THE *HERALD OF FREE ENTERPRISE* DISASTER (1987)

The circumstances surrounding the sinking of the *Herald of Free Enterprise* on 6 March 1987, are discussed in Chapters 1 and 7 of this thesis, but the failed corporate manslaughter prosecution against the ship's owner-operator is discussed in greater detail here.

P&O European Ferries (Dover) Ltd (formerly Townsend Thoresen), as the owner-operators of the *Herald*, alongside five individuals, were charged with manslaughter for the 192 people who were killed as a result of the ferry capsizing. However, despite Mr Justice Sheen's Inquiry finding that "all concerned in management, from the members of the board of directors down to junior superintendents were guilty of faults",[619] the prosecution failed when the trial judge, Mr Justice Turner, directed the jury to acquit.

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[616] ibid at 353.
[617] [1994] 1 AC 171.
[618] The issue of proving the 'gross' element of the offence is discussed in detail in the following chapter.
[619] *Report 8074: Herald of Free Enterprise* (Department of Transport 1987) at para 14.1.

Wells argues that the main reason why the prosecution against P&O (and the five individuals) failed was because there was evidence that the ferries had sailed safely in the past with their doors open.[620] However, it is rightly suggested by Haigh, amongst others, that in fact the main reason Mr Justice Turner directed the acquittal against P&O and the senior managers charged was that there was no individual who could be identified, in accordance with the *Nattrass* identification doctrine, as a 'controlling officer' of the company, with both the *actus reus* and *mens rea* of the offence of manslaughter. In this case, the *actus reus* was creating an "obvious and serious risk", and the *mens rea* was negligently or carelessly not realising that this risk had been created, but a prudent person would have done so under the same circumstances.

Wells points out that, although the prosecution against P&O failed, the trial was "pivotal" for the development of the law of corporate manslaughter. This was because it was the first time that a judge had ruled that a corporation could be properly indicted for manslaughter.

5.3.2 THE SOUTHALL RAIL DISASTER (1997)

On 19 September 1997, a Great Western Train (GWT) went through a red light and collided with a freight train, resulting in the injury of 159 passengers and the death of seven. It was revealed that the cause of the accident was the train driver's failure to notice and respond to two cautionary signals preceding the red light that the train went through, and with disastrous consequences. In addition, GWT had not repaired the Automatic Warning System (AWS), which would have provided an audible and visual warning to the driver. Had this system been working, it would have required the driver to acknowledge the warning. The driver's failure to acknowledge the warning would have then caused the train's brakes to be automatically applied, and so the train would have safely come to a stop.

The train driver was charged with gross negligence manslaughter, and GWT was later charged with corporate manslaughter. The trial was heard at the Central Criminal Court, where Mr Justice Scott Baker ruled that the offence of involuntary manslaughter had to be found against an individual before GWT, as a company, could be convicted.

[620] There had been over 50,000 sailings in the past without "mishap" (C Wells, *Corporations and Criminal Responsibility* (2nd edn, Oxford University Press 2001), including regular sailings with the bow and stern doors open.

It was held that the relevant test to be applied was that of the identification doctrine, as established by *Nattrass*. However, as the train diver could not be identified as a 'controlling officer' of the company under the *Nattrass* identification doctrine, the prosecution against the train driver, and thus GWT, failed.[621]

As a result of this failed prosecution, on 8 December 1999, Lord Williams, the Attorney-General (as he then was), referred the following two questions on points of law to the Court of Appeal for its opinion:

1. Can a defendant be properly convicted of manslaughter by gross negligence in the absence of evidence as to the defendant's state of mind?
2. Can a non-human defendant be convicted of the crime of manslaughter by gross negligence in the absence of evidence establishing the guilt of an identified human individual for the same crime?[622]

Richard Lissack QC, acting for the Attorney-General, drew attention to the problem of the law (in its then present state) 'permitting' larger companies to escape conviction for corporate manslaughter.

Lord Justice Rose delivered the opinion of the Court of Appeal on the points/questions referred to it by the Attorney-General. With regards to the first question from the Attorney-General, Lord Rose answered in the affirmative and stated that:

> "evidence of a defendant's state of mind was not a prerequisite to a conviction for manslaughter by gross negligence."[623]

Regarding the second question referred to it by the Attorney-General, the Court of Appeal responded negatively:

> "Unless an identified individual's conduct, characterisable as gross criminal negligence, could be attributed to the corporation, the corporation was not in the present state of the common law liable for manslaughter."[624]

In essence, the Court of Appeal held that the identification doctrine remained the only basis in common law for corporate liability for gross negligence manslaughter. This

[621] Instead GWT were prosecuted under the Health and Safety Act 1974 and fined £1.5 million.
[622] Attorney General's Reference (No. 2 of 1999) [2000] QB 796.
[623] ibid at 809.
[624] ibid at 815.

decision 'made legal history', as it was the first time that an appellate court had been asked to consider the law relating to corporate manslaughter. The Court of Appeal's decision, however, was greeted with criticism by lawyers and the academic community alike; primarily for missing an opportunity to develop and restate the law on corporate manslaughter, and to move away from the restrictions imposed by the narrow *Nattrass* identification doctrine. Contrast this with Wells, who states that the Court of Appeal's decision "did indeed clarify the law but only to tell us that the narrow identification doctrine of *Tesco v Nattrass* still applied." If the Court of Appeal had taken the opportunity to broaden the test, then a successful prosecution against a larger company may have been possible post-2000.

5.3.3 THE HATFIELD RAIL DISASTER (2000)

On 17 October 2000, a Great North Eastern Railway (GNER) train derailed because of a broken rail near Hatfield Railway Station, and resulted in the deaths of four passengers, and the injury of a further 70. The investigation into the accident revealed that the part of the track had broken because it had become fragmented over time, as trains had passed over it. It was discovered that the companies involved were aware of the problem prior to the accident, and furthermore that replacement track was available, but it was never installed. In 2003, six individuals and two companies (Network Rail (the successor of Railtrack) and Balfour Beatty, both of which were jointly responsible for maintaining the track) were charged with manslaughter. The charges were dismissed against Network Rail and some of the individuals in September 2004. The trial against Balfour Beatty and the remaining individuals began in January 2005, and, at the time, represented the biggest corporate manslaughter prosecution of its kind. However, on 14 July 2005, Mr Justice Mackay directed the jury to acquit all defendants owing to there being insufficient evidence to secure a conviction under the applicable *Nattrass* identification doctrine.[625]

The Crown Prosecution Service (CPS) used this case to highlight the repeated concerns about the law in this area, and it voiced these concerns in a press release:

[625] Both Balfour Beatty and Network Rail were convicted under the Health and Safety at Work etc Act 1974, and received fines of £7.5 million (lowered from £10 million on appeal) and £3.5 million respectively.

> "The judge's [Mr Justice Mackay] ruling on manslaughter demonstrates again the very real difficulties the Crown has in securing convictions against corporate business or individuals."[626]

Despite the clear problem with the law in holding companies accountable for manslaughter, the Government still did not take action to legislate in the area of corporate manslaughter at this time.

5.3.4 THE POTTERS BAR RAIL DISASTER (2002)

On 10 May 2002, a West Anglia Great Northern (WAGN) train derailed south of Potters Bar Railway Station, and resulted in 76 injuries and seven deaths. The subsequent investigation into the accident found that the train derailed because of a set of faulty points, which were poorly maintained by the two companies jointly responsible for their maintenance (Network Rail (once again) and Jarvis Rail). However, these two companies were never charged with corporate manslaughter because the CPS felt that there was no realistic prospect of securing a conviction, owing to there being no individual who could be identified under the *Nattrass* identification doctrine as having committed the offence,[627] and so "without an individual being identified, no prosecution could proceed against a corporation."[628]

Ormerod and Taylor claim that this case illustrated once again that the identification doctrine had become the major obstacle to securing a conviction against a company under the common law offence of gross negligence manslaughter, particularly with larger companies with any complexity in its management structure. Therefore, it has been said that successful prosecutions are only possible in respect of small companies and this, Parsons claims, represents the failure of the law to adapt to the organisational reality of large companies. Clough aptly summarises this criticism with the following brief phrase: "it works best in cases where it is needed least, and works least in cases where it is needed most." The Potters Bar rail disaster reiterated the need for a reform of the law of corporate manslaughter.

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[626] 'CPS was right to prosecute over Hatfield train crash, says DPP' (*The Crown Prosecution Service*) <http://www.cps.gov.uk/news/latest_news/144_05/> (accessed 16 November 2013).
[627] 'CPS Statement: Potters Bar rail crash' (*The Crown Prosecution Service*) <https://www.cps.gov.uk/news/latest_news/151_05/> (accessed 16 November 2013).
[628] Network Rail was later convicted under the Health and Safety at Work etc Act 1974 and received a fine of £3 million, but not until 13 May 2011, nine years after the accident.

5.4 THE DEVELOPMENT OF THE CORPORATE MANSLAUGHTER AND CORPORATE HOMICIDE ACT 2007

5.4.1 LAW COMMISSION REPORT 237

It is often said that the genesis for the Corporate Manslaughter and Corporate Homicide Act 2007 can be found in the capsize of the *Herald of Free Enterprise* disaster, and the subsequent failed corporate manslaughter prosecution of P&O. Following the Sheen Inquiry, the Law Commission was asked by the Government to review the law on involuntary manslaughter, including corporate manslaughter, and to offer its recommendations for reform in this area of law. On 4 March 1996, the Law Commission published its report[629] and submitted it to Lord Mackay of Clashfern, the (then) Lord Chancellor. In this report, the Law Commission made it clear that significant reform was needed. Underpinning the report was the acknowledgment that it was especially difficult to apply the *Nattrass* identification doctrine to large companies with diffuse management structures.[630]

Significant to this research project are Parts VI and VII of the report, entitled 'Corporate Manslaughter: The Present Law' and 'Our Proposal in Consultation Paper No 135,[631] and our present view', respectively. Part VI discusses in detail, the development of corporate manslaughter from the original establishment and acceptance of the concept of corporate criminal liability, and the origins of the directing mind and will theory through to the notorious *Nattrass* identification doctrine. The Law Commission, in this Part of the report, analyses the key cases and judgments in this area of law, and critiques the effectiveness of the identification doctrine (as it was at the time of the report being published). To conclude its critique of the law on corporate manslaughter at the time, the Law Commission scrutinises the failed prosecution of P&O; using the case to illustrate the failings in the law and to reaffirm that the *Nattrass* identification doctrine does not work.

Part VII of the Report examines the Law Commission's provisional proposals, as contained in its Consultation Paper No 135, and also the responses to these proposals.

[629] Report 237: Legislating the Criminal Code: Involuntary Manslaughter (The Law Commission 1996).
[630] ibid at para 1.17.
[631] Consultation Paper No 135: Criminal Law – Involuntary Manslaughter (The Home Office 1994).

Part VII also examines the justification for the creation of an offence of corporate manslaughter, and the public need for such an offence. This Part of the report concludes with the examination and consideration of the options available for extending criminal liability to companies, and concludes that the most favorable option for reform is to apply the elements of the 'individual' offence of killing by gross negligence manslaughter to companies in principle, but in a form adapted to a corporate context and, in particular, in a form that does not include the identification doctrine.[632]

To reinforce the view that the identification doctrine should not be used for corporate manslaughter, it was stated in the report that, at the time the report was published, only one company had ever been successfully prosecuted for the offence of corporate manslaughter under the *Nattrass* identification doctrine, and this company, OLL Ltd, was a one-man company and therefore the failing of the 'senior management' was not examined in detail, and did not need to be considered by the courts.[633]

So significant was the Law Commission's recognition that the identification doctrine only worked in the prosecution of small companies, that rather than recommending any change to the doctrine, it proposed the creation of a new, separate offence of 'corporate killing' instead. This offence sought to escape the narrowness of *Nattrass* by establishing that the fault element of the proposed offence should be based on the notion of 'management failure', defined as the situation where the company's activities were managed or organised in a way that failed to ensure the health and safety of persons employed in or affected by those activities.[634]

Essentially, the offence of corporate killing would require a gross management failure and it would be found by assessing the conduct of *all* (emphasis added) of the individuals within the company with responsible for safety.

In its Report 237, the Law Commission acknowledges that in similar corporate offences (though it could be argued that an offence of 'corporate killing' is unique, and therefore not similar to any other type of corporate offence), a provision imposing secondary liability upon certain individuals within the company is usually included. An example

[632] The other three being: vicarious liability, the aggregation doctrine, and the creation of a new corporate liability regime specific to each individual offence.
[633] Report 237: Legislating the Criminal Code: Involuntary Manslaughter at p. 82.
[634] Clause 4(2)(a) of the Law Commission's Draft Involuntary Homicide Bill.

cited in support of this point is that of Section 37(1) of the Health and Safety at Work etc Act 1974. However, the Law Commission strongly advised against the inclusion of any secondary liability being imposed upon individuals, maintaining the position that to do so would be contrary to the purpose of the law of corporate manslaughter prosecuting companies for their culpable conduct. Instead, the Law Commission proposed that, if an individual's conduct so warranted, they should be prosecuted under the common law offence of manslaughter, or one of the Commission's proposed individual statutory offences of reckless killing or killing by gross carelessness.[635] Due to the author's theories and thesis hypothesis, the arguments put forward for the inclusion and exclusion of individual liability are considered in the following chapter, rather than as part of the general discussion in this chapter pertaining to the Act's development.

5.4.2 THE GOVERNMENT'S PROPOSALS AND DRAFT BILL 2000

In response to the Law Commission's proposals outlined in its Report 237, the Government established an inter-departmental working group of officials and lawyers, including a representative from the Law Commission itself, to consider the Law Commission's proposals in detail. The group was charged specifically with examining how the proposed offences would work in practice, and its opinions were published in a consultation paper by the Government in May 2000.[636]

When examining the Law Commission's proposals for a new offence of 'corporate killing', the Government begins by acknowledging and highlighting that there had been a number of disasters, and failed prosecutions against those companies responsible, which had led to a heightened public perception that the law regulating corporate manslaughter was inadequate. The main disaster cited as the cause for this justified perception was that of the *Herald of Free Enterprise*,[637] where the Government criticised the failure of the (then) current law in dealing with the various acts of criminal negligence committed by P&O.

[635] Report 237: Legislating the Criminal Code: Involuntary Manslaughter at p. 118.
[636] Reforming the Law on Involuntary Manslaughter: the Government's Proposals (The Home Office 2000).
[637] ibid at p. 13.

In this paper, the Government stated that it welcomed the Law Commission's Report and had "considered [its] proposals […] with great care," and that it also accepted the "vast majority of the proposals."[638] It is worth noting that, at this stage, the Government had accepted the Law Commission's proposed corporate killing offence,[639] outlined in Clause 4 of the Law Commission's Draft Involuntary Homicide Bill, as well as its management failure test.[640] However, although it was stated that "there may prove to be difficulties in proving [such] a management failure,"[641] the Government did not, at this stage, discuss adopting any other test. This would appear to suggest that, whilst the Government did not believe the Law Commission's proposed test to be suitable, it was unable to offer a more suitable alternative.

5.4.3 THE GOVERNMENT'S DRAFT BILL 2005

In his thesis, Haigh highlights that there was a three-year gap between the publication of the 2000 Draft Bill and the Government's confirmation that it would be producing another Bill, this time specifically for the offence of corporate killing (rather than for the broader offence of involuntary manslaughter, with its constituent corporate killing offence, as previously announced). The Government's desire to legislate in this area was re-energised, Haigh believes, because of the public outcry that came from the Hatfield and Potters Bar rail disasters and the subsequent failed prosecutions of the companies involved.

However, the Government's Draft Corporate Manslaughter Bill was not published until March 2005.[642] In the five years that had passed since the Government's proposals in 2000, many revisions had been made, including the name of the offence changing from 'corporate killing' to 'corporate manslaughter'. Despite this obvious change in terminology, the Government did not provide an explanation as to why the name of the proposed offence had changed. Haigh hypotheses that this change in terminology was probably as a result of increased lobbying by the business community for a more neutral term/label to be adopted, rather than a one that denotes significant wrongdoing.

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[638] ibid at p. 6.
[639] The term 'corporate manslaughter' was not adopted until the Corporate Manslaughter and Corporate Homicide Act 2007.
[640] See Reforming the Law on Involuntary Manslaughter: the Government's Proposals at p. 32.
[641] ibid at p. 15.
[642] See Corporate Manslaughter: The Government's Draft Bill for Reform (The Home Office 2005) at p. 32.

However, there was also a subtle, but significant, difference in the test used to establish the company's failure. The Government abandoned the Law Commission's suggested management failure test, and proposed that a company's fault/guilt was to be found in the way in which the company's activities were managed by its *senior* (emphasis added) managers. Clause 1(1) states:

> **Clause 1 The Offence**
> (1) An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised by its senior managers—
> (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.

In essence, according to the Clause, a company's guilt must be established through its senior management.

Clough claims that this 'senior management' test arose from a concern that the Law Commission's proposed test would create too broad a basis for liability. The Government contended that:

> "[The] heart of the new offence lies in the requirement for a management failure on the part of its senior managers. This is intended to replace the identification principle with a basis of corporate liability that better reflects the complexities of decision taking and management within modern large organisations, but which is also relevant for smaller bodies."[643]

Thus the senior management failure test was seen as a means of broadening the established *Nattrass* test for fault, whilst at the same time narrowing the Law Commission's proposed management failure test, and sought to ensure that companies were held liable only for the conduct that could truly be described as failings of the company itself; rather than the localised failings or the conduct of rogue employees.[644]

Mujih directs criticism towards the Government's senior management failure test by arguing that, although the Government provides a definition of 'senior management' in Clause 2 of the 2005 Draft Bill, the definition is unclear, and so it provides no certainty as to what senior management actually is. Clause 2 states:

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[643] Corporate Manslaughter: The Government's Draft Bill for Reform at p. 12.
[644] ibid at p. 34.

Clause 2 Senior Manager
A person is a "senior manager" of an organisation if he plays a significant role in
(1) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or
(2) the actual managing or organising of the whole or substantial part of those activities.

Clarkson observes that the requirement of identifying who constitutes senior management under this definition, now contained in Section 1(4)(c) of the Corporate Manslaughter and Corporate Homicide Act 2007,[645] is:

> "unduly restrictive and threatens to open the door to endless arguments in court as to whether certain persons do or do not constitute senior managers."

However, from literature available, it is clear that the academic community has serious concerns with this senior management test. Many have argued that the Government's test reintroduces the same inherent problems of the *Nattrass* identification doctrine i.e. where, under *Nattrass*, there were problems with identifying whether an individual was part of a company's 'directing mind and will', these have been replaced with the problem of identifying which individuals can be said to be 'senior management'. This argument receives further support from Bebb, who claims that the "endless legal debate" as to whether a defendant can be said to be the directing mind and will of the company under the *Nattrass* identification doctrine has been replaced with similar debate as to whether or not the defendants are senior managers.[646]

5.4.4 THE HOUSE OF COMMONS JOINT COMMITTEE

In addition to criticism of the Government's definition of senior management, both in the 2005 Draft Bill and now in the 2007 Act, criticism has also been directed towards the insistence that the fault of the company be at a *senior* level.

In 2005, a report was produced by a Joint Committee comprised of a House of Commons Home Affairs Committee and a Work and Pensions Committee. In this report, the Joint Committee welcomes the introduction of the Government's Draft Bill, though it does criticise the proposed senior management test in detail; believing that it

[645] Discussed below.
[646] G Bebb, 'Plus Ca Change?' (2006) 68 Employment Law Journal 22 at p. 24.

reintroduces the identification doctrine in a broader form by aggregating the conduct of senior managers. The Joint Committee further describes the senior management test as a fundamental weakness of the Draft Bill.[647] In addition, the Joint Committee also observes that if the (then) proposed offence was to be tested in a court of law, it would "undoubtedly lead to a legal argument as to who is and who is not a senior manager."[648]

Criticising the focus on *senior* management further, Mujih argues that a management failure is ultimately a company failure, no matter if it arises at a senior, middle, or junior management level, and therefore the issue of whether the failure was at senior level or not, should not be relevant in establishing liability.

Although the Joint Committee was of the opinion that the Government's senior management test was too narrow, it also believed that the Law Commission's management failure test was too broad and too vague, and therefore that:

> "it could cover the failings within a company that occur at too low a level to be fairly associated with the company as a whole."[649]

The Committee recommended that the Law Commission's test be used as a starting point, but the relevant management failure should be:

> "related to either an absence of correct process or an unacceptably low level of monitoring or application of a management process."[650]

5.5 THE CORPORATE MANSLAUGHTER AND CORPORATE HOMICIDE ACT 2007

On 26 July 2007, the Corporate Manslaughter and Corporate Homicide Act was enacted and entered into force on 6 April 2008.[651] It is apt to state that the legal and academic communities alike are somewhat disappointed with the final Act. Many feel that it is limited in its vision, lacks imagination, and retains many of the evidentiary problems

[647] *First Joint Report of Session 2005-06: Draft Corporate Manslaughter Bill* (The House of Commons: Home Affairs and Work and Pensions Committees 2005) at p. 39.
[648] ibid at p. 40.
[649] ibid at p. 52.
[650] ibid at p. 44.
[651] A copy of the Corporate Manslaughter and Corporate Homicide Act 2007 is included in Appendix 2.

associated with the previous *Nattrass* identification doctrine, from which it had been the Law Commission's and the Government's aim to reform.

The offence of corporate manslaughter is defined in Section 1(1) of the Act as:

> **Section 1 The offence**
> (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.

5.5.1 SENIOR MANAGEMENT

Once again, the main body of criticism of the Act has been directed towards its senior management requirement. The wording of the offence has been revised since the 2005 Draft Bill, with the focus on senior management being removed from Clause 1(1) and inserted into a new Section 1(3):

> **Section 1 The offence**
> (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).

This Section is an important new provision, intended to satisfy the Joint Committee's concern that there had been no clear guidance as to who constituted senior management for the purposes of corporate manslaughter. In requiring that the activities of senior management be a 'substantial element', a degree of guidance is provided as to the level of involvement required in order to find the company at fault.

The definition of 'senior management' is contained in Section 1(4)(c) of the Act:

> **Section 1 The offence**
> (4) For the purposes of this Act—
> (c) "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.

A significant difference between the 2007 Act and the Government's 2000 Draft Bill is that of Section 1(4)(c)'s linking of senior management to those persons who play a significant role in the decision making, management or organisation of the whole or a substantial part of the company's activities. Ormerod and Taylor claim that this element of the test returns the focus to the evaluation of the relative contribution of groups of individuals. Gobert argues that this linking means that the previous issues, which were related to identifying a specific individual within the company who committed the offence of manslaughter under the *Nattrass* identification doctrine,[652] have now been replaced with issues relating to identifying individuals who play a 'significant role' in the making or carrying out of company policy i.e. that the senior management test reintroduces the problems of the identification doctrine, with the requirement of identifying a 'directing mind' simply being replaced by that of identifying 'senior management.'

Some such as Gobert, have argued that while the reference to senior management in Section 1(3) of the Act, and its subsequent definition in Section 1(4)(c), may have been intended to signify the Government's belief that companies should not be held liable where the responsibility for a death rests with relatively junior managers, it is perhaps questionable whether "culpability can be so neatly compartmentalised"[653] in a modern business-orientated society. It would therefore appear that the Law Commission's attempt to instigate reform has been thwarted by the Government's failure to deal with the "Achilles heel"[654] of the *Nattrass* identification doctrine i.e. the failure of the law to deal successfully with large companies with diffuse management systems.

Gerry Sutcliffe MP (then Parliamentary Under-Secretary of State for the Home Office), in response to criticisms of the senior management test contained in Section 1(3) of the Act, stated that the new test had been improved; with the original senior management test being replaced by a wider test, based on the management of the organisation's activities, whilst also needing to show a substantial failing at senior level. This, Mr

[652] As discusses above.
[653] Gobert, 'The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?' at p. 418.
[654] See Haigh, 'An analysis of the Corporate Manslaughter and Corporate Homicide Act (2007): A Badly Flawed Reform?' at p. 122.

Sutcliffe argues, gets the "balance right"[655]. Although Haigh affirms this view, and states that the new senior management test does not appear to have strong echoes with the *Nattrass* identification doctrine, he also argues that the test is merely a "gloss upon the old identification doctrine", and that Section 1(3) is equivalent to an "identification-plus doctrine".[656] Despite this apparent contradiction, it is suggested that the latter view is a more accurate reflection of the view of the overall academic community, and Section 1(3) does appear, at least indirectly, to continue the law's pre-occupation with the identification doctrine.

5.5.2 CAUSATION

Some criticism has also been directed towards the requirement that the prosecution prove that the management failure was the 'cause' of the victim's death (Section 1(1)(b)). Gobert, for example, argues that the Act's reference to causation is overly simple. He claims that the Law Commission's proposal that the management failure was to be 'the cause or merely one of the causes of death'[657] is the most appropriate means of determining causation.[658] However, Paragraph 15 of the House of Lords' Explanatory Notes to the Act states that:

> "[The] usual principles of causation in the criminal law will apply to determine the question. This means that the management failure need not have been the sole cause of death; it need only be a cause (although intervening acts may break the chain of causation in certain circumstances)."[659]

Therefore, it is suggested that Gobert's concern on this point is moot.

5.5.3 DUTY OF CARE

The academic community has also evaluated the need to show a pre-existing and relevant duty to the victim, as per Section 1(1)(b). Before examining academic critique of this requirement, it is apt to first state how the Act defines a 'relevant duty of care'

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[655] HC Deb 4 December 2006, vol 454, col 116.
[656] Haigh, 'An analysis of the Corporate Manslaughter and Corporate Homicide Act (2007): A Badly Flawed Reform?' at p. 1.
[657] Clause 4(1)(a) of the Law Commission's 2000 Draft Bill.
[658] Gobert, 'The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?' at p. 418.
[659] Corporate Manslaughter and Corporate Homicide Bill: Explanatory Notes (The House of Lords 2006) at p. 4.

for the purposes of Section 1(1)(b). This definition is to be found in Section 2 of the Act:

> **Section 2 Meaning of "relevant duty of care"**
> (1) A "relevant duty of care", in relation to an organisation, means any of the following duties owed by it under the law of negligence—
> (a) a duty owed to its employees or to other persons working for the organisation or performing services for it;
> (b) a duty owed as occupier of premised;
> (c) a duty owed in connection with—
> (i) the supply by the organisation of goods or services (whether for consideration or not),
> (ii) the carrying on by the organisation of any construction or maintenance operations,
> (iii) the carrying on by the organisation of any other activity on a commercial basis, or
> (iv) the use or keeping by the organisation of any plant, vehicle or other thing.

This requirement was not in the Law Commission's Draft Bill, nor in the Government's 2000 consultation document (though it was in the 2005 Draft Bill). Furthermore, the Joint Committee, in its review of the 2005 Draft Bill, strongly advised against the inclusion of any duty of care requirement, as it believed it an unnecessary requirement that would compromise the effectiveness of the Act. It is arguably an unnecessary requirement, according to Gobert, because companies are already under a legal duty not to kill innocent persons, and so to require proof of a duty of care simply provides defendants with another avenue for deflecting the trial from its main objective i.e. determining the role of the company in the resulting death and convicting it if culpable.

5.5.4 GROSS BREACH AND FACTORS FOR THE JURY TO CONSIDER

The Act's requirement in Section 1(1)(b) that the management failure must have amounted to a 'gross breach' of a relevant duty of care, and the definition of a 'gross breach' provided in the Act, have received criticism from academics for being vague and ambiguous. The definition of a 'gross breach' is to be found in Section 1(4)(b) of the Act:

Section 1 The offence

(4) For the purpose of this Act—

(b) a breach of a duty of care by an organisation is a "gross" breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances.

This definition is somewhat vague and raises several questions. Firstly, how to determine what is to be reasonably expected of companies under different circumstances; secondly, how to set the standard for how far an organisation's breach must fall below before it can be characterised as 'gross'; and thirdly, which circumstances to hold as relevant when considering liability. Although Section 8 of the Act goes some way to address this ambiguity, the questions still remain unanswered to a certain extent. Section 8 specifies factors for the jury to consider when determining whether a breach of a relevant duty of care by a company amounted to a 'gross breach'. Factors which the jury *must* (emphasis added) consider are listed in Section 8(2):

Section 8 Factors for jury

(2) The jury must consider whether the evidence shows that the organisation failed to comply with any health and safety legislation that relates to the alleged breach, and if so—

(a) how serious that failure was;

(b) how much of a risk of death it posed.

This provision has received little criticism as it is a clear and unambiguous instruction to the jury. However, the same cannot be said for Section 8(3)-(5), which details factors the jury *may* (emphasis added) consider:

Section 8 Factors for jury

(3) The jury may also—

(a) consider the extent to which the evidence shows that there were attitudes, policies, systems or accepted practices within the organisation that were likely to have encouraged any such failure as is mentioned in subsection (2), or to have produced tolerance of it;

(b) have regard to any health and safety guidance that relates to the alleged breach.

(4) This section does not prevent the jury from having regard to any other matter they consider relevant.

(5) In this section "health and safety guidance" means any code, guidance, manual or similar publication that is concerned with health and safety matters and is made or issued (under a statutory provision or otherwise) by an authority responsible for the enforcement of any health and safety legislation.

Essentially, Section 8(3)(a) refers to a company's 'culture' and it is this provision that has received the most criticism. Relevant to this research project is the question posed by Griffin, who asks whether the culture to be considered by the jury will be measured against a universal standard, or against a standard specific to that particular industry i.e. whether companies that engage in hazardous activities, such as is the case with the shipping industry, have a culture standard of reasonableness measured at a far higher standard than those companies engaged in 'safer' enterprises. This question is discussed in greater detail in the following chapter.

On a larger scale, these criticisms suggest that it is 'unsafe' to permit a jury to be influenced by a company's culture of compliance or non-compliance with health and safety legislation/guidance. Some, such as Gobert, even suggest that it is inappropriate for juries to consider a company's culture, as they are not the best able body to assess it. He argues that this is because it would be difficult to accurately determine in a given case where a company's values and priorities lie, and what message it conveys to its workforce regarding the need to comply with the law, or whether it merely pays 'lip service' to legal requirements. It has also been suggested that juries are not in fact qualified to assess a company's culture, and so consideration and influence of it will lead to inconsistent results depending on the composition of the jury.

5.5.5 INDIVIDUAL LIABILITY

The lobbying efforts of the business community against individual liability being included in the offence bore fruit in the 2007 Act. Section 18 specifically provides that no individual can be prosecuted under the 2007 Act:

> **Section 18 No individual liability**
> (1) An individual cannot be guilty of aiding, abetting, counselling or procuring the commission of an offence of corporate manslaughter.

The issue of individual liability is key to the thesis hypothesis, and is therefore discussed in greater detail in the following chapter.

5.6 CONVICTIONS UNDER THE CORPORATE MANSLAUGHTER AND CORPORATE HOMICIDE ACT 2007

At the time of the publication of this thesis, there have been 21 successful convictions under the Corporate Manslaughter and Corporate Homicide Act 2007. The author has summarised and depicted these convictions with the use of a table, and provided detailed analysis of the key cases below.

Company Convicted	Date of Conviction	Cause of Death	Fine (£)	Individuals Convicted of Other Offences
Cotswold Geotechnical Holdings	15 February 2011	Geological pit collapsed onto victim	385,000	
JMW Farm	8 May 2012	Metal bin fell onto victim	187,500	
Lion Steel	3 July 2012	Fell through a factory roof	480,000	
J Murray and Sons	7 October 2013	Pulled into an animal feed mixing machine	100,000	
Princes Sporting Club	22 November 2013	Struck by speedboat	135,000	
Mobile Sweepers (Reading)	2 December 2013	Crushed whilst repairing sweeping hopper	8,000	Director fined £8,000 for health and safety offences
Cavendish Masonry	22 May 2014	Crushed by two-ton block of limestone	150,000	
Sterecycle (Rotherham)	7 November 2014	Killed by plant explosion	500,000	
Diamond and Son (Timber)	17 December 2014	Crushed whilst carrying out machinery maintenance	75,000	
Peter Mawson	19 December 2014	Fell through a skylight	200,000	Director sentenced to 8 months (suspended for 2 years) and ordered to undertake 200 hours of unpaid work for health and safety offences
Pyranha Mouldings	12 January 2015	Locked inside an industrial oven	200,000	Director sentenced to 9 months in prison (suspended for 2 years) and fined £25,000 for health and safety offences
Nicole Enterprises	28 April 2015	Crushed by a static caravan	100,000	
CAV Aerospace	27 May 2015	Crushed by aircraft components	600,000	

Kings Scaffolding	14 July 2015	Fell through a skylight	300,000	
Cheshire Gates and Automation	17 November 2015	Trapped between a gate and a retaining wall	50,000	
Huntley Mount Engineering	7 September 2015	Entangled on a lathe	150,000	One director sentenced to 8 months in prison for health and safety offences. One director sentenced to 4 months in prison (suspended for 2 years) for health and safety offences
Linley Developments	24 September 2015	Crushed by a wall whilst excavating	200,000	Two directors sentenced to 6 months in prison (suspended for 2 years) for breaching construction regulations
Sherwood Rise	3 December 2015	Died in a care home	300,000	Director sentenced to 3 years and 2 months for gross negligence manslaughter. Manager sentenced to 1 year in prison (suspended for 2 years) for health and safety offences
Baldwins Crane Hire	22 December 2015	Crane crashed into an earth bank	700,000	
Monavon Construction	9 May 2016	Fell through roadside hoarding	500,000	
Bilston Skips	16 August 2016	Fell from a skip	600,000	Director sentenced to 2 years in prison (suspended for 2 years)
SR and JR Brown	28 March 2017	Fell from a roof	300,000	Two directors sentenced to 1 year in prison. A count of manslaughter for the two is to lie on file

Table 5.2: Convictions Under the Corporate Manslaughter and Corporate Homicide Act 2007

5.6.1 COTSWOLD GEOTECHNICAL HOLDINGS

The first case that was heard under the Corporate Manslaughter and Corporate Homicide Act 2007 was against Cotswold Geotechnical Holdings.[660] The company was charged with the corporate manslaughter of an employee, Alexander Wright, who had been obtaining a soil sample from the bottom of a 3.5-metre-deep pit on 5 September 2008. Whilst it was not disputed that it had been dangerous for the employee to enter the pit, the walls of the pit were unsupported and it was this, which resulted in the soil collapsing into the pit and killing Mr Wright.

[660] [2011] EWCA Crim 1337.

The prosecution's case was that Cotswold Geotechnical Holdings had failed to take all reasonable steps to protect Mr Wright from unsafe working conditions, and that it had ignored recognised industry guidance that prohibited entry into pits more than 1.2 metres deep without the walls being supported. Furthermore, the unsafe working conditions were exacerbated by the lack of supervision of Mr Wright at the time of the incident.

In order for the prosecution to secure a conviction under the Corporate Manslaughter and Corporate Homicide Act 2007, it had to prove that:

1. Cotswold Geotechnical Holdings' conduct had *caused* Mr Wright's death and amounted to a *gross breach* of a relevant duty of care (i.e. its duty of care as an employer), under Section 1(1) of the Act;
2. A *substantial* element of the breach was the way in which the company's *senior management* had managed or organised its activities, under Section 1(3) of the Act.

On 17 February 2011, the company was found guilty of the offence of corporate manslaughter, and fined £385,000 (to be paid over a 10-year period; paying £38,500 every year of that period).

In determining an appropriate amount to impose, the trial judge considered the company's annual turnover of £333,000 for 2008 (the year of the incident). The fine was wholly beyond the means of the company, and so it appealed the decision. However, the appeal was dismissed on the basis that it was clearly foreseeable that the way in which the company conducted its operations could cause serious injury or death.

The conviction of Cotswold Geotechnical Holdings was the first under the Corporate Manslaughter and Corporate Homicide Act 2007, and whilst it illustrated the importance for UK businesses to have in place a safety culture, the company was small (with only one director and eight employees), and so there was no difficulty in identifying senior management. Therefore, the failings within the Act, as outline above, were not highlighted by this case.

5.6.2 JWM FARM

The second successful conviction under the Corporate Manslaughter and Corporate Homicide Act 2007 was that of JMW Farm.[661] The company was convicted on 8 May 2012, for the corporate manslaughter of their employee, Robert Wilson, who was killed on 15 November 2010. Mr Wilson was killed when he was struck by a metal bin that fell from the raised forks of a forklift truck. The joint investigation by the HSE and the police found that it was not possible to insert the lifting forks into the sleeves of the bin, as the forks were too large and incorrectly spaced, causing the bin to fall.

The company pleaded guilty to the offence of corporate manslaughter, and was fined £187,500 (and ordered to pay £13,000 in costs).

5.6.3 LION STEEL

On 3 July 2012, Lion Steel became the third company to be convicted under the Corporate Manslaughter and Corporate Homicide Act 2007. The company pleaded guilty to the corporate manslaughter of a maintenance worker, Steven Berry, who died of his injuries after an incident on 28 May 2008, when he fell through a fibreglass roof light 13 metres above the factory floor, whilst undertaking a roof repair.

The route to the corporate manslaughter conviction in this case was somewhat unconventional. Although the company was originally charged with corporate manslaughter, the judge severed the corporate manslaughter charge, and so the trial proceeded against the company on health and safety charges, and against the directors of the company on gross negligence manslaughter charges. The cases of gross negligence manslaughter were dismissed against two of the directors. Following this, an agreement was made between the company and the prosecution (approved by the court and akin to a plea bargain), whereby Lion Steel agreed to plead guilty to corporate manslaughter in exchange for the remaining charges against the individual directors being dropped.

The company was fined £480,000, to be paid in instalments by September 2015, and ordered to pay prosecution costs of £84,000, to be paid within two years. The reason

[661] [2012] NICC 17.

behind this large amount, it has been suggested, was because of the Sentencing Guidelines Council's published guidance in 2010, which stated that the appropriate fine should seldom be less than £500,000.[662]

At the time of the Lion Steel conviction, concern was raised over the Act's ability to achieve the intended aim of delivering better corporate accountability than under the common law. One lawyer stated:

> "It is hard to believe that of the hundreds of deaths at work that have so far occurred since the Act came into force, only three have involved corporate failings sufficiently bad to warrant a charge of corporate manslaughter."[663]

This point would certainly accord with the concerns over the ability of the Corporate Manslaughter and Corporate Homicide Act 2007 to convict culpable corporations, due to the inherent difficulties of the Act, and so fails as an effective deterrent for safety complacency as discussed in this chapter and the following one. Furthermore, the lawyer's concluding point in his article on this case is well made, and supports the author's research and the findings of the survey in Chapter 7 of this thesis, as well as the author's theories regarding individual liability:

> "Despite the substantial fine imposed on Lion Steel, there may be those who suggest that a deal in which a company is punished by way of a fine, to reduce, it may be speculated, the risk of one of its directors being convicted of manslaughter and sent to prison, is poor justice."[664]

5.6.4 J MURRAY AND SONS

The fourth company, J Murray and Sons, was convicted of corporate manslaughter under the 2007 Act on 7 October 2013,[665] for the death of Norman Porter. Mr Porter was killed on 28 February 2012, when he was pulled into an animal feed mixing machine.

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[662] J Grimes, 'Corporate manslaughter' *The Law Society Gazette* (29 August 2012) <https://www.lawgazette.co.uk/law/corporate-manslaughter/67055.article> (accessed 4 January 2016).
[663] ibid.
[664] ibid.
[665] See 'J Murray and Sons pleads guilty to manslaughter' *BBC News* (7 October 2013) <http://www.bbc.co.uk/news/uk-northern-ireland-24433723> (accessed 15 September 2017).

Like the convictions of JMW Farm and Lion Steel, the conviction followed a guilty plea by the company. Also, like the guilty plea of Lion Steel, the guilty plea in this case was as a result of an agreement not to proceed with the prosecution for gross negligence manslaughter of one of the company's directors. The decision to offer a guilty plea on behalf of a company in exchange for the removal of the risk of a personal conviction, and likely prison sentence of the sole director, was not a difficult one,[666] but it was an offer that should not have been accepted by the prosecution and/or approved by the court. Corporate liability should not have replaced individual liability in this case. Both the company and the director should have been convicted; the company of corporate manslaughter, and the director of gross negligence manslaughter. However, the author accepts that the conviction for gross negligence manslaughter may not have been easy to secure, due to the stringent test that needs to be satisfied, as discussed in the following chapter.

As a result of the agreement, J Murray and Sons was convicted on 7 October, and sentenced on 15 October 2013, and ordered to pay a fine of £100,000 (as well as costs of £10,000).

At this point, a pattern started to emerge from the corporate manslaughter convictions: i) the prosecutions were of small, owner-managed companies; ii) convictions were usually secured by guilty plea due to the alternative being the risk of an individual being personally convicted and imprisoned for gross negligence manslaughter; and iii) fines were below the lower threshold of the £500,000 suggested by the Sentencing Guidelines Council.

This pattern would suggest that the 2007 Act was/is incapable of securing convictions against "[companies] of any size or with any complexity in its management structure."[667] Furthermore, and more worryingly, this pattern evidences the practice of 'senior management'/'controlling minds' of the company escaping individual liability and punishment by holding the company up for conviction.

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[666] J Grimes, 'Fourth statutory corporate manslaughter conviction – are trends emerging?' (*Kingsley Napley*) <https://www.kingsleynapley.co.uk/insights/blogs/criminal-law-blog/fourth-statutory-corporate-manslaughter-conviction-are-trends-emerging> (accessed 14 March 2016).
[667] D Ormerod and RD Taylor, 'The Corporate Manslaughter and Corporate Homicide Act 2007' (2008) Criminal Law Review 589 at p. 592.

5.6.5 MOBILE SWEEPERS (READING)

On 26 February 2014, Mobile Sweepers (Reading) was convicted of the corporate manslaughter of Malcolm Hinton, who was killed on 6 March 2012, when he was crushed as a result of the hopper that he was working underneath, falling back after losing hydraulic pressure (as a result of its poor maintenance).

The company pleaded guilty to corporate manslaughter and was fined only £8,000 (and ordered to pay £4,000 in costs). Mr Owens, the company's sole director, however, was fined £183,000 for health and safety offences (and banned from holding the position of a director for five years).[668] This case, once again, supports the suggestion that individuals should be held accountable for corporate manslaughter, and not just the company. It is significant as Mr Owens' level of culpability was essentially placed above that of the company. It is surmised that he would have been charged with the author's proposed offence of corporate manslaughter (for individuals), outlined in the following chapter, had it been available to the courts.

5.6.6 PYRANHA MOULDINGS

On 12 January 2015, Pyranha Mouldings was convicted of the corporate manslaughter of Alan Catterall, who was killed as a result of being trapped inside an industrial oven.[669] On 23 December 2010, a fault developed in one of the company's ovens that was used to create kayak moulds. When the fault was fixed, Mr Catterall began cleaning from the inside. However, the oven was turned back on and Mr Catterall had no means of escape. It was revealed that there had been no risk assessments undertaken, and staff had received no suitable training.[670]

The company was fined £200,000. The company's sole director, Mr Mackereth, was sentenced to nine months in prison (suspended for two years) and fined £25,000 for health and safety offences. The company and Mr Mackereth had to pay costs of £90,000 between them. It is with these later cases (from December 2014 onwards) that we start to see a trend emerging where individual directors are being convicted for

[668] 'Mobile Sweepers (Reading) boss fined over worker death' *BBC News* (26 February 2014) <http://www.bbc.co.uk/news/uk-england-hampshire-26359482> (accessed 7 July 2015).
[669] [2014] EWCA Crim 533.
[670] 'Oven death firm Pyranha Mouldings guilty of manslaughter' *BBC News* (12 January 2015) <http://www.bbc.co.uk/news/uk-england-merseyside-30717512> (accessed 13 January 2015).

health and safety offences (alongside the company's conviction for corporate manslaughter). This is effectively the courts' way of using legislation available to sentence those culpable individuals for corporate manslaughter.

5.6.7 LINLEY DEVELOPMENTS

On 22 September 2015, Linley Developments, a building firm, was convicted of corporate manslaughter for the death of its employee, Gareth Jones, when a wall collapsed on him on 30 January 2013.

A joint HSE and police investigation found that: i) the wall in question was inherently unsafe; ii) Linley Developments failed to undertake any risk assessment for the work being undertaken; and iii) it had not installed support or buttresses to prevent the wall falling forward.

Linley Developments was fined £200,000, plus costs of £25,000. Two of the company's directors, Mr Hyatt and Mr Barker, were given six-month prison sentences, suspended for two years, after pleading guilty to breaching the Construction (Design and Management) Regulations. Mr Hyatt was further fined £25,000 and ordered to pay costs of £7,500. Mr Barker was ordered to pay costs of £5,000. The judge also made a publicity order against the company, which stated:

> "Linley Developments Ltd was convicted on 7 September 2015 of corporate manslaughter arising out the death of Gareth Jones, a subcontracted employee, at a development in St Albans on 30 January 2013.
>
> On 30 January Mr Jones was working in an excavation adjacent to a 2.9-metre-high retaining wall which collapsed on top of him, causing him fatal injuries.
>
> Linley Developments Ltd admitted acting in gross breach of their duty by failing to take sufficient care for his safety. Failings included failing to prepare a risk assessment for the excavation works, failing to assess and monitor the stability of the wall and failing to ensure that the wall did not become unstable as a result of the excavation work.
>
> On 24/09/2015 Linley Developments Ltd was fined a total of £200,000.00."[671]

[671] A Morby, 'HSE Publicity Order – Linley Developments' *Construction Enquirer* (1 December 2015) <http://www.constructionenquirer.com/2015/12/01/hse-publicity-order-linley-developments/> (accessed 9 June 2016).

This text appeared on the Construction Enquirer's website throughout month of December 2015, with up to 60,000 people viewing it every day. This was the first time that a judge had ordered a publicity order to be made as a notice in the trade press, rather than in local newspapers or on the company's own website. Again, this case evidences the move, post-2014, to hold individuals to account alongside the company that they control.

5.6.8 SHERWOOD RISE

One of the most significant prosecutions under the 2007 Act, in terms of supporting the author's research, is that of Sherwood Rise on 3 December 2015. The company was fined £300,000 for the corporate manslaughter of Ivy Atkin, a resident at the care home owned by the company. Mrs Atkin died of pneumonia, brought about by debility and low body mass, as a result of the company's neglect in her care.

Significantly, two individuals were convicted alongside the company. Yousef Khan, a director of the company, was sentenced to three years and two months in prison after pleading guilty to gross negligence manslaughter. He was also banned from being a company director for 8 years. Mohammed Khan, a manager of the care home, was sentenced to one year in prison (suspended for two years) for health and safety offences, and banned from being a company director for 5 years.

5.7 CONCLUDING REMARKS

The Government's decision to reform the law of corporate manslaughter was driven by a public perception of injustice, resulting from the Crown's failure to obtain criminal convictions for deaths following major disasters related to corporate failings, such as the *Herald of Free Enterprise* disaster.

However, as has been noted above, the final Act is somewhat of a disappointment. It retains many of the evidentiary problems associated with the *Nattrass* identification doctrine. Some commentators may even regard the Act as succeeding primarily in marking a symbolic statement about corporate responsibility, but which it struggles to fulfil in practice.

From the cases analysed above, it is clear that corporate manslaughter prosecutions are gathering momentum and becoming more frequent. Whilst this is true, all of the companies that have been prosecuted under the Corporate Manslaughter and Corporate Homicide Act 2007 have been small companies, with a small number of 'senior management' (often with only one director). It has therefore been relatively easy for the prosecution to prove the constituent elements of the offence of corporate manslaughter. The absence of any convictions of large companies with a complex corporate/management structure, supports the author's contention that the Act is incapable of holding large companies accountable. Furthermore, in the absence of any secondary/individual liability within the Act, it would appear as though courts are now looking for ways to hold those corporate individuals accountable for their role in the corporate manslaughter alongside the company. These observations support fully the author's theories and the thesis hypothesis, as outlined in the following chapter.

CHAPTER 6
THE THESIS HYPOTHESIS

6.1 INTRODUCTION

This chapter begins with critical analyses of the sentences handed down to the parties found to be liable for the *Sewol* and the *Costa Concordia* maritime disasters, with particular focus on the individuals concerned, especially Captain Lee Joon-Seok and Captain Francesco Schettino. Although these two disasters, and the subsequent inquiries and criminal trials, do not fall within the jurisdiction of the UK, they do provide for valuable academic consideration relevant to this thesis.

The chapter then expands upon the discussion in the previous chapter regarding the inclusion of individual liability in a reformed UK Corporate Manslaughter and Corporate Homicide Act. The focus is on an academic reflection/consideration as to how the law in this area could obtain the international maritime community's desired 'safety culture'. The means of achieving this safety culture would be through the introduction of secondary individual liability for corporate manslaughter. For the purpose of ship companies, and the focus of this thesis, this proposed individual liability would work alongside the ISM Code to attribute criminal liability to those culpable corporations *and* 'corporate individuals',[672] whose management activities resulted in death(s) at sea.

Although the overall scope of this chapter relates to the UK maritime industry, and those ships within the territorial waters of the UK, there is the possibility that action taken by the UK may ultimately influence, in the longer term, the international maritime community as a whole. Historically, this influence has existed and can be seen with the significant example of the UK's Maritime & Coastguard Agency (MCA)'s lobbying of the IMO for the adoption and enforcement of more stringent safety standards, following the *Herald of Free Enterprise* disaster, which brought about the IMO Resolution that

[672] For the purposes of this chapter, a 'corporate individual' is a person covered by Section 2 of the Proposed and Improved Corporate Manslaughter and Corporate Homicide Act (discussed below) i.e. members of the company's management who make decisions regarding the activities of the company (e.g. directors, executives and other senior managers).

implemented the formal assessment of ship safety.[673] It was this first step towards safety assessment that led to the development and adoption of the ISM Code.

6.2 THE *SEWOL* TRIALS

Details of the official inquiry into the *Sewol* ferry disaster, and its reported causes are provided in Chapter 4 of this thesis, but a detailed discussion surrounding the relevant South Korean law and the sentences handed down to the culpable parties, especially the master of the *Sewol*, is appropriate here.

6.2.1 RELEVANT SOUTH KOREAN LAW[674]

South Korea has incorporated the SOLAS Convention and, ergo, the ISM Code, into its domestic legislation via its Ship Safety Act. However, as already noted in Chapter 2 of this thesis, the ISM Code only applies to passenger ships engaged in international voyages; the safety standards of passenger ships engaged in domestic voyages are left to each Flag State Administration to regulate. In the case of South Korea, safety standards for domestic passenger ships were, at the time, also regulated by the Ship Safety Act. It is worth observing that at the time of the *Sewol* disaster, the task of safety-management inspection had been delegated exclusively to the Korean Shipping Association (KSA); a cooperative association of domestic shipping companies established in 1949 to promote the shipping industry.[675] Under this delegated responsibility/authority, the KSA was to, *inter alia*, monitor passenger ships to ensure that they were not being overcrowded or overloaded.[676]

Whilst there is no international law specifically requiring a ship's master to stay on board in the event of an incident, such as its emergency evacuation, South Korea is an exception to the norm. By virtue of Article 10 of South Korea's Seafarers Act, it is a

[673] Resolution A.741(18), International Management Code for the Safe Operation of Ships and for Pollution Prevention.
[674] All English translations of relevant South Korean were obtained from 'Korean Laws in English' (*Ministry of Government Legislation*) <http://www.moleg.go.kr/english/korLawEng> (accessed 15 September 2017).
[675] Due to the clear conflict of interest existing here, as evidenced by the *Sewol* disaster, the task of safety inspections of passenger ships was transferred to the Korea Safety Technology Authority (a public corporation responsible for ship inspections and surveys) following the disaster.
[676] By virtue of Article 15.8 of the Ship Safety Act.

criminal offence for the master to depart the ship before all of the passengers have been evacuated:

> **Article 10 (Duty to Stay in Ship)**: A captain shall not leave his/her ship from the time cargoes are loaded and passengers start to go on board until the time all cargoes are unloaded from his/her ship an all passengers leave his/her ship.

The breaching of Article 10 will result in a fine of ₩5,000,000 (approximately £3,500) upon conviction, but no custodial sentence. However, Article 11 of the same Act makes it a legal duty of the master to take all necessary measures to save the lives of those on board his ship, and breaches of this duty could lead to a maximum of five years in prison upon conviction.

> **Article 11 (Measures to be Taken when Ship is in Danger)**: Where a ship is in crucial danger, a captain shall take all the measures necessary to rescue human lives, the ship and cargoes.

Beyond this provision, there is no specific offence of corporate manslaughter in South Korea, nor is there a comparable offence as is the case with Italian law (discussed below). As a result of this apparent gap in South Korea's law, the individuals concerned with the *Sewol* disaster were charged with accidental homicide i.e. the equivalent to a charge of gross negligence manslaughter in the UK.[677] The *Sewol*'s ship operating company itself escaped criminal liability for the 304 deaths, though it was essentially punished by means other than a criminal conviction.[678]

6.2.2 CHONGHAEJIN MARINE COMPANY

As discussed in Chapter 4 of this thesis, the causes of the *Sewol* disaster were that: i) the ship had been illegally redesigned; ii) it was overloaded with cargo (on the day of the disaster, it was carrying 3,608 tonnes; the maximum permitted was 987 tonnes); and iii) it was being steered by an inexperienced and incompetent helmsman.[679]

With regards to the illegal redesigns of the *Sewol* (namely that between October 2012 and February 2013, Chonghaejin Marine redesigned the ferry to create additional

[677] Discussed below.
[678] Discussed below.
[679] 'South Korea ferry 'steered by inexperienced third mate'' *BBC News* (20 April 2014) <www.bbc.co.uk/news/world-asia-27087243> (accessed 4 July 2015).

passenger space on the third, fourth and fifth decks at the aft of the ship, in order to accommodate an additional 114 passengers and an art gallery), there exists both national and international legislation available to the South Korean courts to hold Changhaejin Marine accountable. On 16 April 2014, the *Sewol* was carrying too much cargo and not enough ballast water. It was revealed during trials that Chonghaejin Marine had regularly and dangerously overloaded the *Sewol* in order to maximise profit.[680]

In May 2014, South Korea's Ministry of Oceans and Fisheries cancelled Chonghaejin Marine's licence to operate ferries on the Incheon-Jeju Island route i.e. the route that the *Sewol* was engaged in on the day that it sank. This 'punishment' has the equivalent effect as the disbarments under Italy's Decree 231, as discussed below. However, Chonghaejin Marine has not been prosecuted as a corporation, in the same way as it would have been had it been a UK-registered company brought before a UK court. Instead, the Chief Executive Officer (CEO) of the company, and others at senior management level, were prosecuted as individuals. The owner of the company, Yoo Byung-eun, was also charged with individual offences relating to the *Sewol* disaster, but will never face trial as he fled the authorities and was later found dead.

6.2.3 KIM HAN-SIK

At the same time as the revocation of Chonghaejin Marine's licence to operate ferries, the CEO of the company, Kim Han-Sik, was arrested and charged with, *inter alia*, causing death by criminal negligence.

On 20 November 2014, Mr Kim, then 71-years old, was sentenced to 10 years in prison for accidental homicide. In its ruling, the court said that Mr Kim had failed to act after junior management within the company had previously warned him about the ship's instability, and he had even encouraged the overloading of the ship with poorly lashed cargo in order to generate profits.[681] It is suggested that this liability and level of punishment is appropriate and fair in the circumstances.

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[680] SK Kim, 'The *Sewol* Ferry Disaster in Korea and Maritime Safety Management' (2015) 46 Ocean Development & International Law 345 at p. 346.
[681] S-H Choe, 'Chief of Ferry Company in South Korea Is Given 10-Year Jail Sentence' *The New York Times* (20 November 2014) <https://www.nytimes.com/2014/11/21/world/asia/chief-of-ferry-company-in-south-korea-given-10-year-jail-sentence.html> (accessed 5 December 2015).

Mr Kim was amongst 11 officials from Chonghaejin Marine, Union Transport (a cargo company), and the Korean Shipping Association (as the port inspector) who were on trial for their roles in the disaster. All but one were convicted of accidental homicide, as well as other criminal charges. Seven were sentenced to between two and six years in prison. Two others were given suspended custodial sentences. Another official, a senior ship inspector, was acquitted of charges of obstructing justice (the only offence he had been charged with).[682]

On 12 May 2015, a South Korean appeals court upheld the accidental homicide conviction against Mr Kim, but reduced his overall prison sentence to seven years. During the appeals process, Mr Kim had challenged the allegation that he was personally to blame; asking the court to reconsider the accidental homicide charge/conviction, and claiming that he was "just a salaried employee under the thumb of company owner Yoo Byung-eun". The court rejected this argument.[683]

In this instance, the law appropriately and fairly apportioned responsibility and liability to the culpable corporate individuals for their role in the disaster. Furthermore, the company itself was reprimanded with the revocation of its operating licence. However, the latter was not in the form of a criminal conviction and/or punishment due to a gap in the law. Legislation containing both corporate and secondary individual liability for corporate manslaughter would have ensured a more appropriate apportionment of liability and punishment for all culpable parties, both corporate and individual.

6.2.4 CAPTAIN LEE AND HIS CREW

It is appropriate to consider the trials of the 15 *Sewol* crew members collectively, as all 15 were tried together. On 10 June 2014, Captain Lee Joon-seok, Chief Engineer Park Gi-ho, First Officer Kang Won-sik, and Second Officer Kim Young-ho were in court in Gwangju to answer charges of murder, which carries a maximum sentence of death in South Korea. Two crew members were also in court to answer charges of fleeing and abandoning ship, and faced a maximum sentence of life imprisonment. Nine crew

[682] ibid.
[683] 'Sewol ferry disaster: South Korean Court upholds manslaughter and embezzlement convictions for company CEO' *ABC News* (12 May 2015) <www.abc.net.au/news/2015-05-12/sewol-ferry-ceo-manslaughter-and-embezzlement-charges-upheld/6463954> (accessed 24 July 2016).

members were charged with criminal negligence, and also faced prison terms if convicted.[684]

During the initial trial, Lee Kwang-jae, Captain Lee's lawyer, stated to the court that Captain Lee had no power to stop Chonghaejin Marine's practice of overloading the *Sewol* with cargo (the primary cause of the disaster), and that because Captain Lee had no *intention* (emphasis added) to cause the accident, there were no grounds for charging him with murder.[685]

The prosecution, however, had called for Captain Lee (and the others facing charges of murder) to be convicted of murder and given the death penalty, after branding him a liar who abandoned the *Sewol* despite knowing that hundreds of passengers were still trapped on board.

The only person convicted of murder was the *Sewol*'s Chief Engineer. He was sentenced to 30 years in prison, not for offences relating to the deaths of the passengers trapped on board, but for not assisting two injured fellow crew members. The court found Captain Lee not guilty of murder, but convicted him of accidental homicide and sentenced him to 36 years in prison. The remaining 13 surviving crew members were found guilty of offences ranging from criminal negligence to accidental homicide, and given prison terms of between five and 20 years.[686]

In finding Captain Lee and the First and Second Officers guilty of accidental homicide, and not murder, the court made the following statement as part of its judgment:

> "We find it hard to conclude that the defendants… were aware that all of the victims would die because of their actions and they had an intention to kill them. Therefore, the murder charges are not accepted."[687]

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[684] J-M Park, 'South Korea ferry disaster: Shouts of 'murderer' in court as Sewol captain and crew go on trial' *The Independent* (10 June 2014) <http://www.independent.co.uk/news/world/asia/south-korea-ferry-disaster-shouts-of-murderer-in-court-as-sewol-crew-go-on-trial-9520349.html> (accessed 6 November 2014).
[685] See ibid.
[686] J McCurry, 'South Korea ferry verdict: Sewol captain sentenced to 36 years in prison' *The Guardian* (11 November 2014) <https://www.theguardian.com/world/2014/nov/11/south-korea-ferry-verdict-sewol-captain-sentenced-to-36-years-in-prison> (accessed 15 November 2014).
[687] See ibid.

On the day that Captain Lee and his crew were convicted, the prosecutor said that it would appeal against the decision on all 15 crew members, calling the rulings "disappointing", particularly the not guilty verdicts of Captain Lee, and the First and Second Officers, of murder.

On 28 April 2015, the Gwangju High Court, hearing the appeals, overturned the lower court's initial ruling that acquitted Captain Lee of murder and convicted him of accidental homicide (and dereliction of duty) instead. The High Court substituted the lower court's conviction with a conviction of murder, and sentenced Captain Lee to life in prison; declining to impose the death penalty that was available to the court.[688]

In delivering the court's ruling, Judge Seo Kyeong Hwan stated:

> "The captain prematurely ended the students' lives and scarred their parents for life. His action tarnished South Korea's image, and could not be justified under any circumstances."[689]

However, it has been observed that "the decision is likely to be academic because the captain is nearly 70 and so was never likely to be freed under his previous sentence."[690]

The High Court reduced the sentences of the other 14 crew members, ranging from 18 months to 12 years (from the initial sentences of between five and 20 years). In giving reason for reducing the sentences, Judge Jeon Il-ho explained that the new sentences were designed to reflect the fact that the crew were acting under Captain Lee's orders: "We drew a distinction between Captain Lee Joon-seok, who had a grave responsibility, and crew members who took orders from the captain."[691]

Although Captain Lee's conviction for accidental homicide was substituted for a conviction of murder, Chief Engineer Park's murder conviction was substituted for accidental homicide, and his prison term reduced from 30 years to 10 years.

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[688] S Park, '(2nd LD) Sunken ferry captain gets life imprisonment for murder' *Yonhap News Agency* (28 April 2015) <http://english.yonhapnews.co.kr/national/2015/04/28/55/0302000000AEN20150428003552315F.html> (accessed 5 November 2015).
[689] See ibid.
[690] S Evans, 'Sewol ferry: S Korea court gives captain life sentence for murder' *BBC News* (28 April 2015) <http://www.bbc.co.uk/news/world-asia-32492263> (accessed 5 November 2015).
[691] ibid.

6.2.5 SUMMARY

There have been arguments put forward by some legal experts and academics that Captain Lee, and to some extent the other crew members, would not be able to receive a fair trial because of the way in which they were targeted and vilified by the media and the public.[692] Most notable of these critics was Judge Hahn Jee-hyung, who is responsible for handling the Gwangju (lower) court's relations with the media.[693]

It has also been claimed that the world press' coverage of the disaster, of Captain Lee and his crew's arrest, and of the trials, was "coloured by a presumption of guilt." Furthermore, before the trials even began, the country's President, Park Geun-hye, publicly stated that the actions of Captain Lee and his crew had been "tantamount to murder."[694]

Whilst the author accepts that these claims are well-founded, when having regard to the facts of the disaster, as outlined in Chapter 4 of this thesis, it is difficult to envisage Captain Lee and his crew not being found guilty; the only issue to be determined by the courts was which specific offence(s) each individual was guilty of, and to impose an appropriate punishment.

Although a conviction of accidental homicide (the equivalent to gross negligence manslaughter in the UK) and a 36-year prison sentence may have been more appropriate for Captain Lee in the circumstances, having regard to the nature of the causes of *Sewol* disaster, it is the author's opinion that the South Korean courts have punished Chonghaejin Marine, its corporate individuals, and the master and crew harshly, but also appropriately, for their respective roles in the disaster and the resulting loss of life.

[692] McCurry, 'South Korea ferry verdict: Sewol captain sentenced to 36 years in prison'.
[693] See Park, 'South Korea ferry disaster: Shouts of 'murderer' in court as Sewol captain and crew go on trial'.
[694] See McCurry, 'South Korea ferry verdict: Sewol captain sentenced to 36 years in prison'.

6.3 THE *COSTA CONCORDIA* TRIALS

Although the investigation into the *Costa Concordia* disaster is discussed in detail in Chapter 4 of this thesis, it is apt to consider here: the relevant Italian law; the sentences handed down to the parties deemed culpable by the Italian courts; and the criminal trials against the master of the *Costa Concordia*, Captain Schettino.

6.3.1 RELEVANT ITALIAN LAW[695]

The Italian legal system does not include a specific offence of corporate manslaughter. The most comparable offence to that found in the UK Corporate Manslaughter and Corporate Homicide Act 2007 is the one provided by Italy's Legislative Decree No. 231 of 8 June 2001,[696] which introduced criminal (administrative) liability for companies. Its purpose is to urge companies to put in place corporate governance systems, and risk management systems, in order to prevent company executives and management from committing crimes for the benefit of the company. Furthermore, only the adoption of an adequate organisational, management and control structure can exonerate a company from severe criminal liability under Decree 231.

The proviso for this legislation applying is that the liability arises only as a result of particular offences being committed *exclusively* (emphasis added) for the economic interest or benefit of the company, by *individuals* (emphasis added) holding representative, administrative or *de facto* managerial positions;[697] and the company cannot demonstrate to have taken 'adequate measures' to prevent the committing of such crimes. One such means of evidencing such adequate measures is for the company to demonstrate, in accordance with Articles 6 and 7 of Decree 231, that, before the crime was committed, it had adopted and *effectively* (emphasis added) implemented a model or organisational management and control system.[698] This, for ship companies, would be the ISM Code's mandatory Safety Management System (SMS).

It is important to note that the basis for this corporate criminal liability is different from that of the UK Corporate Manslaughter and Corporate Homicide Act, in that a death is

[695] The English translation of the relevant Italian law was obtained from D Contini and S Annovazzi, *Business crime and investigation in Italy: overview* (Practical Law, Thomson Reuters 2016).
[696] Herein referred to as 'Decree 231'.
[697] By virtue of Article 5.
[698] This is equivalent to the 'due diligence' defence discussed below.

not required in order to trigger liability under Decree 231. Furthermore, the acts of the individual need to be *intentional* (emphasis added), which means that the law requires 'direct intention' and willingness from the individual; negligence is insufficient to trigger liability under Decree 231, except where the offence relates to involuntary manslaughter and personal injury caused by the violation of workplace safety laws. These safety laws would include, *inter alia*, the ISM Code (as incorporated into Italian domestic law by virtue of Regulation (EC) No 336/2006).[699]

There are several sanctions that the Italian courts can impose upon conviction of these offences. These include, *inter alia*: i) the issuing of a large fine, of which the highest possible amount is €1,549,000 (in the case of multiple offences through the same action, the overall fine may amount to up to three times the fine issued for the most serious of the offences i.e. €4,647,000); ii) the suspending of licences, permits and/or authorisations (these debarments essentially prevent the company from operating/trading with specific or all parties); iii) the ceasing and confiscating of the price and profit (or the equivalent) deriving from the crime itself. Furthermore, the court's decision may be published in the media. For large ship companies, debarments and negative publicity (from the media's publication of the court's decision) would have the most detrimental financial effect on the company, and therefore serve as the most effective punishments and deterrents under Decree 231.

Applying Decree 231 to the facts of the *Costa Concordia* disaster, the facts revealed by the subsequent investigation and interviews, and the ISM analysis provided by Sagen, it is clear that Costa Crociere could (and some would rightfully argue *should*) have been charged with criminal (administrative) liability under Decree 231. Liability under Decree 231 would exist in this instance in relation to the acts committed by individuals within the company, which ultimately contributed and led to the deaths of 32 people on board the *Costa Concordia*. However, these individuals were tried separate from the company, and the company itself therefore escaped all criminal liability.[700]

Furthermore, the court held that it could not hold Costa Crociere responsible for the company's negligently hiring and supervision of the crew, namely the Helmsman, in

[699] No national legislation was enacted to implement the ISM Code into Italy's domestic law due to the binding legal effect of this Regulation.
[700] Discussed below.

accordance with Article 2043 of Italy's Civil Code. The reason for this was because all issues regarding hiring and the tolerating of the practice of sailing along the coast, are not attributable to Captain Schettino. The reason for this inability to attribute liability is due to the ISM Code not being implemented fully into Italy's domestic legislation; national legislation should be used to directly implement the Code, in the same way as the UK's 2014 ISM Regulations, in order to ensure full and effective implementation, which can then be used by the courts with a degree of certainty.

As a result, the judicial decision is in conflict with the ISM Code. The essence of the ISM Code is that it is to be used by the relevant authorities to establish ship companies' and individuals' duties and liabilities, and to 'measure' their standards with regards to operating ships safely. It is clear that this is not what has happened in the *Costa Concordia* investigation and subsequent trials.

6.3.2 COSTA CROCIERE

Following the publication of the marine casualty investigation report into the disaster by Italy's Ministry of Infrastructures and Transport, which went some way to highlight the role of Costa Crociere in the disaster, the company was under investigation by both the police and the prosecution. However, on 10 April 2013, Costa Crociere *accepted* (emphasis added) a fine of €1,000,000 (approximately £850,000 at the time) in order to settle potential criminal charges against the company itself i.e. to prevent Costa Crociere from ever being prosecuted in a criminal court for the *Costa Concordia* disaster. Valeria Matesarchio, the court judge for the preliminary hearing, accepted this plea bargain. The prosecution was quick to point out that the 'fine' was very close to the maximum that the preliminary court was permitted to impose under Italian law.[701] Marco De Luca, a lawyer acting for Costa Crociere, termed the settlement a "balanced decision [and] the most reasonable solution."[702] However, critics of Costa Crociere have condemned the size of the fine and have claimed that "it hardly seems a lot given the magnitude of the disaster the company was involved in."[703] Although this is true, it

[701] S Scherer, 'Costa accepts $1.3 million fine to avoid criminal charges in Concordia disaster' *Skift* (10 April 2013) <https://skift.com/2013/04/10/costa-cruises-accepts-1-3-million-fine-avoids-criminal-charges-in-concordia-disaster/> (accessed 12 April 2013).
[702] ibid.
[703] M Day, '€1m cap on Costa Concordia fine: 'It hardly seems a lot given the magnitude of the disaster'' *The Independent* (10 April 2013) <www.independent.co.uk/news/world/europe/1m-cap-on-costa-concordia-fine-it-hardly-seems-a-lot-given-the-magnitude-of-the-disaster-8567570.html> (accessed 12 April 2013).

is also unlikely that a lower court could ever impose a fine that would be deemed sufficient and adequate, given the nature of the 'crime'. It is suggested, therefore, that the most appropriate course of action would have been for the lower court to have rejected the plea bargain, and to have allowed the upper court, with its wider sentencing powers, to impose a larger fine, or to have revised the plea bargain entirely.

Bundesstelle für Seeunfalluntersuchung (the German Federal Bureau of Maritime Casualty Investigation) has heavily criticised Italy's investigation into the *Costa Concordia* disaster, and have called for necessary further investigations; stating that there were responsibilities for the events on 13 January 2012, that cannot be ascribed to Captain Schettino, and that the company shared some of the blame for the loss of the 32 lives.[704] Despite this, Costa Crociere has escaped criminal liability because of, as some have argued, the desire of the company, the prosecution, and the media, to pin the blame wholly on Captain Schettino. There has been increased lobbying for the investigation into Costa Crociere's role in the disaster to be reopened, and for criminal charges to be filed against the company itself,[705] including by one of the maritime community's most prominent non-profit NGOs and maritime safety pressure groups; the Skagerrak Safety Foundation.

6.3.3 THE SKAGERRAK SAFETY FOUNDATION

The Skagerrak Safety Foundation[706] was founded by survivors of the *Scandinavian Star* ferry disaster that occurred in the Skagerrak Strait on 7 April 1990. It is committed to advancing maritime safety, supporting survivors and relatives of maritime disasters, and providing legal assistance to seafarers facing trial, including, most recently and most notably, Captain Schettino.[707]

Immediately following the *Costa Concordia* disaster, whilst rescue operations were still underway, Sagen, a senior director of the Skagerrak Foundation, was asked to comment on the likely causes of the accident i.e. who or what was to blame for the ship sinking and the loss of life.[708] Sagen then, and many times since, identified the apparent and

[704] See *Press Release 18/15* (Bundesstelle für Seeunfalluntersuchung 2015) and *2014 Annual Report* (Bundesstelle für Seeunfalluntersuchung 2015).
[705] Discussed below.
[706] Herein referred to as the 'Skagerrak Foundation'.
[707] Discussed below.
[708] See C Eason, 'Cruise safety culture to come under scrutiny' *Lloyd's List* (31 January 2012).

immediate shifting of blame from Costa Crociere to Captain Schettino; specifically drawing upon the CEO's statement to the press, before any internal or external investigation had even began, that Captain Schettino may be guilty of "significant human error" that resulted in the *Costa Concordia* running aground and the sparking of a frantic evacuation operation.[709]

Sagen also questioned, and continues to question, how the tape recording of the conversation between Captain Schettino and Captain De Falco of the Italian Coastguard, which took place during the rescue operation on 13 January 2012, was leaked to the press whilst the rescue operation was still underway, especially considering such radio communications are meant to be privileged and confidential.[710] Sagen has since stated that it is his belief that the tape recording was released by Costa Crociere's emergency officer on that evening, in order to vilify Captain Schettino and so the company would escape insurance liability.[711] If Costa Crociere can place the responsibility for the accident wholly on Captain Schettino, it *escapes* (emphasis added) all insurance liability and thus receive a full payment of almost €2 billion; instead of €1 billion if any blame is attributed to the company. However, it should be observed that this is not the official position of the Skagerrak Foundation, but merely the personal opinion of Sagen.

Since the *Costa Concordia* disaster, the Skagerrak Foundation, spearheaded by Sagen, has strived and campaigned continuously for a full and proper investigation into the causes of the *Costa Concordia* disaster and for a fair trial, as well as a fair punishment, for Captain Schettino. It is pertinent here to discuss key parts of this campaign, which has been largely supported by key players in the international maritime community.

On 1 March 2016, following extensive research and analysis of existing reports from inquiries and investigations, the Skagerrak Foundation issued a bulletin, entitled 'An ISM Code analysis of the navigational aspect of *Costa Concordia*'. This 64-page

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[709] N Squires, 'Cruise disaster: company say errors made by ship's captain may have caused crash' *The Telegraph* (16 January 2012) <www.independent.co.uk/news/world/europe/1m-cap-on-costa-concordia-fine-it-hardly-seems-a-lot-given-the-magnitude-of-the-disaster-8567570.html> (accessed 20 January 2012).

[710] A copy of the transcript can be found at 'Costa Concordia transcript: coastguard orders captain to return to stricken ship' *The Guardian* (17 January 2012) <https://www.theguardian.com/world/2012/jan/17/costa-concordia-transcript-coastguard-captain> (accessed 19 January 2012).

[711] Though there is no clear evidence to substantiate this belief.

document serves as a damning attack on Costa Crociere; concluding that the accident was caused by what is categorised as an "organisational accident",[712] where several of the management elements necessary to ensure the safe operation of the ship seem to have been lacking.[713]

On 23 May 2016, the author, during a face-to-face interview with Sagen at his home in Sandvika, Norway, was handed an abridgement of the culmination of the Skagerrak Foundation's research and work concerning the *Costa Concordia*. In this comprehensive 54-page dossier, entitled 'Costa Concordia's Captain Fights Back',[714] the Skagerrak Foundation uses both legal and expert analysis to identify both the root causes and immediate causes of the disaster, including organisational and technical causes/aspects (i.e. findings of fact and law), and to appropriately attribute and apportion responsibility and blame to the relevant parties, including, *inter alia*, Captain Schettino and the five other individuals discussed below. Neither surprisingly, nor unfoundedly, the Skagerrak Foundation admonish Costa Crociere for its failure to implement the ISM Code, and for fostering a culture of complacency and blame at top-management level.

The Skagerrak Foundation then sent a letter on 4 August 2016, to the IMO, the EMSA, and all the Regional Port State Control MOU organisations, entitled 'Cruise Ships Safety Status: the need for more effective control of the various Flag States' compliance with IMO Regulations'. In this 22-page letter, the Skagerrak Foundation raises its concerns over the current status of navigation and rescue operations in emergency conditions for cruise and passenger ships, using the high-profile *Costa Concordia* disaster to illustrate such concerns. The Skagerrak Foundation also used this letter as an opportunity to lobby and make recommendations to the IMO, to develop a 'public white list' of cruise ships' (and cruise operating companies') compliance with new and amended IMO Regulations. It is envisaged that this white list would operate in much the same manner as the IMO's White, Grey and Black lists of ship registries, but would be more readily accessible to the public. It is hoped that this would then, in turn, affect the overall sales of individual cruise ship operators, and therefore act as a financial impetus for operators to implement and embrace a safety culture throughout the

[712] Document with the author.
[713] This document is discussed in greater detail in Chapter 4 of this thesis.
[714] Document with the author.

company. However, this proposal is concerned only with the cruise ship industry and, although the most 'significant'[715] maritime disasters involve ships from the cruise (and ferry) industry, it is suggested that all merchant ships required to comply with the ISM Code should be covered under such a proposed 'public white list'. In any event, there is no evidence to suggest that this letter has had any effect on the IMO's position regarding the *Costa Concordia* disaster or cruise-ship safety in general.[716]

On 31 October 2016, the Skagerrak Foundation issued an appeal, in the form of a letter, to seafarers' unions regarding the use of plea bargains in maritime accident cases.[717] In this 24-page letter, the Foundation raises concerns that the use of plea bargains, such as those discussed in this chapter, which in practice seem to transfer the company's responsibility and liability to the master. This is a violation of the ISM Code, as such plea bargains contradict the Code's requirements; specifically, the regulating of authority and responsibility between the company and the ship's master (Paragraphs 1.2 and 1.4). The master thereby seems to be made solely responsible for the condition and operation of the ship, and of all faults committed by himself and all of the crew who led to the accident, whilst the company's liability seems to be negated fully by the plea bargain. Furthermore, such shifting of responsibility over to the master may lead to the "unwanted criminalisation" of the individual. This has certainly been the case with Costa Crociere's plea bargain.

On 13 January 2017, and coinciding with the five-year anniversary of the *Costa Concordia* disaster, the Skagerrak Foundation delivered a letter to the Italian Government (via the Italian Embassy in Oslo, Norway).[718] Copies of this letter were also sent to key maritime institutions and organisations. In it, the Skagerrak Foundation demand that the relevant Italian authorities: i) re-open the investigation into the causes of the disaster, with particular focus on the role of Costa Crociere; and ii) ensure that Captain Schettino receives a fair trial as well as a fair punishment for his role in the disaster (rather than receiving all of the blame). This brief, but concise, three-page letter, entitled 'Italy must investigate the *Costa Concordia* accident according to EU-

[715] In terms of the number of casualties, media attention and public impact/opinion.
[716] This same letter was sent to: the Italian Maritime Administration, the Italian Coast Guard, the Norwegian Maritime Directorate, the Danish Maritime Administration, the Nautical Institute, the International Federation of Shipmasters' Association, and the Confederation of European Shipmasters' Associations.
[717] Document with the author.
[718] Document with the author.

Directive and establish organisational responsibility according to the ISM Code', accuses the Italian Government itself of failing to investigate the multiple failings of Costa Crociere, failure that evidence systemic deficiencies in Costa Crociere's organisational culture (i.e. the company's failure to implement an effective safety culture, as required by the ISM Code), and indicative of the cruise-ship industry as a whole. In the letter's conclusion, the Skagerrak Foundation make the following appeals to the Italian Government:

> "1. The Italian authorities are requested to re-open the investigation of the *Costa Concordia* accident such that it fulfils the criteria of and requirements of the IMO and EU Directive 2009/18/EC;
>
> 2. The Italian judicial system is requested to investigate, indict and pass judgment on the company's legal responsibility for the *Costa Concordia* accident, in accordance with the responsibilities set forth in the ISM Code."

When Sagen and Jan Harsem (the Chair of the Skagerrak Foundation) delivered the letter to the Italian Embassy, the Deputy Ambassador met with them to discuss the issues raised in the letter. Beyond this initial meeting, there has been no official response from the Italian Government.

6.3.4 THE PLEA BARGAINS OF THE FIVE EMPLOYEES/CREW MEMBERS

On 20 July 2013, Judge Pietro Molino, of the Tuscan court in the town of Grosseto, accepted the plea bargains for five Costa Crociere employees and imposed on each of them a custodial sentence for the offence of manslaughter. Under the plea bargains, which were fully supported by the prosecution, Costa Crociere's Emergency Manager in Genova at the time of the disaster, Roberto Ferrarini, was sentenced to two years and ten months in prison and Manrico Giampedroni, who was the Hotel Director for the *Costa Concordia*, was given two years and six months.

With regards to the bridge officers: the *Costa Concordia*'s First Officer, Ciro Ambrosio, who was the Officer of the Watch, and in command of the *Costa Concordia* when it went off course, was given a sentence of one year and 11 months; Third Officer Silvia Coronica, who was second in command to Ambrosia at the time of the disaster, received an 18-month sentence; and Helmsman Jacob Rusli Bin, whose failure to speak English or Italian ultimately led to the ship turning too late and hitting the rock, was sentenced

to 20 months in prison. According to Paragraph 4 of Regulation 14 to Chapter V of the SOLAS Convention:

> "English shall be used on the bridge as the working language […] on board […] unless those involved […] speak a common language other than English."

Due to the aforementioned plea bargain, however, Costa Crociere will not be held accountable for its appointment of an unqualified/incapable helmsman in contravention of international law.

Regarding the sentences handed to the individuals above, in Italy, custodial sentences of less than three years do not generally have to be served, except in cases of murder/homicide. However, manslaughter does not fall into this exception.[719] Therefore, none of the five employees who made a plea bargain with the prosecution will serve a day in prison. Arguably, these individuals are not deserving of harsher sentences, given their role and level of culpability for the disaster.

These sentences are appropriate for the level of culpability of the individuals concerned, but the manner in which they were dealt with, and the sentence later handed to Captain Schettino, highlight two key issues. Firstly, Captain Schettino's custodial sentence of 16 years and one month is both disproportionate and unfair when measured against his level of culpability. This further draws attention to, and emphasises, the second issue: many are of the opinion that Captain Schettino has been vilified by the media, used as a scapegoat by the prosecution, and "sacrificed" by Costa Crociere to safeguard the company's economic interests.[720]

6.3.5 CAPTAIN SCHETTINO

Interestingly, immediately following the sentences handed to the five named individuals above, Prosecutor Francesco Verusio made a statement to reporters outside of the court, to the effect that Captain Schettino's trial was the sole concern of the prosecution:

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[719] 'Five guilty in Costa Concordia trial' *BBC News* (20 July 2013) <http://www.bbc.co.uk/news/world-europe-23388680> (accessed 22 March 2014).
[720] Document with the author.

> "Justice is beginning to be done but there will be real justice in the end, when we can determine with certainty what the responsibilities of the captain are."[721]

Whilst this statement gives the illusion that the prosecution was looking to establish responsibility and liability, other public statements made by the prosecution, and in deed its actions throughout the trial process, would indicate that the true intention was not to determine responsibility, but to place all liability with Captain Schettino. The prosecution has also publicly described Captain Schettino as "a reckless idiot."[722] It is, to a certain extent, *understandable* (emphasis added) why media attention has been focused on Captain Schettino. However, it is not understandable, nor is it acceptable (when bearing in mind the author's analysis of the disaster in Chapter 4, as supported by Sagen) why the prosecution seemingly, and unfairly, placed its *entire focus* (emphasis added) on the prosecution of Captain Schettino. These statements, coupled with the fact that the prosecution had originally requested an overall prison term of 27 years and three months, some have argued, evidence an unfair attack on Captain Schettino, fuelled by media headlines and the self-serving commercial interests of Costa Crociere.[723]

This 'unfair attack' can further be seen when Captain Schettino's lawyers requested a plea bargain during pre-trial hearings on 14 May 2013, in which Captain Schettino offered to serve three years and four months in prison, in exchange for a ruling that he was only *partially* (emphasis added) responsible for the disaster. However, as his lawyers anticipated, this request for a plea bargain was rejected by the prosecution, and therefore not presented to the court for its consideration.

In a second and final attempt to secure a plea bargain, Captain Schettino's lawyers proposed a prison term of three years and five months on the same condition regarding the acceptance of partial responsibility. Donato Laino, one of Captain Schettino's lawyers, said at the time that he had little hope that the court would accept the plea bargain and that, in any event, it was "essentially a formality since the prosecution will tell us 'no'."[724] As anticipated, this plea bargain request was also rejected by the

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[721] 'Five guilty in Costa Concordia trial'.
[722] 'Costa Concordia captain begins appeal against conviction' *The Guardian* (28 April 2016) <www.theguardian.com/world/2016/apr/28/francesco-schettino-costa-concordia-captain-appeal-manslaughter-conviction> (accessed 29 April 2016).
[723] This is a view shared by Bundesstelle für Seeunfalluntersuchung. See, for example: *Press Release 18/15* and *2014 Annual Report*.
[724] 'Costa Concordia captain requests new plea bargain' *BBC News* (17 July 2013) <www.bbc.co.uk/news/world-europe-23347244> (accessed 4 August 2013).

prosecution. However, this is not surprising, considering that there was no significant difference between the two plea bargain requests, and the prosecution had repeatedly, and publicly, stated that it was hoping for a 27-year prison sentence.

To add weight to the claim by those, such as the Skagerrak Foundation, that the malicious prosecution of Captain Schettino was based on his character assassination by, *inter alia*, the media's melodramatic presentation of him as "Captain Coward",[725] is the fact that the initial trial took place in Grosseto's theatre, rather than the town's small courthouse, so as to accommodate the large public audience and the world's press that were in attendance. This media debacle contributed to the unfair portrayal and treatment of Captain Schettino during the lengthy trial process.

On 11 February 2015, Captain Francesco Schettino was found guilty of multiple accounts of manslaughter, abandoning ship and causing a maritime disaster. He was sentenced to 16 years and one month in prison (10 years for multiple manslaughter, five years for causing the shipwreck, one year for abandoning the passengers,[726] and one month for providing false information to the authorities). The verdict was handed down by a bench of three judges at the court of Grosseto in Tuscany, at the culmination of a trial lasting 19 months. Captain Schettino was absent when the verdict was read out, due to him being mobbed by the media outside of the court on previous occasions.

In April 2015, both the prosecution and defence entered appeals against the initial judgment, both with regards to sentencing. The prosecution requested that its original application for a sentence of 27 years and three months be imposed. Defence lawyers for Captain Schettino argued that the original trial was an "absurdity" and that, whilst Captain Schettino has accepted some responsibility for the disaster, he denies criminal charges. They went on further to assert that the 16-year prison sentence was "excessive and inappropriate"[727] and they requested that it be substituted with the sentence that

[725] 'Costa Concordia captain's appeal rejected' *The Guardian* (31 May 2016) <www.theguardian.com/world/2016/may/31/costa-concordia-captain-appeal-rejected-francesco-schettino> (accessed 4 July 2016).
[726] See the author's discussion in Chapter 4 of this thesis regarding the two accounts as to the manner in which Captain Schettino's disembarkation of the *Costa Concordia*.
[727] M Day, 'Costa Concordia trial: Captain Francesco Schettino may never serve 16-year jail sentence as lawyers prepare appeals' *The Independent* (12 February 2015) <www.independent.co.uk/news/world/europe/costa-concordia-trial-captain-francesco-schettino-may-never-serve-16-year-jail-sentence-as-lawyers-10042649.html> (accessed 4 July 2015).

they had proposed in their offer for a second plea bargain (i.e. three years and five months).

However, on 31 May 2016, Florence's appeals court dismissed both appeals and upheld the original 16-year (and one month) prison term imposed by the lower court. Once again, Captain Schettino was not present in court when the verdict was read out by the presiding judge; Grazio D'Onofrio. Captain Schettino's lawyers immediately started their final appeal with Italy's Court of Cassation (Italy's highest criminal court) and hoped for a reduction in sentence.

Whilst the final stage of the appeals process was taking place, lawyers for Codacons (an organisation that fights for the legal enforcement of consumer rights, and which is taking a class action against Costa Crociere) made the following statement:

> "We've pointed out the absurdity of this trial from the beginning. Schettino should be punished, but he has been made a scapegoat."[728]

This would certainly align with and echo the opinions of those such as the Skagerrak Foundation. The same lawyers are demanding that the investigation into Costa Crociere's role in the disaster be reopened because "there are still some guilty parties to identify"[729] in the case, and the consideration of the entire organisation, not just one person, is essential in order to determine actual liability. It could be argued that it is difficult to envisage Costa Crociere's "guilt" being revealed by any inquiry due to the plea bargain accepted by the preliminary court on 10 April 2013. However, it is suggested that the inquiry's remit would only be concerned with findings of fact relating to responsibility; leaving the findings of law and liability to be determined by any subsequent *fair* (emphasis added) trial.[730] Regardless of Costa Crociere's plea bargain, any report coming from such an inquiry would have assisted the court in reaching a fair decision with regards to Captain Schettino.

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[728] Day, 'Costa Concordia trial: Captain Francesco Schettino may never serve 16-year jail sentence as lawyers prepare appeals'.
[729] 'Schettino's Sentence Upheld at Sixteen Years' *The Maritime Executive* (31 May 2016) <www.maritime-executive.com/article/schettinos-sentence-upheld-at-sixteen-years> accessed (1 August 2016).
[730] In terms of the court being presented with the full facts and thus a truer picture of who was responsible and liable.

On 12 May 2017, Italy's Court of Cassation upheld Captain Schettino's lower court convictions and his 16-year (and one month) prison sentence: 10 years for manslaughter, five years for causing the shipwreck, one year for abandoning the ship before all passengers and crew had evacuated, and one month for providing false information to the authorities after the disaster).[731] Once more, Captain Schettino was not present in court when the verdict was read out. Instead, he was outside Ribibbia prison in Rome, where he surrendered himself immediately following the verdict.

Outside of the court, Captain Schettino's lawyer, Saverio Senese, said to reporters:

> "Schettino is the only one to have paid a price. He was made a scapegoat. Schettino admits he is responsible but not that he is guilty, because on the *Concordia* there was a command team. He was not alone and the ship had many problems."[732]

The lawyers for Codacons also expressed their disappointment that only Captain Schettino is being punished, since they contend that corporate individuals within Costa Crociere also share the blame for the disaster.[733]

Following the verdict, Sagen, during an interview with *The Telegraph* newspaper, stated that the Skagerrak Foundation would be lobbying the maritime/cruise industry for changes to the ISM Code in the wake of the *Costa Concordia* case, as the Italian authorities "clearly breached" the Code by approving Costa Crociere's plea bargain with the prosecution.[734]

In attacking this plea bargain further, Sagen said of the ship company:

> "They paid themselves free of any management and operational responsibility, leaving the court no option but to find the captain solely responsible."[735]

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[731] F d'Emilio, 'Costa Concordia captain jailed for disaster that killed 32 after court upholds sentence' *The Independent* (12 May 2017) <http://www.independent.co.uk/news/world/europe/costa-concordia-captain-francesco-schettino-jailed-a7733611.html> (accessed 15 May 2017).
[732] 'Costa Concordia captain hands himself into prison' *The Guardian* (12 May 2017) <https://www.theguardian.com/world/2017/may/12/costa-concordia-captain-hands-himself-into-prison> (accessed 15 May 2017).
[733] d'Emilio, 'Costa Concordia captain jailed for disaster that killed 32 after court upholds sentence'.
[734] A Vogt, 'Captain jailed over Costa Concordia disaster says he will go back to being a 'ship boy'' *The Telegraph* (14 May 2017) <http://www.telegraph.co.uk/news/2017/05/14/captain-jailed-costa-concordia-disaster-says-will-go-back-ship/> (accessed 15 May 2017).
[735] ibid.

At the time of publication of this thesis, Captain Schettino's lawyers are considering an appeal to the European Court of Human Rights.[736] Captain Schettino has rightfully accepted a certain degree of wrongdoing but Costa Crociere should also share the blame and be held accountable for its failings; failings which significantly contributed to the disaster and which, if these had been prevented, would have meant that necessary safety barriers (using Reason's terminology) would not have been breached, and therefore the 32 lives would not have been lost. This collective failure argument would certainly correspond with the ethos of Safety Culture Theory.

6.3.6 SUMMARY

The author has discussed arguments put forward by others, which are well supported, and which may have some force, especially when regarding the evidence presented in this thesis. They argue that the public opinion of Captain Schettino has been tainted by the media's vilification and character assassination of him in an attempt to create headlines and to sell stories. This, in turn, it has been alleged, has encouraged and resulted in the malicious prosecution of the master, who was used as a "scapegoat", in order to satisfy the self-serving economic interests of a multibillion pound company. In doing so, the company has (so far) escaped all liability; both from a criminal law perspective and from an insurance liability perspective. That the company has escaped *all* (emphasis added) liability is wholly unjust and unfair, and it is worryingly indicative of a very serious problem with the law; where there is an apparent concerted effort and practice of shifting responsibility, and therefore liability and accountability, from the ship company to the master,[737] who is then handed a lengthy and extreme prison sentence for manslaughter (or that jurisdiction's equivalent offence) when a death occurs as a result. The law and practice (by the international maritime community) in this area needs reform.

[736] 'Costa Concordia captain hands himself into prison'.
[737] This view is supported by the author's survey, as discussed in the following chapter.

6.4 INDIVIDUAL LIABILITY FOR CORPORATE MANSLAUGHTER IN THE UK

Although the Corporate Manslaughter and Corporate Homicide Act 2007 is examined in the previous chapter, it is appropriate at this point to discuss in greater detail: i) the arguments initially put forward by the various parties involved in the Act's development and consultation process, for both the inclusion and exclusion of individual liability; ii) the reasons why such individual liability in a reformed and improved Corporate Manslaughter Act would benefit, *inter alia*, the maritime community; and iii) how this individual liability would manifest in the author's Proposed and Improved Corporate Manslaughter and Corporate Homicide Act.

6.4.1 THE LAW COMMISSION: REPORT NO 237 (1996)

As a direct result of the failed corporate manslaughter prosecution of P&O,[738] the first key development in the law relating to corporate manslaughter came with a report published by the Law Commission in 1996, following a detailed consultation process. In its report, entitled 'Legislating the Criminal Code: Involuntary Manslaughter', the Law Commission, *inter alia*, laid out its proposals for the creation of an offence of 'corporate killing' based on its consultation process.[739] During the consultation process, the Health and Safety Executive (HSE) submitted an opinion, whereby it stated that "a single individual [is] rarely the *sole* (emphasis added) cause of death."[740] The essence of this opinion appeared to be unsupported by the Law Commission, when it stated that "whatever the true right or wrongs" of the prosecutions resulting from disasters such as the *Herald of Free Enterprise*, public confidence suffers if individual perpetrators *appear to* (emphasis added) escape prosecution/conviction, rather than "having [their] culpability tested" at the same standard as those who are prosecuted for manslaughter offences.[741] Despite this latter statement, however, the Law Commission in the end concluded that no individual liability should be included in any new Act of Parliament dealing with corporate manslaughter, or 'corporate killing' as the proposed offence was then termed:

[738] R v P&O European Ferries (Dover) Ltd (1991) 93 Cr App 72.
[739] Report 237: Legislating the Criminal Code: Involuntary Manslaughter (The Law Commission 1996).
[740] ibid at para 7.13.
[741] ibid at para 7.12.

> **Recommendation 15**: We recommend that the offence of corporate killing should not be capable of commission by an individual, even as a secondary party.[742]

The Law Commission further recommended that the health and safety law (under the Health and Safety at Work etc Act 1974), and individual manslaughter law in force at the time of its report being published, were appropriate means of attributing criminal liability to any culpable individuals within a corporation. However, the 1974 Act is wholly insufficient to deal with those offences where a death results, at sea or otherwise. Prosecutions for breaches of the Health and Safety at Work etc Act 1974 focus entirely on an individual or organisation's failure to comply with a prescribed duty; it is not concerned with whether or not a death (or injury) has resulted from that failure. The courts are therefore unable to take this into account when sentencing, and so impose only small fines for health and safety offences.[743] This is seriously insufficient and does not reflect the consequence of the individual's or organisation's actions, or in deed the public's expectations of the law in this area.

Under the common law, individual directors or officers of a company[744] can be prosecuted for gross negligence manslaughter if their own grossly negligent behaviour caused the death. This offence is punishable by a maximum of life imprisonment.[745] However, there are four elements of gross negligence manslaughter, as decided by the case of *R v Bateman*,[746] which need to be satisfied in order to prove the offence:

1. the defendant owed a duty of care to the deceased;
2. the defendant negligently breached that duty of care;
3. the breach caused the death of the deceased; and
4. the defendant's negligence was so gross that it showed such a disregard for the life and safety of others (as to amount to a crime and thus deserve punishment).

The small number of directors and senior management successfully prosecuted for individual gross negligence manslaughter evidences how difficult it is to prove the

[742] ibid at para 8.58.
[743] Sentencing for health and safety offences is discussed below.
[744] These would be the equivalent of 'senior management' under the Corporate Manslaughter and Corporate Homicide Act 2007.
[745] By virtue of Section 5 of the Offences Against the Person Act 1861, as amended.
[746] [1925] All ER Rep 45.

common law offence,[747] especially with regards to proving the negligence standard. This difficulty has recently been demonstrated by the case of *R v Sellu (David)*.[748]

In this case, the appellant appealed against his conviction for gross negligence manslaughter on the grounds that the directions given by the trial judge to the jury rendered the conviction unsafe. In particular, that the judge's direction on the 'gross negligence' aspect of the offence was inadequate.

Mr Sellu was a consultant surgeon, whose conviction arose from the death of a patient who had died after sustaining a perforated colon following an operation. It was argued that Mr Sulla should have performed an operation to repair the perforated colon much earlier than he did. The trial judge, Mr Justice Nicol, gave the following direction on the 'gross negligence' aspect of the offence:

> "But your task is not just to decide whether Mr Sellu fell below the standard of a reasonably competent consultant colorectal surgeon, but whether he did so in a way that was gross or severe. Start with what Mr Sellu knew or ought reasonably to have known about the risk to Mr Hughes' life if the proper standards were not observed. Then ask yourselves, did Mr Sellu's behaviour or failure to act fall so far below those standards that his conduct and omissions deserves to be characterised as gross? When we want to weigh a physical object we can use scales marked in ounces or grams. There is nothing similar which I can give you to measure or weigh whether any negligence was 'gross'. As in many other contexts we leave it to juries to apply their own common and good sense to decide whether the line has been crossed. Using that good and common sense, it is for you to decide whether Mr Sellu acted in a way that was grossly negligent. If you conclude he was then it will mean that his behaviour was potentially criminal."

The Court of Appeal agreed with Mr Sellu and granted the appeal. Mr Justice Nicol had not sufficiently assisted the jury in understanding the difference between 'very serious mistakes' (which would not constitute gross negligence) and conduct that was 'truly exceptionally bad' (which would constitute gross negligence).

Whilst this case makes it clear that trial judges will have to give clear and robust guidance to the jury as to the nature of the negligence that must be proven in order to establish gross negligence manslaughter, the Court of Appeal declined to provide the

[747] *First Joint Report of Session 2005-06: Draft Corporate Manslaughter Bill* (The House of Commons: Home Affairs and Work and Pensions Committees 2005) at para 309.
[748] [2016] EWCA Crim 1716.

exact phrasing for trial judges to use. Therefore, the difficulties with proving 'gross negligence' remain.

Although the elements of the offence of gross negligence manslaughter are similar to those of corporate manslaughter (i.e. that the defendant's grossly negligent breach of a relevant duty of care caused a person's death), with regards to the common law offence, a specific individual must be identified. This is not the case with corporate manslaughter, where collective management failings are sufficient to convict the body corporate.[749]

In the case of prosecuting individuals for deaths at sea, examination of the DPA's activities should be the starting point, owing to their role within the company, as outlined by the ISM Code itself (i.e. to ensure the safe operation of each ship). If the DPA acted grossly negligent, then they should be convicted and sentenced to an appropriate prison term. However, as a defence, 'blame' could be shifted to more senior management, and thus the DPA's liability negated, if it can be shown that the DPA had brought the attention of the 'risk'[750] to more senior management, and it was the latter who had failed to act on the advice or information provided. If this is one particular individual, then it may be possible for their failure (to act on the information provided to them by the DPA) to constitute the gross negligence element of the common law offence of gross negligence manslaughter. If the DPA is not at fault, and failings are to be placed higher up the body corporate, problems arise where 'collective management' failings are found to be the cause of the safety breach resulting in death (i.e. no *one particular* (emphasis added) individual is identified); all individuals would escape liability (and punishment). If individual liability for corporate manslaughter were to be included in any reform of the 2007 Act, in the manner discussed in the thesis hypothesis below, then it would be possible to establish the guilt of all those individuals responsible for the company's actions or omissions that led to the death. It would then be for the courts to determine the level of culpability and reflect this in the sentences given to each individual convicted. There is a gap in the law where corporate individuals responsible for collective management failings are going unpunished.

[749] By virtue of a 'qualified aggregative principle', as discussed below.
[750] i.e. the safety-related risk, which ultimately led to the death.

6.4.2 THE GOVERNMENT'S PROPOSALS FOR REFORM (2000)

The Government considered the Law Commission's recommendations and published its own report in 2000.[751] From this report, it would appear that the Government was not fully convinced by the Law Commission's Recommendation 15; inviting views and recommendations (during a consultation process) on whether individual directors or officers should be liable to imprisonment if it was found that they had contributed to the management failure that resulted in death.[752] It is worth noting the use of the term 'contributed to', which is in stark (legal) contrast to the third element of gross negligence manslaughter requiring causation, as discussed above.

After a period of consideration and deliberation during the somewhat lengthy consultation process, the Government decided against pursuing new criminal sanctions against individuals under an offence of corporate manslaughter. It justified this decision on the grounds that:

> "The need for reform arises from the law operating in a restricted way for holding organisations to account […] and this is a matter of corporate not individual liability."[753]

Whilst there is certainly merit in this statement, acknowledging the need for the (then) long overdue reform of the law relating to corporate manslaughter, there is no sufficient reason why both a corporation *and* an individual cannot be liable under corporate manslaughter legislation. The Home Affairs and Work and Pensions Committees' Corporate Manslaughter Bill Sub-Committee echo the author's view on this point (discussed below).

Further support for the inclusion of individual liability comes from a report by Public Concern at Work, a leading 'whistleblowing charity' concerned with furthering organisational accountability. This report was published shortly after the Government published its proposals for reform in 2000 and, although it was not submitted as part of the consultation process, it is very critical of the Government's proposals; stating that

[751] Reforming the Law on Involuntary Manslaughter: the Government's Proposals (The Home Office 2000).
[752] ibid at para 3.4.13.
[753] Corporate Manslaughter: The Government's Draft Bill for Reform (The Home Office 2005) at para 47.

the purpose of the law in the area of corporate manslaughter should be, first and foremost to:

> "ensure that individuals through an organisation understand that they can expect to account for their conduct, where their actions or omissions result in death."[754]

It is clear from this statement that the charity's primary focus is on the actions and resulting culpability of the corporate individuals within the company, rather than the company itself.

The report highlights the public's expectations that the law should be capable of applying to culpable individuals. It asserts that this would be an acceptable and realistic position, provided there was a 'due diligence' defence that individuals could rely upon. This defence would be a 'full defence' and available for an individual charged with corporate manslaughter where they could demonstrate that they: i) exercised reasonable care and due diligence to ensure that they were informed about any serious risk to health and safety within their company; and ii) if so informed about a risk that led to a death, that they had acted reasonably in response to that information to minimise the risk.[755] This defence is very much similar in its approach to both the one theorised above concerning the shifting of blame and liability from the DPA to senior management, and the one contained within the author's Proposed and Improved Corporate Manslaughter and Corporate Homicide Act (discussed below).

Public Concern at Work propose a test to determine culpable management failings falling far below what could reasonably be expected, very similar to that which was included in the Corporate Manslaughter and Corporate Homicide Act 2007. Furthermore, the charity stresses that only a custodial sentence would be an appropriate punishment for those convicted, and an acceptable method of deterrence.[756]

There is no doubt from the public's response to disasters, maritime or otherwise, that there is a clear demand for individuals to be held accountable when a death has occurred as a result of that individual's culpable actions. Despite the Law Commission's report, and reports such as the one from Public Concern at Work, which highlight the need for

[754] Reforming the Law on Involuntary Manslaughter: the Government's Proposals at section 1.3.
[755] ibid at section 1.3.
[756] ibid at section 3.6.

the Government to address and satisfy this public concern and expectation, the Government continued with its proposals to develop corporate manslaughter legislation that specifically excludes individual liability.

6.4.3 THE GOVERNMENT'S DRAFT BILL FOR REFORM (2005)

Despite the Government expressing concern in its 2000 report that without "punitive sanctions" against individuals within the company, there would be "insufficient deterrent force" in any proposals it put forward,[757] a clause was inserted in the March 2005 draft Bill, which stated that "an individual cannot be guilty of aiding, abetting, counselling or procuring an offence of corporate manslaughter."[758] In explanation of this new policy position, the Government stated that at that time it did not intend to pursue sanctions against individuals or to provide secondary liability, as its focus was entirely on the corporation; creating legislation to tackle the specific problem of holding corporations accountable.[759]

6.4.4 THE HOME AFFAIRS AND WORK AND PENSIONS COMMITTEES' CORPORATE MANSLAUGHTER BILL SUB-COMMITTEE (2005)

In the Corporate Manslaughter Bill Sub-Committee's[760] First Joint Report of Session 2005-06, it stated that many witnesses to its committee hearings argued that the lack of proposed punitive sanctions against individuals would provide an insufficient deterrent,[761] echoing the acknowledgement made previously by the Government in its 2005 draft Bill. It then listed three means of making directors or senior managers individually liable, all of which were proposed to it during the committee hearings.[762]

The first proposal was that of 'automatic liability' i.e. whenever a company is found guilty of corporate manslaughter, the senior individuals within the company would automatically be found liable. The Sub-Committee, however, was of the opinion that using automatic liability to convict individuals would be unfair; stating that to hold an individual automatically liable, regardless of whether their actions *contributed*

[757] Corporate Manslaughter: The Government's Draft Bill for Reform at para 46.
[758] Clause 1(5).
[759] Corporate Manslaughter: The Government's Draft Bill for Reform at para 47.
[760] Herein referred to as the 'Sub-Committee'.
[761] First Joint Report of Session 2005-06: Draft Corporate Manslaughter Bill at para 306.
[762] ibid at para 307.

(emphasis added) to the offence of corporate manslaughter or not, would be unfair.[763] However, the Sub-Committee also argued that if the draft Bill was enacted as it stood at the time, without individual liability being included, there would be a "gap in the law" where individuals within a company who had contributed to the offence of corporate manslaughter, but where there was insufficient evidence to prove that they were guilty of individual gross negligence manslaughter, would escape liability.[764] This may be true, but it would be dangerous for the law to convict someone based entirely on their job title.

The second proposal made during the hearings was to introduce an additional offence of 'unlawful killing', which would allow a corporate individual to be held individually liable for a workplace death if they were found to have been responsible for the management failings that led to the death. The Sub-Committee also rejected this proposal; citing the small number of successful convictions of directors for gross negligence manslaughter as proof of how difficult it is to prove such an individual offence.[765]

The final proposal made during the hearings was that an individual offence of 'aiding, abetting, counselling or procuring the commission of an offence of corporate manslaughter' should be included in the draft Bill. However, one witness involved in the hearings argued that it would be difficult to convict an individual of such an offence because it is the nature of the offences falling under the category of 'corporate manslaughter' that they are made up of a chain of actions by a number of people. The witness warned that inclusion of this secondary offence would result in individuals being "labelled with a manslaughter conviction who […] only committed something of very low culpability." This argument is similar to the one detailed above regarding actually contributing to the offence, and the level of culpability associated with that contribution. The same witness argued that it should be necessary that the defendant actually *intended* (emphasis added) the offence.[766] However, actual intention should not be the only means of attributing liability; any negligence on the part of the defendant, which fell below what is reasonably expected in the circumstances, should also be a

[763] ibid at para 308.
[764] ibid at para 308.
[765] The proposed individual offence of 'unlawful killing' would have been similar to the common law offence of gross negligence manslaughter.
[766] First Joint Report of Session 2005-06: Draft Corporate Manslaughter Bill at para 310, per Ms Sally Ireland from JUSTICE.

means of proving culpability and securing a conviction. With regards to maritime disasters, the ISM Code (in combination with best common practice) would be used to determine what was 'reasonably expected in the circumstances'.

After considering the three aforementioned proposals, the Sub-Committee offered a "better alternative", originally recommended to it by the London Criminal Courts Solicitors' Association, in which a secondary offence should be created by inserting clauses into the (then) draft Bill, based on Sections 36 and 37 of the Health and Safety at Work etc Act 1974. The Association suggested that the clauses might take the following form:

> (1) Where an offence of corporate manslaughter is proved to have been committed with the consent or connivance of, or to have been attributable to any neglect on the part of, any director, manager, secretary or other similar officer of the organisation or a person who was purporting to act in such a capacity, he as well as the organisation shall be guilty of the offence of corporate manslaughter.
> (2) Where the affairs of a body corporate are managed by its members, the preceding subsection shall apply in relation to the acts and defaults of a member in connection with his functions of management as if he were a director of the body corporate.
> (3) Where the commission by any person of corporate manslaughter is due to the act or default of some other person, that other person shall also be guilty of the offence, and a person may be charged with and convicted of the offence by virtue of this subsection whether or not proceedings are taken against the first-mentioned person.[767]

The Sub-Committee added to this recommendation by proposing that if an individual was held accountable under this (proposed) offence, even though it would be a secondary offence, the individual should be liable to the full range of sentences available to the courts. The Sub-Committee's recommendation was that it should be less than the maximum available for gross negligence manslaughter (i.e. life imprisonment) and so recommended a maximum custodial term of 14 years.[768] This would have certainly created an offence with a level of liability and punishment appropriately set between that of gross negligence manslaughter and health and safety offences.

[767] ibid at para 312.
[768] ibid at para 314.

The Sub-Committee's recommendation definitely merits consideration for any proposed reforms to the Corporate Manslaughter and Corporate Homicide Act 2007. Not only would the proposed secondary offence ensure that culpable corporate individuals were held accountable for their negligent (or intended) actions, but also that they received an appropriate 'label' for the crime (addressing the concerns of those such as JUSTICE, as outlined above), as well as a custodial sentence appropriate for their level of culpability.[769]

Furthermore, the aforementioned clauses, if adopted, would ensure that the focus of the Act is not only placed on the organisational failures, but *also* on the individuals responsible for such failures. This would alleviate concerns put forward by those, such as Ormerod and Taylor, that the Act's attempt at a strict division between organisational and individual fault has resulted in the law's focus being entirely on organistional faults, whilst allowing individuals to escape liability and censure.[770] It would further alleviate "cynical commentators" who regard the Corporate Manslaughter and Corporate Homicide Act 2007 as being merely a "symbolic statement" about corporate responsibility but with little practical effect.[771] It is this recommendation that heavily influences the thesis hypothesis.

6.4.5 THE GOVERNMENT'S REPLY TO THE SUB-COMMITTEE (2006)

In response to the Sub-Committee's First Joint Report, and the recommendations contained within it, the Government published its draft Corporate Manslaughter Bill in March 2006, and explanatory notes to accompany it. Chapter 13 of these explanatory notes specifically addresses individual liability, albeit with reference to directors only, and not 'senior management'.

The Government fails, however, to successfully address the Sub-Committee's concern that "the small number of directors successfully prosecuted for individual gross negligence manslaughter shows how difficult it is to prove the individual offence."[772] Instead, the Government reiterates its previous assertion that current offences, including manslaughter and those under health and safety laws, already cover individuals who

[769] The issue of appropriate sentences is discussed in greater detail below.
[770] D Ormerod and RD Taylor, 'The Corporate Manslaughter and Corporate Homicide Act 2007' (2008) Criminal Law Review 589 at p. 595.
[771] ibid at p. 589.
[772] Discussed above.

have acted recklessly or been grossly negligent and caused a death.[773] This statement does not address the difficulty associated with prosecuting corporate individuals for gross negligence manslaughter; and it ignores the Sub-Committee's proposed/recommended clause based on Sections 36 and 37 of the Health and Safety at Work etc Act 1974. It is this failure to consider, and eventually incorporate, this proposed clause, which has resulted in an Act that does not fully or effectively address the public's concerns.

6.4.6 THE HOUSE OF COMMONS RESEARCH PAPER (2006)

On 6 October 2006, the House of Commons Library Research Service published its research paper on the Corporate Manslaughter and Corporate Homicide Bill, compiled by Miriam Peck.[774] This research paper was produced for the benefit of Members of Parliament and their staff, and discusses the draft Bill prior to its second reading on 10 October 2006. The research findings indicate that the Bill had been widely welcomed, but that trade unions and health and safety campaigners had expressed concern over the absence of any individual liability in the Bill.[775]

Furthermore, the research paper refers to a Health and Safety Bulletin, in which the Health and Safety Executive (HSE) criticises the Bill's remedial orders for potentially weakening the penalties available for the (new) offence of corporate manslaughter, when compared with those available under health and safety legislation. The HSE argues that:

> "Given that the corporate manslaughter charge is reserved for the gravest of offences, it seems ridiculous that a director cannot be imprisoned for a failure to remedy matters that led to a death, but can be for a failure to remedy matters that led to the risk of a death."[776]

Further criticism is directed towards the exclusion of individual liability when the Centre for Corporate Accountability (CCA) is quoted as saying that the Bill is a

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[773] The Government's Reply to the First Joint Report From the Home Affairs and Work and Pensions Committees Session 2005-06 HC 540: Draft Corporate Manslaughter Bill (The Home Office 2006) at para 53.
[774] M Peck et al., The Corporate Manslaughter and Corporate Homicide Bill: Bill 220 of 2005-06 (The House of Commons Library 2006).
[775] ibid at p. 54.
[776] See ibid at p. 54.

disappointment.[777] Addressing specifically the exclusion of individual liability, the CCA made the following statement:

> "We are concerned that individual offences for aiding and abetting, and that private prosecutions are prohibited by the bill. We see no reason for prohibiting individual offences and private prosecutions for this area of criminal law, where these are allowed in other areas of criminal law. Equally, we believe that the threat of individual accountability by managers and directors of a company will help them focus on their moral and legal obligation to run safe companies, and to take action if they work for a company that might negligently kill people."[778]

It is not surprising that the CCA would hold this view. However, it is a view that is reflective of popular public opinion, and is a one that is supported by most health and safety organisations. It is indicative of this popular public opinion at the time, that the research paper only includes one brief statement in support of the Government's decision to exclude individual liability. This statement comes from John Cridland, the then deputy director-general of the Confederation of British Industry (CBI), who said:

> "So far, the government has taken a sensible approach and rightly continues to focus on collective responsibility and company liability rather than trying to hold one person accountable for corporate failure."[779]

Again, it is not surprising that the CBI would hold this view, when considering that it is predominantly an organisation that lobbies for the interests of member businesses and their leaders.

That the authors of the research paper, under the direction of Peck, chose to give more weight (in terms of both the number of statements and the number of words) to those individuals and organisations critical of the Government's policy regarding individual liability, conveys a significant message. At this stage in the development of corporate manslaughter legislation, the overwhelming popular public opinion was that any legislation dealing with corporate manslaughter should include, in some form, individual liability for corporate individuals.

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[777] ibid at p. 54.
[778] ibid at p. 54.
[779] ibid at p. 54.

6.4.7 THE CORPORATE MANSLAUGHTER AND CORPORATE HOMICIDE ACT (2007)

Despite the strong arguments for the inclusion of individual liability, and the proposals and recommendations made to the Government as to how such liability could manifest in the final Act, the business community's lobbying efforts against the inclusion of individual liability prevailed. Section 18 of the 2007 Act fully negates the concept of individual liability within the application of the offence of corporate manslaughter.[780] The specific exclusion of individual liability in this instance evidences the growing power of companies to influence and control the legal environment in which they operate.[781]

As discussed above, the Government's rationale behind the policy to eschew individual liability in the final Act was so that it could focus entirely on the liability of corporations. However, leading academics, such as Gobert and Wells, are not convinced by this reason for ignoring the culpability of corporate individuals.[782]

Although the Government has repeatedly stated that there are legal mechanisms still available to convict culpable corporate executives, directors and senior managers (i.e. gross negligence manslaughter and/or health and safety offences), there still exists a "vast gulf" between those who can be charged with gross negligence manslaughter (given the evidentiary issues, as discussed above) and those who have been complicit in their company's manslaughter offence.[783] Gobert aptly terms this legal quandary a "no-man's land", whereby such corporate individuals will escape all criminal liability under the "configuration" of the 2007 Act."[784]

Permitting the prosecution of culpable corporate individuals via corporate manslaughter legislation would allow for the placing of blame where it properly belongs, and prevent

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[780] Section 18: (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.
[781] C Wells, 'Corporate manslaughter: why does reform matter?' (2006) 123 South African Law Journal 648 at p. 664.
[782] See ibid and J Gobert, 'The Corporate Manslaughter and Corporate Homicide Act 2007: Thirteen years in the making but was it worth the wait?' (2008) 71 The Modern Law Review 413 at p. 422.
[783] Gobert, 'The Corporate Manslaughter and Corporate Homicide Act 2007: Thirteen years in the making but was it worth the wait?' at p. 423.
[784] ibid at p. 423.

such individuals from hiding behind the "cloak of organisational liability."[785] As such, the Government's failure to include individual liability for corporate manslaughter has resulted in an Act that makes a symbolic statement about corporate responsibility,[786] but which has no 'bite' in practice, and which continues to prove ineffective at instilling a safety culture.

6.5 THE THESIS HYPOTHESIS

If secondary individual liability for corporate manslaughter were to be included as part of any reform package of the 2007 Act, then it would have an advantageous five-stage 'domino effect' for the UK maritime community: i) alongside the ship company, the corporate individuals, whose intentional or negligent actions or omissions resulted in a death on board one of the company's ships, would rightly be found liable and punished; ii) this would in turn act as a significant (if not *the* most significant) deterrent to such corporate individuals, resulting in them being more proactive in operating and maintaining safer ships; iii) this would result in the improvement of ISM Code implementation; iv) a culture of complacency with safety would be replaced with an enhanced safety culture; and v) thus a consequent reduction in the number of on-board accidents and fatalities would follow, in line with Safety Culture Theory.

This thesis hypothesises that reformed and improved corporate manslaughter legislation, which included both corporate and individual liability, could be used as an effective tool to improve maritime safety and reduce maritime fatalities, by reducing complacency and compelling both shore-based and ship-based management to implement the ISM Code fully, and thus maintain the 'safety culture' that the drafters of the Code envisaged. It is therefore prudent to consider here: how the author's Proposed and Improved Corporate Manslaughter and Corporate Homicide Act[787] would manifest so as to be more effective at convicting larger companies *and* culpable corporate individuals; how the ISM Code could be used as a means of establishing or negating liability under the Proposed Act; which category of corporate individuals would be liable under the Proposed Act; and how this would in turn ensure that a safety culture is better implemented by the UK maritime industry. To support and strengthen the overall

[785] ibid at p. 426.
[786] Ormerod and Taylor, 'The Corporate Manslaughter and Corporate Homicide Act 2007' at p. 589.
[787] Herein referred to as the 'Proposed Act'.

hypothesis, the facts of the *Herald of Free Enterprise* disaster are examined in a hypothetical scenario, as if both the Proposed Act and the ISM Code were in force at the time, in the following chapter.

A copy of the Proposed Act's key provisions, and a table comparing the provisions of the Proposed Act with those of the 2007 Act, are included in the appendices to this thesis.[788]

6.5.1 APPLICATION OF THE PROPOSED ACT TO SHIP COMPANIES AND THEIR SHIPS UNDER SECTION 30

> **Section 30 Extent and Territorial Application**
> (3) Section 1 applies if the harm resulting in death is sustained in the United Kingdom or—
> (a) within the seaward limits of the territorial sea adjacent to the United Kingdom;
> (b) on a ship registered under Part 2 of the Merchant Shipping Act 1995 (c. 21);

Whilst the Proposed Act would apply to all companies registered in and/or operating within the UK, regardless of which industry they were a member of, it is the application of Section 30(3)(a)-(b), which would trigger liability for deaths at sea. Furthermore, Section 30(3)(b) would allow for jurisdiction should the death occur on board a foreign ship within UK territorial waters. Therefore, in a maritime context, the Proposed Act would apply to UK-registered ship companies, UK-registered ships, and all ships (regardless of their flag) that are within UK territorial waters,[789] as well as those corporate individuals who are considered to be a part of the 'senior management' of these companies, and who were responsible for the company's actions that led to the death at sea.

6.5.2 THE PROSECUTION OF THE SHIP COMPANY UNDER SECTION 1

> **Section 1 The Offence: Corporations**
> (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.

[788] Appendices 12 and 13.
[789] This is the same under the 2007 Act, by virtue of its Section 28.

(2) The organisations 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).
(4) For the purposes of this Act—
  (a) "relevant duty of care" has the meaning given by section 4, read with sections 7 to 9;
  (b) a breach of a duty of care by an organisation is a "gross" breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances;
  (c) "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.

The method of prosecuting corporations under the Proposed Act would remain the same as it currently stands under the 2007 Act. Once the requirements of Section 30 were satisfied, the prosecution would then need to prove that the company's 'corporate individuals' managed or organised the company's activities in such a way that it caused the person's death, and that this amounted to a gross breach of a relevant duty of care. For ship companies, the relevant duties of care would be as that of 'employer' to a member of the ship's crew under Section 4(1)(a), and/or as a 'provider of a service' to a passenger on board one of its ships under Section 4(1)(c)(i). Establishing a relevant duty of care in these circumstances would not prove difficult for the prosecution.

6.5.3 CORPORATE INDIVIDUALS UNDER SECTION 1(4)(C)

The Government's decision to abandon the identification doctrine and replace it with, what Ormerod and Taylor term, a "qualified aggregation principle"[790] has been mostly welcomed. There has, however, been some concern raised over the Government's decision to insist on the aggregation of the company's failings being attributable to 'senior management' in the final Act, as opposed to simply 'management', as initially recommended by the Law Commission.[791] This is due to the fear that companies could

[790] Ormerod and Taylor, 'The Corporate Manslaughter and Corporate Homicide Act 2007' at p. 592.
[791] Report 237: Legislating the Criminal Code: Involuntary Manslaughter at para 8.39, per

escape liability by successfully arguing that the individual whose actions resulted in the death was not *senior* (emphasis added) management, but merely lower-level management.[792] However, it could be argued that with regards to ship companies, these concerns are somewhat moot due to the ISM Code (via the 2014 ISM Regulations) lending the prosecution guidance as to which individuals within the company fall under the category of 'senior management'. It could also be argued that the term 'senior management' is a broad one, and would include the usual directors, executives, managers (with responsibility typically given to those in senior positions, regardless of their job description/title) and, it would seem, for the purposes of ship companies, DPAs and masters too. Within the UK, the law considers both DPAs and masters sufficient enough to amount to 'senior management' for the purposes of the 2014 ISM Regulations; specifically identifying these individuals alongside the company as having a prescribed role and specific legal duties with regards to safety.[793]

However, to avoid a situation where defendant companies could escape liability on a technicality, owing to the ambiguous term 'senior management' being used without the Act stating who within the company would actually constitute 'senior', the Proposed Act uses the term 'corporate individuals'. This is a broader, more-encompassing term, which would allow the court a wider discretion to accept that an individual played a significant role in the management of the company's activities, in accordance with Section 1(3).

THE MASTER

Although Douglas believes that it would be the DPA and his management activities that would be examined first by any investigation or prosecution, following a death occurring on board one of the company's ships,[794] common practice *and* common sense would seem to indicate that the master would be the starting point for any investigation. The master is responsible for implementing the company's approved SMS and safety policy on board,[795] as well as having the overriding authority and responsibility to make

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Recommendation 12.

[792] Discussed in the previous chapter.

[793] The 2014 ISM Regulations are discussed in detail in Chapter 2 of this thesis.

[794] TJ Douglas, 'Master or Servant: A Corporation's Liability for the Activities of a Ship's Master' (2008) 72 Journal of Criminal Law 497 at p. 508.

[795] Regulation 7 of the 2014 ISM Regulations holds that the master of each ship must operate his ship in accordance with the company's SMS. If he fails to do this, he is liable under Regulation 15 for up to two years in prison if convicted.

decisions pertaining to the safety of the ship and crew.[796] It is therefore appropriate to consider the master a member of senior management for the purposes of both the 2007 Act and the Proposed Act, and thus sufficient to trigger the company's liability (if his actions fell far below what was reasonably expected in the circumstances).

Although it is prudent to start any investigation/inquiry with the master (as the 'front-line manager' responsible for safety), it is important that it is not directed solely at him; others within the company may bear the overall responsibility. An example of this would be if the DPA was aware of, or should have been aware of, the risk posed by the master's actions, but failed to act. It is suggested, therefore, that the DPA's actions should be examined closely alongside those of the master.

THE DESIGNATED PERSON ASHORE

If the master is found to be blameless, or if he acted recklessly and was in breach of both the company's SMS and the ISM Code in general, it is important to investigate the management activities of the DPA in order to ascertain whether he was aware of, or ought to have been aware of, the risk posed by the situation on board. It is therefore suggested that the DPA is the second person within the company whose actions should be examined.

In 2006, Anderson wrote of his experience with DPAs and raised concerns over the great diversity in what he witnessed as the roles that the DPAs played within the company, with regards to who was appointed to act as DPA and the status they held within the company. At the lower extreme, Anderson observed that some DPAs were not actually part of the company's management, but were merely subcontracted and external to the day-to-day operations of the company. Whilst it could be argued that such external, sub-contracted DPAs, and/or management companies, fall outside of the ambit of the ship company's senior management, and therefore prove problematic when attempting to hold them liable under the Corporate Manslaughter and Corporate Homicide Act 2007, as well as the Proposed Act, guidance comes from the case of *The Charlotte*.[797]

[796] By virtue of Paragraph 5 of the ISM Code.
[797] [1921] 9 Lloyd's Rep 341, as discussed in the previous chapter.

In *The Charlotte*, the court looked beyond the ship-owning company; looking instead at the external sub-contracted management company, in order to determine who was to blame for the ship being operated in an unsafe manner. As it was the latter who actually managed the ship on a day-to-day basis, it was they who were held liable. Therefore, for the purposes of both the 2007 Act, as well as the Proposed Act, external, sub-contracted DPAs, and/or management companies, would fall under the scope of 'senior management', by applying the reasoning in the case of *The Charlotte*.

At the upper extreme of Anderson's observations, and arguably the most welcome for the maintenance of a safety culture, is the following:

> "The DPA sits at the right hand of the Shipowner – holding a very senior position in the Company, with many years sea service as well as shore management experience, and the Shipowner consults the DPA before making any major decision."[798]

Furthermore, Anderson makes the observation that, in his experience, the DPA is often "ineffective and not really knowing or understanding their role or what is expected of them," and believed familiarisation was the main hindrance to the DPA being effective at performing their job; suggesting that this could be due to the role of the DPA being "so poorly defined" by the ISM Code.[799] However, since the time of Anderson making these comments, the international maritime community's understanding as to what is expected of the DPA has greatly improved. It is therefore suggested, or at least hoped, that the DPA holds the role and position of that which is quoted above. In any event, the DPA *should* (emphasis added) have access to the highest levels of management so that he can advise them of matters relating to safety, and so he can therefore fulfil his primary responsibility of acting as the personal link between the company and those on board the company's ships, in accordance with Paragraph 4 of the ISM Code (and Regulation 8 of the 2014 ISM Regulations).

It is theorised that the issue before the court in any corporate manslaughter trial, would be whether those at the highest levels of management were made aware of the risk that

[798] P Anderson, 'The ISM Designated Person: Keystone or Scapegoat?' *Maritime Risk International* (1 December 2006) at p. 1.
[799] ibid at p. 4.

ultimately led to the death in question. It will therefore be for the prosecution to prove one of the following scenarios:

1. the DPA was aware of, or ought to have been aware of, the risk but he failed to notify more senior management, or take any action himself to reduce the risk and thus prevent the death from occurring;
2. the DPA was aware of the risk and he took action to reduce it, but this was insufficient to prevent the death from occurring;
3. the DPA was aware of the risk and he notified more senior management, but they failed to take any action to reduce the risk and thus prevent the death;
4. the DPA was aware of the risk and he notified more senior management, and they took action to reduce it, but this was insufficient to prevent the death from occurring.

For the purposes of convicting a company under Section 1 of the 2007 Act, it makes little difference which of these scenarios is established; either is sufficient to trigger the company's liability for corporate manslaughter, if it amounted to a gross breach of a relevant duty of care. However, under the Proposed Act, it would be significant, owing to the individual(s) concerned being exposed to secondary liability under Section 2 upon the successful conviction of the company. Due to this exposure, the Proposed Act specifically includes a due diligence defence as a means of ensuring that individuals are not unduly convicted (discussed below).

6.5.4 USING THE ISM CODE TO DISPROVE A SAFETY CULTURE UNDER SECTION 10

Section 10 Factors for the Jury

(2) The jury must consider whether the evidence shows that the organisation failed to comply with any health and safety legislation that related to the alleged breach, and if so—
  (a) how serious that failure was;
  (b) how much of a risk of death it posed.

(3) The jury should also—
  (a) consider the extent to which the evidence shows that there were attitudes, policies, systems or accepted practices within the organisation that were likely to have encouraged any such failure as is mentioned in subsection (2), or to have produced tolerance of it;
  (b) have regard to any health and safety guidance that relates to the alleged breach.

(4) This section does not prevent the jury from having regard to any other matters they consider relevant.

(5) In this section "health and safety guidance" means any code, guidance, manual or similar publication that is concerned with health and safety matters and is made or issued (under a statutory provision or otherwise) by an authority responsible for the enforcement of any health and safety

legislation.

Once it was proven that the actions of one or more members of senior management caused the death, it would be for the prosecution to then prove that these actions amounted to a gross breach of a relevant duty of care. The mechanism for doing this would be through Section 10, which refers to health and safety legislation and the organisation's culture. This is similar to Section 8 of the 2007 Act.

Section 10(2) states that a jury *must* (emphasis added) consider whether evidence shows that the company failed to comply with any relevant health and safety legislation, and if so, how serious that failure was and how much of a risk of death it posed, having regard to 'health and safety guidance'. In a maritime context, by virtue of Section 10(5), relevant health and safety legislation would primarily be the ISM Code (and the 2014 ISM Regulations) and, to a lesser extent, the Health and Safety at Work etc Act 1974. Health and safety guidance would include, *inter alia*, non-binding notices, instructions and bulletins from the IMO, the MCA and Classification Societies.

Section 8(3) of the 2007 Act offers the jury further guidance by stating that they *may* (emphasis added) also consider the extent to which evidence shows that there were attitudes, policies, systems or accepted practices within the company that were likely to have encouraged such a breach of the duty of care, or to have produced tolerance of it (i.e. the company's ethos/safety culture). For any prosecution of a ship company for corporate manslaughter under the 2007 Act, consideration of the ISM Code under Section 8(2) should automatically lead to consideration of the company's safety culture due to the ISM Code's primary aim and purpose being to create and maintain an enhanced safety culture within the international maritime community. However, for the avoidance of doubt, the Proposed Act's equivalent Section 10(3) provides that the jury *should* (emphasis added) consider the company's safety culture regardless as to whether any legislation makes specific reference to it or not, as in the case of the ISM Code. Thus, if a ship company were to be prosecuted for corporate manslaughter under the Proposed Act, its safety culture would most certainly be considered by the jury in its determination of whether there was a gross breach of duty.

Useful to this point, are Gobert's five questions, which he argues must be considered by the jury when assessing a company's safety culture, although he warns that they may be

difficult for a jury to answer.[800] However, with regards to determining whether a ship company had, at the time the death occurred, implemented an effective safety culture, these questions should be asked and they should be relatively easy for the jury to answer, when the ISM Code is used as the means of answering them. The questions listed by Gobert are as follows:

1. Where lies an organisation's values and priorities?
2. What message does it convey to its workforce about the need to comply with the law?
3. Does it indicate that it takes compliance seriously, or does it give the impression that lip service is grudgingly being paid to 'legal technicalities'?
4. Are employees encouraged to report violations, and, if they do, are they rewarded, humoured, or indirectly punished (e.g. by subsequently being passed over for promotion)?
5. Are reported violations rectified or ignored?[801]

Whilst some such as Anderson vigorously argue that the ISM Code was never intended to create new 'inter-party liabilities' or to make individuals such as the DPA the scapegoat when things go wrong,[802] it is difficult to imagine such a legal instrument not being used by lawyers and the courts to measure standards and to determine liability. With regards to a death at sea amounting to corporate manslaughter under the Proposed Act, as well as under the 2007 Act, the ISM Code would most certainly be used in this way, and rightfully so. Therefore, in determining whether a ship company had, at the time of the death, implemented an effective safety culture, the jury should have regard to the following when answering questions such those recommended by Gobert: i) the company's SMS and safety-related policies; ii) work materials and documents pertaining to safety; and iii) any investigation/inquiry undertaken by relevant authorities following the death or disaster.

THE COMPANY'S SMS AND SAFETY-RELATED POLICIES

The company's SMS is the obvious starting point for the jury for the purpose of Section 10. As discussed in Chapter 2 of this thesis, in accordance with Paragraph 1.4 of the

[800] Gobert specifically refers to the safety dimension of a company's ethos and culture.
[801] Gobert, 'The Corporate Manslaughter and Corporate Homicide Act 2007: Thirteen years in the making but was it worth the wait?' at p. 425.
[802] Anderso, 'The ISM Designated Person: Keystone or Scapegoat?' at p. 2.

ISM Code, an effective (and approved) SMS must contain, as a minimum, the following:

> **Paragraph 1.4 Functional requirements for a safety management system**
> **.1** a safety and environmental-protection policy;
> **.2** instructions and procedures to ensure safe operation of ships and protection of the environment in compliance with relevant international and flag State legislation;
> **.3** defined levels of authority and lines of communication between, and amongst, shore and shipboard personnel;
> **.4** procedures for reporting accidents and non-conformities with the provisions of this Code;
> **.5** procedures to prepare for and respond to emergency situations; and
> **.6** procedures for internal audits and management reviews.

The jury would not have to examine fully the complex and lengthy SMS; a review of the records pertaining to the audit and certification of the SMS by the MCA[803] should be sufficient to satisfy Section 10. Such records should indicate the level of awareness and understanding of the company's SMS and safety-related policies, by both shore-based and ship-based employees, which will, in turn, be sufficient to answer questions such as those suggested by Gobert.

Records of the master's audits of the various departments on board, as well as records/minutes of the on-board safety committees that took place, will also go some way to 'painting a clearer picture' for the jury, as to the company's safety culture. Further pertinent information falling under this heading would include the relevant ship's 'Ship Risk Profile', as calculated by the Paris MOU, including each specific component used to perform the calculation.[804]

WORK MATERIALS AND DOCUMENTS RELATING TO SAFETY

Extrinsic to the SMS and SMS-related audits, presentation of the company's work materials and documents relating to safety may also prove beneficial to the jury. These will primarily be produced by, or at least involve, the DPA. Relevant materials may include such items as: organisational charts, which outline authority and safety-related responsibilities; crew training programmes with clear procedures and requirements for

[803] As the UK's Flag State Administration. For foreign ships falling under the UK's courts' jurisdiction by virtue of Section 30(3) of the Proposed Act, this would be the SMS certified by the relevant Flag State Administration or recognised organisaiton.
[804] Discussed in Chapter 2 of this thesis.

advancement/promotion; safety awareness events, such as the screening of films, safety debates and lectures etc. Relevant documents may include: *ad hoc* reports between the DPA and senior management; emails and memos; minutes of meetings where safety was discussed; and records of the DPA's visits to the company's ships.

INVESTIGATIONS FOLLOWING THE DEATH

Any subsequent investigation/inquiry into the cause of death and, where applicable, any investigations into the maritime disaster that led to the death, will also be useful to the jury. Any investigation undertaken by the MAIB, for example, would present the jury with the established causal factors as to the course of events leading up to the disaster and consequent death(s). Furthermore, the findings of such an investigation would most likely be the basis for the prosecution bringing the case against the company for the offence of corporate manslaughter under the Proposed Act, in the same way that the findings of the Sheen Inquiry were the basis for the initial prosecution of P&O for the *Herald of Free Enterprise* disaster.

6.5.5 THE DUE DILIGENCE DEFENCE UNDER SECTION 11

> **Section 11 Defence:** It shall be a defence for an organisation charged with an offence under this Act to show that its senior management took all reasonable precautions and exercised all due diligence to avoid the commission of the offence.

Due to the Proposed Act containing secondary liability for those corporate individuals, identified by Section 1(3) during the course of the prosecution of the company, with the possibility of a lengthy custodial sentence being imposed,[805] it is important that there is a clearly defined defence available for the offence, rather than the mere suggestion of one like in Section 8 of the 2007 Act.[806] This defence is contained in Section 11 of the Proposed Act, and is based on the due diligence defence similar to that which is found in Regulation 16 of the 2014 ISM Regulations, and also that recommended by Public Concern at Work, as discussed above.

[805] Discussed below.
[806] In its requirement that the breach of duty be 'gross'.

Therefore, once the prosecution has proven that the ship company's senior management caused the person's death,[807] and that this amounted to a gross breach of a relevant duty of care,[808] then to avoid conviction the company must prove, in accordance with Section 11, that its senior management exercised reasonable precautions and exercised all due diligence to ensure that they were informed about any serious risk to health and safety within the company and, if so informed, that had acted reasonably in response to that information to minimise the risk.[809] Once again, in a maritime context, the ISM Code, as well as best common practice, would be used by the company as a means of proving that its senior management had "kept up to the mark"[810] and acted with due diligence. This will be the company's, and the identified corporate individuals, last chance of avoiding conviction.

6.5.6 PROSECUTING THE SHIP COMPANY'S CORPORATE INDIVIDUALS UNDER SECTION 2

> **Section 2 The Offence (Corporate Individuals):** Where an offence of corporate manslaughter is proved to have been committed with the consent or connivance of, or to have been attributable to any neglect on the part of, any member of senior management referred to in section 1(4)(c), or a person who was purporting to act in such a capacity, he as well as the organisation shall be guilty of the offence of corporate manslaughter.

It is significant that Section 2 of the Proposed Act would repeal Section 18 of the 2007 Act, which states that there can be no individual liability for corporate manslaughter. Section 2 is a provision based on the one proposed by the Corporate Manslaughter Bill Sub-Committee, as recommended to it by the London Criminal Courts Solicitors' Association.[811]

It is clear from the research undertaken as part of this thesis, that there needs to be individual liability for corporate manslaughter. After examination and consideration of the research (namely, the arguments and statements made in the aftermath of the failed corporate manslaughter prosecution of P&O for its role in the *Herald of Free Enterprise* disaster, and those made during the development and consultation process of the Corporate Manslaughter and Corporate Homicide Act 2007), it is suggested that the best

[807] Under Section 1(a).
[808] Under Section 1(b).
[809] Reforming the Law on Involuntary Manslaughter: the Government's Proposals at section 1.3.
[810] Report 237: Legislating the Criminal Code: Involuntary Manslaughter at para 7.21.
[811] Discussed above.

means of introducing this individual liability would be through secondary individual liability, not primary liability.

The reasons for this are as follows: i) the nature of corporate manslaughter legislation is, like the Government has argued previously, to focus on corporations. However, there is no reason why corporations cannot be the primary focus and individuals the secondary focus; ii) it would ensure that both the culpable company *and* the corporate individual(s) were appropriately held accountable, with neither escaping liability (as would appear to be the case with Costa Crociere); iii) combining the primary liability of the company with the secondary liability of the corporate individual(s) would result in strong corporate manslaughter legislation with 'bite', which would prove effective at implementing a safety culture.

This method of combining the company's and the corporate individuals' liabilities would also accord with the essence of organisational cultural theory (the parent/supra-theory of Safety Culture Theory),[812] in that it recognises that whilst a corporation is a separate legal entity, it has no physical existence and can therefore only act through its senior management.[813] It would also satisfy the concerns of those such as Public Concern at Work and the Corporate Manslaughter Sub-Committee, as discussed above.

6.5.7 SENTENCING THE SHIP COMPANY UNDER SECTION 3

Section 3 Sentencing

(1) The offence under sections 1 and 2 is called—
  (a) corporate manslaughter, in so far as it is an offence under the law of England Wales or Northern Ireland;
  (b) corporate homicide, in so far as it is an offence under the law of Scotland.
(2) An organisation that is guilty of corporate manslaughter or corporate homicide under section 1 is liable on conviction on indictment to a fine.
(3) An individual that is guilty of corporate manslaughter or corporate homicide under section 2 is liable on conviction on indictment to imprisonment for life or any shorter term.
(4) The offence of corporate homicide is indictable only in the High Court of Justiciary.

[812] Discussed in Chapter 1 of this thesis.
[813] See Report 237: Legislating the Criminal Code: Involuntary Manslaughter at para 6.1.

The options available to the courts for sentencing companies under the Proposed Act would remain the same as under the 2007 Act. In this respect, the Sentencing Council guidelines on sentencing organisations for corporate manslaughter[814] is the most authoritative and definitive guidance available to the courts, and therefore highly relevant for this chapter. The latest version of these guidelines was published on 3 November 2015, and entered into force on 1 February 2016. They advise that when sentencing a company for corporate manslaughter, the courts should take the following steps:

1. Determine the seriousness of the offence
2. Categorise the organisation in terms of size and finances
3. Assess the fine's impact and adjust accordingly
4. Consider Remedial and Publicity Orders
5. Justify the amount of fine imposed

These are discussed in turn below, with regards to the table recommended by the Sentencing Council, for courts to use when determining an appropriate sentence.

Large organisations Turnover more than £50 million		
Offence category	**Starting point**	**Category range**
A	£7,500,000	£4,800,000 - £20,000,000
B	£5,000,000	£3,000,000 - £12,500,000
Medium organisations Turnover £10 million to £50 million		
Offence category	**Starting point**	**Category range**
A	£3,000,000	£1,800,000 - £7,500,000
B	£2,000,000	£1,200,000 - £5,000,000
Small organisations Turnover £2 million to £10 million		
Offence category	**Starting point**	**Category range**
A	£800,000	£540,000 - £2,800,000
B	£540,000	£350,000 - £2,000,000
Micro organisations Turnover up to £2 million		
Offence category	**Starting point**	**Category range**
A	£450,000	£270,000 - £800,000
B	£300,000	£180,000 - £540,000

Table 6.3: Sentencing Council's Starting Point & Category Range Table for Corporate Manslaughter

[814] Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences: Definitive Guideline (Sentencing Council 2015).

1. DETERMINE THE SERIOUSNESS OF THE OFFENCE

In considering factors likely to affect the seriousness of the offence, the court would listen to arguments, similar to those made in determining if the breach was gross, as to how foreseeable the death was and how far short of the appropriate standard the defendant fell. Best common practice, as well as testimony from expert witnesses, would be used to determine this. Documentary evidence already submitted to the court, such as audit and inspection reports, would go some way towards determining how common this kind of breach was in the company (i.e. how widespread the non-compliance with the SMS/ISM Code was, and whether it was an isolated breach, or indicative of a systematic departure from safety standards).[815]

Where the court is of the opinion that the responses to the above questions indicate a high level of seriousness, then the offence will be categorised as 'Offence Category A'; similarly, where responses indicate a lower level of seriousness, the offence will be categorised as 'Offence Category B'.

2. CATEGORISE THE ORGANISATION IN TERMS OF SIZE AND FINANCES

At this stage, the court is required to focus on the company's annual turnover in order to reach a starting point for the fine. Whilst it is accepted that there should not be a fixed correlation between a company's turnover and the fine imposed, the court must have regards to the funds and assets available to the company in order to strike a balance between imposing a fine that inflicts a harsh punishment, and imposing a one that is affordable for the company to pay. That is not to say that the fine needs to be paid within the usual 28 days; if the court deems it appropriate, it may grant permission for the fine to be paid over a number of years. With regards to ship companies, such fines should be capable of being paid relatively soon due to the financial circumstances of such companies.

AGGREVATING FACTORS AFFECTING SERIOUSNESS

In weighing up factors affecting the level of sentence to be given, those which would aggregate the offence, and thus lengthen the sentence, if present, would include: whether there was more than one death (or if there were grave personal injuries in

[815] ibid at p. 22.

addition to the death, which would likely be the case with maritime disasters); any previous convictions relating to corporate manslaughter and health and safety; whether the company failed to act on warnings or advice given by inspectors/auditors, or failed to respond to near-miss reports submitted in accordance with the company's SMS and Paragraph 9 of the ISM Code; whether there was any deliberate attempt to conceal the breach in safety; and evidence that the breach in safety was as a result of a cost-cutting exercise, which would have been revealed by the prosecution during the trial when proving that the breach was 'gross'.[816]

MITIGATING FACTORS AFFECTING SERIOUSNESS

On the other side of the scales, factors which would mitigate the offence, and thus serve to reduce the sentence, would include: evidence of the company promptly accepting responsibility for the death(s) and co-operating fully with subsequent investigations/inquiries; evidence of the company's genuine efforts to remedy the problem that led to the breach in safety and consequent death(s); a general good safety record, including records of ISM inspections/audits and the relevant 'Ship Risk Profile'; and evidence of a general responsible attitude to safety (i.e. an effective safety culture), especially evidence of a noticeable improvement following the death(s). Once the court has ascribed a 'level of seriousness' for the offence, it is then for it to decide on the level of fine to impose.

Although there is no upper limit to the size of the fine the courts can impose under corporate manslaughter legislation, and the Sentencing Council recommend that if a convicted company's annual turnover "greatly exceeds" the threshold for large companies, it may be appropriate to go "outside the suggested range" in order to achieve a "proportionate sentence",[817] it is theorised that the courts would stick to the range/tariff closely, and if a ship company were to ever be convicted under the Proposed Act, a fine in the millions would most certainly be imposed.

[816] ibid at p. 4.
[817] ibid at p. 24.

3. ASSESS THE FINE'S IMPACT AND ADJUST ACCORDINGLY

Aptly, the Sentencing Council points out that "fines cannot and do not attempt to value a human life in money",[818] but they are intended to punish the company, remove the profit made from the commission of the offence, and reduce offending (and re-offending) through effective deterrence. The fine must therefore be sufficiently substantial to have a real economic impact and, as such, it must be tailored to the company and its financial circumstances.

Whilst it is important, for the reasons outlined above, that companies are punished harshly for corporate manslaughter offences, it is also important to remember that although a company is a legal entity, it is made up of its employees and controlled by its senior management. Therefore, when determining an appropriate fine to be imposed, the court should consider: the impact that the fine may have on the employment of staff; the effect on the provision of any services to the public (e.g. if the company operated ferries, then a large fine may mean a reduction in the number of journeys or routes); whether the fine will impact on the company's ability to improve safety and bring it in compliance with the law (e.g. to improve crew training); and whether the fine will have the effect of bankrupting the company. However, in certain cases, putting the company out of business may be the acceptable course of action, though it would be hoped that this could be avoided.[819]

The court should also take into account any assistance that the company and/or its senior management gave to the prosecution or any investigation/inquiry,[820] any prompt acceptance of responsibility and an early guilty plea,[821] and make any reduction in the fine as the court deems appropriate.

4. CONSIDER REMEDIAL AND PUBLICITY ORDERS

In addition to a fine, the court may make a Publicity Order and/or a Remedial Order against the company.

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[818] ibid at p. 25.
[819] ibid at p. 26.
[820] Under Sections 73 and 74 of the Serious Organised Crime and Police Act 2005.
[821] Under Section 144 of the Criminal Justice Act 2003.

At the time of sentencing, if the company had not remedied the breach, or made steps towards remedying it, then not only would this reduce the mitigating factors available to the company, and so adversely affect the amount of the fine, but the court should also issue a Remedial Order (under Section 12 of the Proposed Act), which would specify steps that the company need take in order to remedy the breach.[822] For a ship company, this may be an order to implement specific crew training or to make specific amendments to its SMS.

The Sentencing Council advise that in a case of corporate manslaughter, a Publicity Order should ordinarily be made. This would be by virtue of Section 13 of the Proposed Act. Ordinarily the court would order the company to publicise: the fact that the company was convicted; the particulars of the offence, including any corporate individual identified as being culpable (although this is not necessarily required under the 2007 Act, it would most certainly be the case under the Proposed Act, due to the latter's secondary focus on individual liability); the amount of the fine imposed (which the public will see as a measure of guilt); and the terms of any Remedial Order imposed. A Publicity Order will serve as more of a punishment that a fine, as well as more of a deterrent to offending (and re-offending), due to the impact on the company's reputation and public image.

5. JUSTIFY THE AMOUNT OF FINE IMPOSED

By virtue of Section 174 of the Criminal Justice Act 2003, the court is under a legal duty to justify the sentence that it imposes. It must, therefore, give reasons for, and explain the effect of, the fine and any orders that it imposes, including the consequences for not paying the fine or complying with the orders.[823]

6.5.8 SENTENCING THE SHIP COMPANY'S CORPORATE INDIVIDUALS UNDER SECTION 3

Individual liability for corporate manslaughter is key to the thesis hypothesis, and consideration has been given above as to which form this liability should take (primary or secondary) and how this should be incorporated into a reformed Corporate Manslaughter Act (the Proposed Act). It is also important to consider, in support of the

[822] See Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences: Definitive Guideline at p. 28.
[823] Ignoring/refusing to comply with any Order would amount to contempt of court; a criminal offence in itself.

thesis hypothesis, how those individuals convicted under the Proposed Act would be sentenced. For reasons outlined throughout this thesis, the committing of corporate manslaughter (under Section 2 of the Proposed Act) would warrant a custodial sentence. As there are no sentencing guidelines for individuals committing corporate manslaughter, consideration must be had to the sentencing guidelines for both health and safety offences[824] and manslaughter offences;[825] due to the level of culpability of corporate manslaughter being perceived to be somewhere between the two of these.

The sentencing guidelines pertaining to health and safety offences list four categories of defendant: those with a very high level of culpability; those with a high level of culpability; those with a medium level of culpability; and those with a low level of culpability. The sentences available to the courts for these offences is best depicted by the table produced by the Sentencing Council:

Culpability Level	Starting point	Category range
Very High Intentionally committing the offence	18 months	1 – 2 years
High Actual foresight or wilful blindness	1 year	6 months – 18 months
Medium High level of negligence	6 months	Large fine – 1 year
Low Little fault e.g. attempting to remedy breach	Small fine	Low fine – 6 months

Table 6.4: Sentencing Council's Starting Point & Category Range Table for Health & Safety Offences

For reasons discussed above, the custodial sentences for health and safety offences would be far from sufficient to deal with individuals convicted under the Proposed Act. Therefore, consideration of the sentencing guidelines for manslaughter is necessary. Upon initial examination, it would certainly appear that these guidelines are more appropriate in terms of the levels of punishment that would be imposed.

Where the guidelines for health and safety offences list four categories of defendant, the manslaughter guidelines list two; distinguishing between those who commit voluntary manslaughter and those who commit involuntary manslaughter. The maximum

[824] Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences: Definitive Guideline at pp. 3-20.
[825] *Sentencing for Manslaughter* (Sentencing Council 2016).

sentence that a court can impose for manslaughter is life imprisonment, which is reserved for those defendants that the court deems the most "dangerous."[826]

The sentencing levels/terms for manslaughter would be more appropriate for Section 2 corporate manslaughter offences. Furthermore, in keeping with previous guidelines, these guidelines would advise the court to do the following when sentencing individuals under the Proposed Act:

1. Determine the individual's level of involvement/culpability
2. Consider mitigating and aggravating circumstances
3. Justify sentence

It is suggested that any guidelines produced for Section 2 corporate manslaughter offences should advise the court to categorise the defendant's culpability into one of three levels (high, medium or low). In determining the individual's level of culpability, the court should have regard to arguments presented to it during the trial, as to how involved the defendant was in the decision/actions that led to the breach in safety and resulting death(s), as well as the same factors as those discussed above relating to mitigating and aggravating factors. The court should use the following table when deciding on which sentence to impose. The table is based on that which is provided by the Sentencing Council for health and safety offences, developed in a Section 2 context, and using figures proposed in support of the thesis hypothesis. The proposed sentencing levels are designed to impose a harsh but appropriate punishment for the offence, and act as an effective deterrent for offending (and re-offending).

Culpability Level	Starting point	Category range
High Intentionally committing or allowing the breach in safety	14 years	10 years - life
Medium Actual foresight or wilful blindness as to the risks	7 years	4 – 10 years
Low Negligently unaware of the risks.	2 years	1 – 4 years

Table 6.5: The Author' Proposed Table to Use When Sentencing Individuals for Section 2 Offences

When sentencing those corporate individuals deemed to have had a low level of culpability for the offence, the court would have the option to suspend the sentence, if it

[826] ibid at p. 1.

was appropriate in the circumstances. This would primarily be the case with sentences imposed for two years or less, in accordance with common judicial practice.

6.6 CONCLUDING REMARKS

The trials surrounding the two maritime disasters, that are analysed in Chapter 4 of this thesis, have been discussed and critiqued in this chapter. In the South Korean case, the ship company, its senior corporate individuals, and the master and crew were found liable and punished harshly, but appropriately, for their respective roles in the disaster and the subsequent loss of life. Although the ISM Code was not applicable in this case due to the ship being engaged in a domestic voyage, lessons can be learned from the way in which both the ship company and the individuals were punished for their respective roles.

In the Italian case, where the ISM Code was applicable, the courts chose not to use the Code to determine liability and culpability. Instead, the ship company was allowed to make a plea bargain with the prosecution whereby the company escaped all liability, and the ship's master was then made fully liable. As a result of this, and because of the absence of any individual liability for corporate manslaughter in Italy, the master was given a lengthy custodial sentence for manslaughter; a sentence that is too harsh and inappropriate for his role in the disaster.

The ISM Code has been incorporated into the UK's domestic law adequately, but the methods of enforcing compliance with the Code fall short.[827] So too does the law's ability to hold both the company and the individual accountable for corporate manslaughter, especially when it comes to large companies such as the ship companies operating within the UK maritime industry. In attempting to circumvent this shortfall in corporate manslaughter legislation, there is a growing trend by the courts to hold corporate individuals to account for related offences alongside the companies that they control.[828]

In acknowledging that the Corporate Manslaughter and Corporate Homicide Act 2007 falls short, the author has outlined proposals for the inclusion of secondary individual

[827] As outlined in Chapter 2 of this thesis.
[828] As discussed in the previous chapter.

liability in a ‘Proposed and Improved Corporate Manslaughter and Corporate Homicide Act’, as well as considering ‘effective, proportionate and dissuasive’ punishments for the offences committed under this Proposed Act, in support of the author’s theories and the thesis hypothesis.

CHAPTER 7
TESTING THE THESIS HYPOTHESIS

7.1 INTRODUCTION

This chapter tests the author's thesis hypothesis:

> **A 'Proposed and Improved Corporate Manslaughter and Corporate Homicide Act', which includes both primary liability for the company and secondary liability for the individual, could work alongside the ISM Code to appropriately punish companies and corporate individuals who operate unsafe ships and death occurs as a result; and this would act as a sufficient deterrent and so ensure that complacency with safety is replaced with an effective safety culture in the maritime community.**

The chapter begins by considering, in a hypothetical context: i) what the situation would have been like with P&O and the *Herald*, had the ISM Code been in force at the time the *Herald* was being operated and; ii) how any corporate manslaughter trial against P&O might have resulted, had the Proposed and Improved Corporate Manslaughter and Corporate Homicide Act been in force at the time the *Herald* was being operated, and the disaster had still not been prevented. The chapter then discusses the survey, which was undertaken to test the thesis hypothesis; first outlining the methodology for the collection of both quantitative and qualitative data through the use of questionnaires, and the process by which statistics and trends have been obtained from the data; then a detailed analysis and breakdown of the data is provided, with a discussion regarding the significance and the implications of the results. The chapter concludes with consideration of potential future research that could be undertaken in the areas covered by this thesis.

7.2 THE HYPOTHETICAL *HERALD OF FREE ENTERPRISE* SCENARIO

Not only was the ISM Code developed on the international stage as a result of the *Herald of Free Enterprise* disaster, but the Corporate Manslaughter and Corporate Homicide Act 2007 was so too developed domestically in the UK, as a result of the failed prosecution of P&O, operators of the *Herald*. A summary of the course of events

leading up to the *Herald of Free Enterprise* disaster is provided in the review of the literature in Chapter 1 of this thesis. It is pertinent here, however, to discuss the collapse of the resulting criminal trial against P&O.

7.2.1 COLLAPSE OF THE ORIGINAL TRIAL

Following the findings of the Sheen Inquiry, P&O were charged with four counts of manslaughter. The ship company submitted that the charges should have been quashed on the grounds that the common law (and past precedent) recognised that manslaughter could only be committed when one person killed another person, and there was no offence of corporate manslaughter under UK law. The prosecution, however, submitted that due to there being no statutory definition of manslaughter, there was no reason why a corporation could not be charged with manslaughter. Furthermore, the prosecution submitted that if the court was so inclined to agree with the defendant company that manslaughter could only be committed by a person, then the identification doctrine should apply, and an individual who could be said to be both the embodiment of the company and the person responsible for the death(s), should be found guilty of manslaughter.

The trial judge, Mr Justice Turner, agreed with the prosecution's second submission, and held that manslaughter was the unlawful killing of one person by another person and that in the case where an individual, who was the embodiment of the company and who acted for the purposes of the company (i.e. a corporate individual), caused the death(s), the company *as well* as the culpable corporate individual might be found guilty of manslaughter. Therefore, it was held that P&O could be indicted for manslaughter.

However, as the identification doctrine was the only means of securing a conviction, and no *one individual* could be identified as being responsible for the 192 deaths, *as well as* being the embodiment of the company, the trial collapsed. Essentially, the company and the culpable corporate individuals escaped all criminal liability and punishment, because no one corporate individual could be identified as being responsible for the safe operation of the company's ships.

7.2.2 TESTING THE THESIS HYPOTHESIS

As discussed above, the *Herald of Free Enterprise* disaster, and the subsequent failed manslaughter trial against P&O, led to the development of the ISM Code on the international stage, and the development of the Corporate Manslaughter and Corporate Homicide Act 2007 domestically in the UK. This thesis hypothesises that if the Corporate Manslaughter and Corporate Homicide Act 2007 was developed so as to include secondary individual liability, then the two legal instruments could work together to appropriately punish companies and corporate individuals for deaths at sea, and to act as a sufficient deterrent; ensuring that a culture of complacency with safety is replaced with an enhanced safety culture. At this stage in the thesis, it is appropriate to 'test' this hypothesis by considering, in a hypothetical context: what the situation would have been like with P&O and the *Herald*; and how any corporate manslaughter trial against P&O might have resulted, had the Proposed Act and the ISM Code been in force at the time, and the disaster had still not been prevented.

The immediate cause of the *Herald of Free Enterprise* disaster was the master's error in going to sea with the bow doors open. The Sheen Inquiry, however, concluded that the "underlying or cardinal faults" lay with the company's senior management.[829] The Inquiry criticised those individuals for being "infected with the disease of sloppiness"[830] i.e. *complacent* with their responsibility for the safe management and operation of the company's ships.

P&O'S SAFETY MANAGEMENT

During the Inquiry, Mr Develin, a director of the company (and therefore a senior member of management), stated that the system in place at the time of the disaster for safety-related matters was to take consensus of the senior masters.[831] However, it is quite clear from the Sheen Report that senior management saw little value in the advice and recommendations it received from these senior masters. This is evidenced by the masters meeting only intermittently to discuss safety; there once being a period of two-and-a-half years in which no meetings were held at all. Furthermore, senior management took little notice of the advice and recommendations that it received from

[829] *Report 8074: Herald of Free Enterprise* (Department of Transport 1987) at para 14.1.
[830] ibid at para 14.1.
[831] ibid at para 16.2.

the masters. This was especially so with the most significant request made, which concerned the installation of indicator lights on the bridge.[832] This 'consensus system' was clearly ineffective and, to use Reason's model of accident causation, was full of holes. It was these holes that allowed the breaches in safety that led to the disaster.

In a hypothetical scenario, if the ISM Code was in force at the time that the *Herald* was being operated by P&O, it is hoped that the disaster would have been entirely prevented due to the Code's requirements for the implementation of an effective safety management system (SMS).[833] P&O's 'consensus system' would have been far from satisfactory for ISM purposes. Where Mr Develin claimed that there was no one person responsible for safety within the company, Paragraph 4 of the ISM Code would have required P&O to appoint a DPA to be responsible for monitoring the safety of the company's ships. P&O's SMS would also have needed to outline the responsibilities of all other employees with regards to safety, regardless of whether they were shore-based or ship-based employees, and regardless of their rank/position within the company hierarchy.[834] Significant for this hypothetical scenario, would be that Paragraph 5 of the Code would have required P&O to define the master's responsibility with regards to safety, and to implement a SMS whereby it was clearly stated that the master had the overriding authority on board when it came to safety matters. Paragraph 5, it is argued, not only instils an 'authority' on the master, but also a 'duty', as the master is the front-line manager when it comes to safety.

P&O'S STANDING ORDER 01.09

The Sheen Inquiry also criticised P&O for its Standing Order 01.09, which essentially stated that, in the absence of any report to the contrary, the master should assume that the ship was safe to sail.[835] Clearly, this assumption was dangerous and proved critical for the *Herald*. Due to the ISM Code's requirement that accidents and hazardous situations be reported to the company (via the DPA),[836] any ISM audit of P&O and its ships would have revealed the standing order to be unsatisfactory; encouraging

[832] Discussed below.
[833] See Chapter 2 of this thesis as to what constitutes an *effective* SMS.
[834] By virtue of Paragraph 3.2 of the ISM Code).
[835] Standing Order 01.09 (*Ready for* Sea): Heads of Departments are to report to the Master immediately they are aware of any deficiency which is likely to cause their departments to be unready for sea in any respect at the due sailing time. In the absence of any such report the Master will assume, at the due sailing time, that the vessel is ready for sea in all respects".
[836] By virtue of Paragraph 9 of the ISM Code.

complacency with safety and allowing for ferries to be operated in an unsafe manner. It is theorised that the auditor would have uncovered the five previous occasions when, following Standing Order 01.09, allowed for the ferries to sail with their bow and/or stern doors open.[837] Ultimately, the auditor would have made an observation on the report to the effect that in order to bring the company's SMS into compliance with the ISM Code, P&O would have needed to put in place specific instructions and a 'checklist' for tasks that needed to be carried out before giving the order to set sail.

PRIOR HAZARDOUS INCIDENTS AND REQUESTS FOR CORRECTIVE ACTION

During the Inquiry, it was revealed that there were no less than five occasions when a P&O ferry set sail with its bow and/or stern doors open.[838] Although P&O was aware of some of these incidents, the company was under no specific legal obligation to take action. If the ISM Code had been in force, then *all* incidents would have (or should have) been reported to the DPA and then shore-based management, as part of the company's SMS and in accordance with Paragraph 9.1 of the Code. The DPA would then have been bound by Paragraph 9.2 to undertake an investigation into the incidents, including interviewing the relevant masters and crews in order to establish the course of events that led to the incidents so as to identify causal factors. The DPA would then have consulted with shore-based senior management in order to implement corrective action and measures so as to reduce the risk, and ultimately to prevent recurrence of the incident.[839] This corrective action may not have necessarily meant the installation of indicator lights, though it does seem the most prudent and effective course of action in the circumstances.

Regardless of actual direct knowledge of any (or all) of the incidents, there were numerous requests for indicator lights to be installed; requests made via the 'consensus system', highlighting concerns due to previous incidents. If the ISM Code had been in force, there are two approaches that could have been taken to address these requests. Firstly, the requests could have been said to constitute a notification of a hazardous situation existing on board, in accordance with Paragraph 9, and so P&O would have had to implement corrective action in order to ensure that each ship was safely

[837] Discussed below.
[838] Report 8074: Herald of Free Enterprise at para 12.5.
[839] By virtue of Paragraph 9.2 of the ISM Code.

maintained and operated. Secondly, the requests could have been seen as falling under Paragraph 10 of the Code, which would have also required P&O to implement corrective action,

Whether corrective action was to be implemented under Paragraph 9.2 or 10.2, the immediate installation of the indicator lights may not have been practicable, and therefore temporary measures may have been implemented in the interim. An example of such an interim measure would have been a standing order to replace Standing Order 01.09; requiring the master/bridge crew to actually check that the bow and stern doors were closed before giving the order to leave port.

If P&O had then failed to implement any corrective action, this would have been revealed by any subsequent ISM audit, as part of the standard verification and certification process. The auditor would have then raised this as a major non-conformity in accordance with Part B of the ISM Code; meaning that the company would need to take immediate corrective action, or face the possibility of the ship being detained.[840] This observation of the major non-conformity on the ISM report would have been the last 'barrier' to prevent the disaster.[841]

If P&O had still failed to take any action and the disaster was thus still permitted to occur, then the consequent (and mandatory) MAIB investigation into the disaster would have revealed P&O's failure to comply with the ISM Code, in very much the same way that the Sheen Inquiry identified the company's management failings. It would have then been for the Crown Prosecution Service (CPS) to prosecute P&O for corporate manslaughter under Section 1 of the Proposed Act; using P&O's failure to implement the auditor's 'instruction' in order to satisfy Section 10(2) and (3) of the Act.

APPLICATION OF THE PROPOSED ACT UNDER SECTION 30

At the time of the disaster, the *Herald* was owned and operated by P&O European Ferries (formerly Townsend Thoresen), which had, and continues to have, its headquarters in Dover, England. Therefore, in this hypothetical scenario, the Proposed Act would apply, and the UK courts would have jurisdiction, by virtue of Section 30.

[840] See Chapter 3 of this thesis regarding the enforcement of the ISM Code.
[841] To use Reason's model of accident causation.

PROSECUTION OF P&O UNDER SECTION 1

The initial prosecution against P&O collapsed due to there being a gap in the law. However, under both the 2007 Act and the Proposed Act, P&O would have been successfully prosecuted for corporate manslaughter. Using the causal findings of the Sheen Inquiry, the prosecution would have been able to prove that P&O's corporate individuals[842] managed the company in such a way that it caused the death of the 192 people on board the *Herald*, and that this amounted to a 'gross' breach of a relevant duty of care.

In this hypothetical trial, P&O would have owed a duty of care under Section 4(1) of the Proposed Act as an employer and as a provider of a service. It is theorised that, by using the findings of the Sheen Inquiry, the prosecution would have had no problem in satisfying the Section 10 requirement that the breaches of the relevant duties of care were 'gross' breaches. For reasons discussed above,[843] the ISM Code would have been used as the means of determining this, and it is clear that the management activities of P&O's corporate individuals leading up to the disaster fell far below what was reasonably expected in the circumstances, and that this ultimately led to the breaches in safety that caused the disaster.

THE SECTION 11 DUE DILIGENCE DEFENCE

The due diligence defence contained within Section 11 would have been the last opportunity for P&O to avoid conviction in this hypothetical trial. However, it is safely assumed that this due diligence defence would not have been successful if pleaded.

SENTENCING OF P&O UNDER SECTIONS 3, 12 AND 13

It is theorised that in this hypothetical scenario, P&O would have been found guilty of corporate manslaughter under Section 1 of the Proposed Act. It is further theorised that the court would have made a Publicity Order under Section 13 and imposed a large fine of £20 million, in line with recent Sentencing Council Guidelines for Corporate Manslaughter, as discussed above.

[842] Discussed below.
[843] And in the section that follows.

It is doubtful that the court would have made a Remedial Order under Section 12 of the Proposed Act. Based on the evidence submitted to the Sheen Inquiry, within days of the disaster, P&O implemented corrective action including, *inter alia*, the installation of bridge indicator lights on the company's other *Spirit*-class ferries. However, the Inquiry advised P&O to take other corrective action in addition to that which it had already implemented.[844] If P&O had not implemented these, and it was the opinion of the court that it should have, then the court may have included this advice in the form of a Remedial Order.

CORPORATE INDIVIDUALS UNDER SECTION 2

Under the Proposed Act, once the prosecution has satisfied the requirements of Section 1, and therefore proven the company's guilt for corporate manslaughter, those individuals identified by the prosecution (when satisfying Sections 1(3) and 1(4)(c)) would be liable under Section 2. This secondary liability would essentially be automatic for those corporate individuals who had consented to the offence taking place, or whose negligence contributed to the offence. In this hypothetical scenario, the corporate individuals that would have been prosecuted under Section 2: i) Mr Develin; ii) Mr Alcindor; iii) Mr Ellison; iv) Mr Reynolds; and v) Captain Lewry. In discussing the hypothetical prosecution of these five individuals, the author's Proposed Sentencing Guidelines/Table are used.

The actions of Mr Develin, as the most senior member of management identified by the Sheen Inquiry, would have been used to prove the elements of the Section 1 offence; namely that his specific failure to order the installation of the indicator lights and his general failure to implement an effective system of safety management, contributed to the Section 1 offence. Mr Develin's guilt, therefore, would have essentially already been proven under Section 1, and so it would be for the courts to confirm this guilt under Section 2, then listen to mitigating and aggravating factors and to impose an appropriate sentence. In line with the ethos of the ISM Code that there must be commitment to safety from the top, Mr Develin's level of culpability would have been judged to be 'high' and so the starting point for the courts would have been a custodial sentence of 14 years. Although there is the possibility that during the corporate manslaughter trial, arguments would have been made regarding mitigating and aggravating factors in addition to those presented by counsel during the Inquiry, it is

[844] Report 8074: Herald of Free Enterprise at paras 28-40.

assumed, especially for the purposes of this hypothetical scenario, that only those arguments already presented to the Inquiry would be considered by the court when deciding an appropriate sentence.

From the Sheen Report, it would appear that Mr Develin's only available arguments for mitigation would have been that he inherited the flawed 'consensus system' from his predecessors, and also that he forwarded the requests for indicator lights on to the company's 'think tank' for their consideration, and it was they who declined the requests. However, Mr Develin failed to appreciate his role with regards to safety; failed to develop/implement an effective system to manage safety; failed to adequately supervise the 'think tank', which it was his responsibility to do so; failed to take necessary action to prevent unsafe conditions on board the company's ships; encouraged a culture of complacency with regards to safety, that ultimately allowed for the breach of numerous safety barriers, and which resulted in the disaster and the loss of 192 lives. Consideration of these factors by the court would, it is theorised, have resulted in a custodial sentence being imposed on Mr Develin of around 16-18 years.[845]

It is appropriate for the purposes of this chapter to consider the hypothetical prosecutions of Mr Alcindor, Mr Ellison and Mr Reynolds together, as all three bear the same level of culpability and would have been sentenced as such. For reasons outlined above, Mr Alcindor (as a Deputy Chief Superintendent), Mr Ellison (as a Marine Superintendent), and Mr Reynolds (as an Assistant Marine Superintendent), would all constitute 'senior management' under the Proposed Act. In their total refusal to approve the requests for indicator lights and the effects of such refusals, as P&O's collective 'think tank', they acted negligently and arrogantly, with a total absence of any proper sense of responsibility for safety. It is theorised, therefore, that the culpability level of these three individuals would be considered to be 'medium', with a starting point of seven years custodial sentence. Within the Sheen Report, there is little in the way of mitigating factors for these three individuals. Rather, there is damning criticism of them; the Inquiry stated that if these individuals had given the requests sensible consideration in 1985, when they were first made, it was probable that the indicator lights would have been installed by early 1986, and so the disaster would have been

[845] As there was no direct intention to cause the offence, a life sentence would not have been appropriate.

prevented.[846] Therefore, it is theorised that the court would impose a custodial sentence of around 8-10 years on these three individuals.

The final individual who would have been prosecuted under Section 2 of the Proposed Act in this hypothetical scenario, would have been Captain Lewry. It has already been well documented that masters constitute senior management for the purposes of both corporate manslaughter legislation and the ISM Code, and this has been discussed throughout this thesis. Although the "underlying or cardinal faults" lay with shore-based management, the immediate cause of the disaster was Captain Lewry negligently going to sea with the *Herald*'s bow doors open, and the Proposed Act would recognise that Captain Lewry would need to accept *some* personal responsibility for the loss of his ship and the resulting loss of life. It is theorised that, under the Proposed Sentencing Guidelines/Table, the courts would have found Captain Lewry's level of culpability to be 'low'. He was unaware of the immediate risk, but this amounted to negligence as he should have been aware of the condition of his ship; he was responsible for the safety of his ship and all on board, and he failed in this duty, and Paragraph 5 of the Code would certainly support this contention.

In considering the mitigating factors found in the Sheen Report,[847] and bearing in mind that in this hypothetical scenario, Paragraph 5 of the ISM Code would be in force, it is theorised that the court would impose a custodial sentence of around four years; the maximum amount under the Proposed Sentencing Guidelines/Table for those deemed to be of low culpability.

It is worth noting that although Mr Stanley, the assistant bosun, was derelict in his duties in not closing the bow doors, and therefore at fault, his low rank would have protected him from prosecution under Section 2; the responsibility ultimately lay with his primary supervisor/commanding officer i.e. Captain Lewry. Therefore, punishment of Mr Stanley would need to have been achieved through other legal measures.

It is also worth noting that all those individuals named above, who would have been sentenced under Section 3 of the Proposed Act, would be eligible to be released on

[846] Report 8074: Herald of Free Enterprise at para 18.5.
[847] ibid at para 12.

licence at the half-way point of their sentences, provided that the necessary conditions were met.

7.2.3 CONCLUDING REMARKS

Academic consideration of how the ISM Code could have prevented the *Herald of Free Enterprise* disaster (had it been in force at the time that the *Herald* was being operated), and how, if the Proposed Act was also in force at the time, it could have been used by the courts to successfully hold P&O and its culpable corporate individuals accountable for the management failings that led to the disaster and consequent 192 deaths, as well as providing for an appropriate punishment, has allowed for the testing of the thesis hypothesis from an academic perspective.

7.3 THE SURVEY

7.3.1 THE PURPOSE OF THE SURVEY

Alongside the academic consideration of the hypothetical *Herald of Free Enterprise* case study, the thesis hypothesis was supported by a survey. This survey was designed to capture both quantitative and qualitative data from participants involved in the study and/or practice of maritime safety. It was used to generate additional academic discussion around the research questions, obtain experiential insight and, ultimately, to test and potentially support the author's theories and the thesis hypothesis. It also explored participants' views relating to ISM Code implementation, as well as the Code's ability to instil and maintain an effective safety culture within the international maritime community. The survey also allowed participants to volunteer additional, related commentary and feedback, which was used to contribute to the author's research and understanding of the subject matter.

7.3.2 METHODOLOGY

The survey consisted of a short questionnaire, comprising of 16 questions and divided into three sections:[848]

[848] A copy of the Questionnaire is provided in Appendix 14.

Section A was comprised of four questions, which captured participants' personal details; their name, the company or organisation that they work for, their role within that company or organisation, and their email address. A note at the bottom of this section advised participants that their name and email address would not be disclosed in this thesis. This served to ensure the anonymity of the participants and therefore encouraged them to be more forthcoming with their responses. This further ensured that the answers provided were more accurate, and therefore more reliable, when used to test the thesis hypothesis.

Section B was made up of eight questions, designed to capture participants' understanding of, and perceptions relating to, the ISM Code's purpose and impact on maritime safety, both internationally and within the UK. Participants were also asked to provide their views on the potential of the ISM Code being used to attribute criminal liability to the ship company and/or the individuals within that company for deaths at sea.

Section C consisted of four questions relating specifically to corporate manslaughter. Participants were asked to consider an offence of individual liability for corporate manslaughter being incorporated into domestic law, and to provide their views on how effective this might be at ensuring better implementation of the ISM Code. It was important for the reliability of the answers submitted, that the questions in Section B referred to 'individual liability', and not primary or secondary individual liability. This ensured that the questions were more open; not leading the participant to support the thesis hypothesis.

Sections B and C captured both quantitative and qualitative data, as both contained multiple-choice questions, as well as questions that allowed for free-text responses. However, it should be observed that both Sections referred to the UK maritime industry and UK-specific legislation. As not all participants were from the UK, or had experience/knowledge regarding the UK industry/laws, some participants were unable to provide answers to these questions, and this affected the number of responses.[849] This is reflected in the analysis of the data and the discussion around it.

[849] In total, eight participants were unable to provide answers to questions that related specifically to the UK.

The Questionnaire was accompanied by a 'Participant Information Sheet', which advised participants of the overall aims of the research, the thesis hypothesis, the purpose of the survey and what was expected of them if they agreed to participate.[850] In accordance with the University of Central Lancashire's requirements, the Questionnaire included a consent form for participants to complete, so as to confirm both their consent to participate in the survey and their understanding of what their responses would be used for.

7.3.3 PROMOTING THE RESEARCH

It was important for the quality and the value of the data received, that there was a range of participants who are actively involved in the study and practice of maritime safety, including, *inter alia*, academics, lawyers, seafarers and shore-based employees. As a member of the Nautical Institute,[851] the author was invited to write a letter in the organisation's journal *Seaways*, inviting readers to participate in the survey.[852] The author also contacted Nautilus,[853] which agreed to publish a similar letter promoting the survey, in its magazine *Telegraph*.[854] These letters allowed for the promotion of the survey, as well as the overall research, and resulted in members of both organisations contacting the author and volunteering to participate in the survey. In one case, an article was written by Dr Kevin Ghirxi (the Head of Malta's Marine Safety Investigation Department), in which he criticised both the premise of the author's research and the survey itself.[855] However, it is clear from his article that Ghirxi misunderstood the author's research, its aims, and the thesis hypothesis. As a result, this misunderstanding rendered the premise of Ghirxi's article flawed, and its conclusion unfounded and therefore moot. The article did, on the other hand, provide for 'partially-relevant' feedback, and served to evidence that the author's research is provoking debate and discussion on potential criminal liability and punishment for deaths at sea; one of the overall aims of the research.

[850] A copy of the Participant Information Sheet is provided in Appendix 15.
[851] An international representative body for maritime professionals that provides services to enhance the professional standing and knowledge of its members.
[852] Appendix 16.
[853] A trade union for members of the international maritime community.
[854] Appendix 17.
[855] K Ghirxi, 'ISM and criminalisation' (2016) December Seaways 5.

The total number of completed Questionnaires that were received and suitable for being input into the database[856] was 25. Interesting for the quality of the responses, was that the survey was being distributed around the time that Captain Schettino's appeal was rejected and his custodial sentence of 16 years upheld by Italy's appeals court.[857] Therefore, criminal liability and punishment for causing (or contributing to) deaths at sea was very topical at the time that this stage of the research was being undertaken.

7.3.4 SUPPORTING THE RESEARCH

In relation to the survey, the author was invited to present a paper at the London Universities Maritime Law and Policy Group (LUMLPG)'s annual research conference.[858] This paper discussed the reasons for the research, its aims, the author's theories, and the thesis hypothesis. Preliminary findings obtained from a random sample taken from the survey (using the data analysis software discussed below) were presented in order to prompt academic debate in the room from those leading maritime academics, researchers and lawyers in attendance. This academic discussion resulted in additional feedback and commentary, useful to the author's research and evolving theories.

As a result of the LUMLPG conference, the author was invited to deliver a lecture at the Staatlichen Seafahrtschule (State Maritime College) in Cuxhaven, Germany, on the ISM Code's impact on harbour operations.[859] Although the lecture was primarily delivered to maritime law students and seafarers studying at the college, senior corporate individuals from leading ship companies, as well as Members of the European Parliament and other political institutions, were also in attendance. As part of the lecture, there was discussion around current and potential future liabilities for seafarers emanating from the ISM Code. This lecture was a useful opportunity to debate the author's theories and to receive valuable feedback from those working on board ships, as well as those who are involved in the development and implementation of maritime legislation at a regional and national level.

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[856] Discussed below.
[857] Discussed in the previous chapter.
[858] C Laverick, 'Could Corporate Manslaughter Legislation Be Used to Enforce Better Compliance with the ISM Code?' (The London Universities Maritime Law & Policy Group Annual Research Conference, London, April 2016)
[859] C Laverick, 'The ISM Code and Its Impact on Harbour Operations' (The North Sea International Maritime Conference, Cuxhaven, November 2016).

Two participants in the survey, Arne Sagen and Jan Harsem, who spearhead the Skagerrak Foundation's campaign for maritime safety, and who have provided support to Captain Schettino's legal defence team,[860] were keen to share their unique experiences and insight into the ISM Code and criminal liability for death(s) at sea, beyond the confines of the survey questions. The author was invited to visit Mr Sagen at his home in Sandvika, Norway, on 23 May 2016. At this one-to-one interview, an in-depth discussion took place around maritime safety and the ISM Code generally, as well as the *Costa Concordia* disaster and the resulting criminal trials more specifically. The insight and feedback received from Mr Sagen was extremely valuable, and it led to the author's initial thoughts regarding responsibility and liability for the *Costa Concordia* disaster being developed significantly, and this has been reflected in Chapters 4 and 6 of this thesis.

Mr Harsem engaged the author in dialogue via email over a course of several weeks. Despite Mr Harsem and Mr Sagen being the two senior directors of the Skagerrak Foundation, their strategies regarding the advancement of maritime safety, and their opinions on how the Foundation's aims are best achieved, are in stark contrast with one another. These differing views and approaches provided the author with interesting perspectives and academic consideration for this thesis.

Discussions with Harmsem and Sagen resulted in the author being invited by the Skagerrak Foundation to provide 'expert opinion', in the form of a short note, as part of the Foundation's submission to a Norwegian Parliamentary Commission on maritime safety. The author's research and theories relating to ISM complacency, and the potential for using the criminal law to encourage better implementation of the Code, underpinned the opinion provided to the Foundation and to the Commission.

These invitations evidence the growing interest in the debate surrounding criminal liability for causing or contributing to deaths at sea, and the author's research in the area.

[860] See the previous chapter.

7.3.5 ANALYSING THE DATA

The software 'NVivo', which was available to the author as a PhD candidate at the University of Central Lancashire, was used to analyse the data obtained from the Questionnaires. This software was chosen because it supports qualitative and mixed methods research, and because its purpose is to organise, analyse and find insights and trends in unstructured and qualitative data, including interviews and open-ended questionnaires. This software was therefore highly appropriate, and extremely useful, for the purposes of analysing and obtaining data from the survey.

To ensure that the software was used correctly, so as to obtain reliable and accurate data, the author attended a training course organised by the University of Central Lancashire, entitled 'NVivo for Researchers'. This training course allowed the author to appropriately collect, catalogue, codify and analyse the survey. This included the obtaining of numerical data and statistics, as well as the depiction of this data in the form of charts and tables.

7.3.6 ANALYSIS OF THE SURVEY RESULTS

The key questions and responses were analysed and are discussed accordingly.

SECTION A: PERSONAL PROFILE

The author analysed 25 completed Questionnaires and categorised the participants according to their role or position within the study and/or practice relating to maritime safety. An examination of the Questionnaires revealed six categories of participant, which the author labelled as follows.

Category of Participant	Number of Participants	Percentage
Academic/researcher	7	28
Maritime specialist/practitioner	7	28
Seafarer	4	16
FSA employee	3	12
Onshore management	2	8
Lawyer	2	8

Table 7.6: Categories of survey participant, including number and percentage of each category

Although some participants held more than one position (e.g. most of the maritime specialists had previously served as master mariners), they were categorised according to their most recent position. The number and category of participants represented a good range for the survey.

SECTION B: THE ISM CODE

QUESTION 8

Question 8 was designed to capture participants' understanding of the ISM Code's impact, as well as to assure the author of the participant's suitability with regards to their relevant knowledge and experience. The Question asked participants whether they were of the opinion that the ISM Code had had a positive impact on maritime safety within the international maritime community.

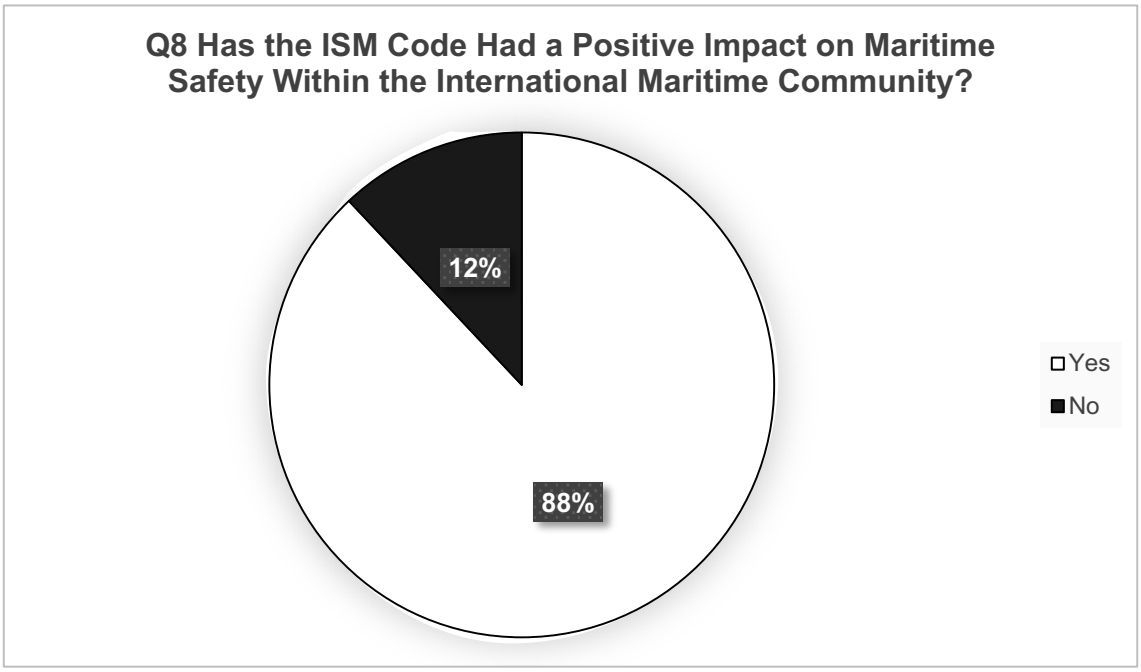

Diagram 7.6: Responses to Question 8

Of the 25 responses, 88% of participants (i.e. 22) were of the opinion that the ISM Code has had a positive impact on the international maritime community. This level of response had been expected due to the author's earlier research.[861] However, the responses received as part of the survey allowed, to a certain extent, for a better understanding as to the reasons why this opinion is held popular in the community. The author identified nine reasons why participants held this opinion, and categorised them accordingly.[862] The main points made by the participants in their responses are discussed here.

Five participants (three maritime specialists, one academic, and one FSA employee) cited an 'increase in safety awareness' as evidence of the ISM Code's positive impact For these participants, the adoption of the Code has resulted in an increase in safety training and education for ship companies and seafarers (i.e. "commitment from the top"[863]), and this has resulted in an increased awareness of safety. One maritime specialist expanded upon this point by stating that the Code's positive impact can be seen even more with "non-traditional maritime countries" i.e. those States with emerging maritime industries that are also developing their economic and social

[861] See Chapters 1 and 2 of this thesis.
[862] See the list of 'nodes' for Question 8 in Appendix 18.
[863] Paragraph 6 of the Preamble to the ISM Code.

conditions. This would certainly accord with the Code's aim of improving safety by harmonising (and raising) standards throughout the community.

Related to the effect of increased awareness, three participants (one academic, one on-shore manager, and one seafarer) were of the opinion that the Code's positive impact can be seen with the improvement in 'attitudes' towards safety (by both ship companies and seafarers). The basis for the academic and the on-shore manager's knowledge of this improvement came from their colleagues who serve at sea, as well as from their colleagues who work for P&I Clubs and law firms. The seafarer who contributed to this 'category' of answer is a Navigational Officer, and offered first-hand experience and knowledge of the ISM Code's impact on board. They stated that, in their experience, prior to the Code coming into force:

> "nobody cared about safety matters and when there was an incident, the [ship] company seldom took responsibility for the breaches in safety that caused it."

The *Herald of Free Enterprise* disaster, amongst others, is an example that supports this opinion. Nowadays, they stated, everyone in the company knows who is responsible for safety at every level, and this is due to the ISM Code's requirements.

For this Question, four responses were received that were extremely valuable in supporting the thesis hypothesis. Four participants (two maritime specialists, one lawyer, and one seafarer) stated that, whilst the ISM Code has improved maritime safety, *complacency* with the Code has started to increase following its initial 'honeymoon period'. A leading maritime specialist, reinforcing this view, stated that:

> "When the implementation period was over, and when it was clear that the tiger had no teeth (no detention), most of the attention was lost for most companies."

In essence, the participant argued that once it was realised that the Code's requirements were not being enforced by Flag State Administrations and national courts, ship companies' enthusiasm waned. This argument was echoed by the other maritime specialist, who was of the opinion that the ISM Code's positive effect is starting to wane due to "the law of diminished returns" (i.e. although ship companies' efforts/investment in safety continues to increase, the benefits they receive do not continue to increase). The seafarer stated that the ISM Code has "over-evolved" and

has resulted in too much on-board paperwork. This has led to *complacency* with the Code and with safety in general. This response certainly accords with the author's research and theories.

Research undertaken at the beginning of this project, established that despite the initial success of the ISM Code, there is now a general consensus amongst ship companies and seafarers that the Code is overly-burdensome, which has led to complacency with safety.[864] Whilst generalisations cannot be drawn from the survey, the four responses support the earlier research already undertaken, and prompt consideration of potential and additional reasons behind ISM complacency beyond the issue of the Code being overly-burdensome.

The remaining responses mainly concerned evidence of improved safety standards from auditing and inspections, as well as the reduction in maritime casualties and fatalities. The latter is, of course, the best indicator of the Code's positive impact on maritime safety. However, whilst the four participants above provided valuable feedback relating to 'trends' of ISM implementation, the Question itself only asked participants to consider whether they thought there had been an (linear) improvement in maritime safety since the Code came into force (i.e. from 2002 until 2016); participants were not asked to consider whether they thought there had been any fluctuations in safety standards during the 14-year period. In hindsight, Question 8 would have better addressed the research aims, and therefore potentially better supported the thesis hypothesis, had it asked participants to consider the effect of the Code on maritime safety since it came into force, *and* to further consider whether the Code's effect had changed during this period at all and, if so, to provide their opinion as to the reason(s) for this.

Whilst most of the participants supported the popular opinion held within the maritime community, as well as the author's earlier research, it is important to consider here the dissenting opinion within the survey. Three participants (two academics, and one lawyer) were of the opinion that the ISM Code has not had a positive impact on maritime safety, and all three provided different reasons for believing this.

[864] As evidenced by the rate of non-compliance with the Code returning to the rate of when it initially came into force in 2002 and the number of fatalities rising.

One academic was of the opinion that the Code has increased the power of the ship company, but has not actually improved on-board safety because unsafe conditions on board are still being ignored by the company. Whilst this may be the case with some ship companies, such as it was with Costa Crociere and the *Costa Concordia*,[865] evidence and popular opinion would suggest that this is not what is happening with most ship companies. Therefore, it is inaccurate to state that the Code is not having a positive impact on maritime safety for this reason. To put the participant's statement into context, it would be more accurate to state that *some* (emphasis added) ship companies are not implementing the ISM Code fully, and this is adversely affecting the Code's overall positive impact; but there is still a positive impact.

It was the lawyer's opinion that the ISM Code amounts to:

> "one more thing that [the ship company] has to deal with and it does not make them prioritise the ISM Code's goals any more than they did before."

They also argued that with the introduction of the ISM Code, some ship companies' safety standards have declined due to them feeling the need to comply only with the *minimum* requirements set by the Code, rather than the higher safety standards they were implementing pre-ISM. Although this is not necessarily indicative of the desired adoption of an enhanced safety culture, even the minimum standards set by the Code are sufficient to ensure the safe operation of all ships, if implemented fully.

An interesting point was made by the other academic, which the author agrees with. They argued that "when the Code was adopted, it was expected that it would have an impact in shaping legal decisions […], but this has not happened." This view certainly accords with the author's findings, and the point is well-illustrated by the *Costa Concordia* case. The issue is further discussed below, as well as in the previous chapter.

QUESTION 9

Question 9 asked the same question, but with regards to the UK maritime industry specifically. Of the 25 participants, eight were unable to provide an answer due to their

[865] Discussed in Chapters 4 and 6 of this thesis.

lack of knowledge/experience of the UK maritime industry (discussed above). Therefore, 17 responses were suitable for analysis.

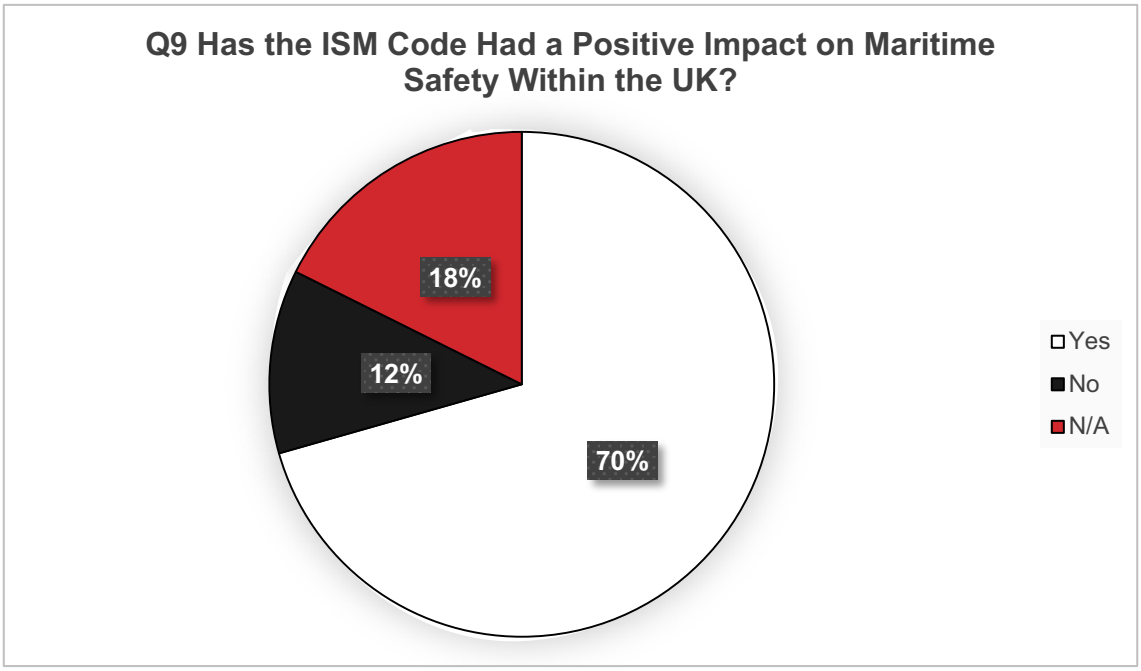

Diagram 7.7: Responses to Question 9

Of the 17 responses analysed, 70% (i.e. 12) were of the opinion that the ISM Code has had a positive impact on the UK maritime industry. The author identified five reasons why participants held this opinion, and categorised them accordingly.[866] As was expected, many of the responses were similar to those provided for Question 8.

Three participants (two academics, and one on-shore manager) cited a change in 'attitudes' as evidencing the Code's positive impact in the UK. The two academics stated that the ISM Code has encouraged an improvement in ship companies' and seafarers' attitudes towards safety, which has led to an increased awareness of common risks and safer working practices. This, they claimed, is supported by reports from P&I Clubs and law firms, as well as research undertaken by maritime students. These comments are not surprising. Existing literature and research clearly indicate that there has been an overall improvement in the community's attitude towards safety, and within the UK too. Therefore, this category of response supported the author's understanding, but did not necessarily develop it.

[866] See the list of 'nodes' for Question 9 in Appendix 18.

Three participants (one academic, one maritime specialist, and one master mariner) cited 'statistics and research' as evidencing the ISM Code's positive impact on the UK maritime industry. For these participants, relevant statistics and research that they had seen (and in one case, had collected as part of a major ISM project) evidence two key things: i) the ISM Code has had a positive impact and this can be seen with the fall in the number of reported casualties and deaths on board UK-registered ships, and ships within UK territorial waters; and ii) since the ISM Code entered into force, the casualties and deaths that have occurred on board the aforementioned ships tend to be as a result of a lack of training/skill, which is not attributable to the ISM Code. However, there is the argument that training requirements do fall under the remit of the ISM Code by virtue of its Paragraph 8.

For three participants (two maritime specialists and one FSA employee), the positive impact that the ISM Code has had on the UK maritime industry is best evidenced by the 'inspections' that have come with the adoption of the ISM Code. The establishment of ISM inspections, as well as the consequent increase in other safety inspections, means that ship companies and seafarers must implement ISM, and this is positively affecting safety standards, as well as "flagging up complacency long before an accident happens."[867] Whilst many seafarers have criticised the Code for being overly-burdensome and creating too much paperwork,[868] one maritime specialist (a former master mariner) stated that being subjected to the "frequent safety inspections (by the MCA, the Irish Maritime Administration, other Flag State Administrations, and Classification Societies) was *excellent*." On the face of it, this response does not appear to reflect popular opinion, as evidenced in the existing literature.[869] However, this response is reflective of the enhanced safety culture that the drafters of the Code intended.

One further response to Question 9, which provided an interesting perspective not anticipated by the author, was that submitted by a senior director of a foreign FSA. As part of their answer, they stated that in their opinion, the UK maritime industry had been positively affected by the ISM Code as a result of foreign ships entering UK territorial waters and ports having to comply with the Code's requirements. The participant stated

[867] This quote comes from one of the maritime specialists.
[868] As discussed in Chapters 1, 2 and 3 of this thesis.
[869] Included as part of the review of the existing literature in Chapter 1 of this thesis.

that these foreign ships had previously been entering UK territorial waters and ports whilst being operated unsafely, primarily as a result of there being no strict regulation of maritime safety in the country where these ships were registered. The participant referred to their own country, one of the least developed countries in the world but with an emerging maritime industry, as a clear example of this. The participant's argument, therefore, is that the ISM Code's positive impact on the international maritime community in turn has a positive impact on the UK maritime industry (a symbiotic and interdependent relationship).

The participant went on to state that due to the clear positive impact that the ISM Code has had on their country's international fleet, they were lobbying for a similar system of safety management to be legally required for the country's domestic fleet. This would be akin to the system put in place in South Korea, post-*Sewol*, as discussed in Chapter 4 of this thesis. Again, this positive attitude is reflective of the enhanced safety culture that the drafters of the Code intended.

Of the 17 responses analysed for Question 9, two participants (one academic and one lawyer) were of the opinion that the ISM Code has not had a positive impact on the UK maritime industry. The academic was of the opinion that the ISM Code has increased the power of ship companies and this has resulted in reduced seafarer involvement with safety. The lawyer was of the opinion that the ISM Code is being implemented by the ship company (in most cases) as well as on the bridge, but not below decks in the engine room, and that this is impacting upon the Code's overall effect in the UK. These responses were not anticipated, but they did serve to develop the author's understanding in two ways. Firstly, whilst the author had made the distinction between the ship company and seafarers with regards to ISM implementation, the author had not considered the potential relationship between the two. Secondly, although the author had made the distinction between ISM implementation by the company ashore and seafarers on board, the author had not considered the potential difference in on-board implementation between, for example, the bridge and the engine room. However, it could be argued that it is the ship company's responsibility to ensure that the master is implementing the ISM Code effectively, and the master's responsibility to ensure that *all* (emphasis added) of the crew are implementing it effectively, by virtue of the Code's Paragraphs 6 and 5 respectively.

Furthermore, for this Question, the author had anticipated only 'yes' and 'no' responses, and had expected most participants to have responded with 'yes'. The author had not anticipated three 'not applicable' responses. For these three participants (one academic, one maritime specialist, and one on-shore manager), there had been no noticeable improvement in maritime safety in the UK because the UK maritime industry was "never really a problem." This is because, for some time, the UK has enjoyed a global reputation of traditionally being one of the safest maritime States/industries in the world. Although the ISM Code (and the Corporate Manslaughter and Corporate Homicide Act 2007) was born from the *Herald of Free Enterprise* disaster, incidents such as this are rare, and only occur as a result of the *culmination* (emphasis added) of unsafe acts and conditions (Anderson's terminology), or the breaching of certain safety barriers (Reason's terminology) by those few members of the maritime community who are being complacent with safety.

QUESTION 10

Question 10 asked participants whether the ISM Code should contain provisions for apportioning liability to ship companies and individuals for their non-compliance with the Code. Of the 25 participants, two failed to provide an answer. Therefore, 23 responses were included as part of the analysis.

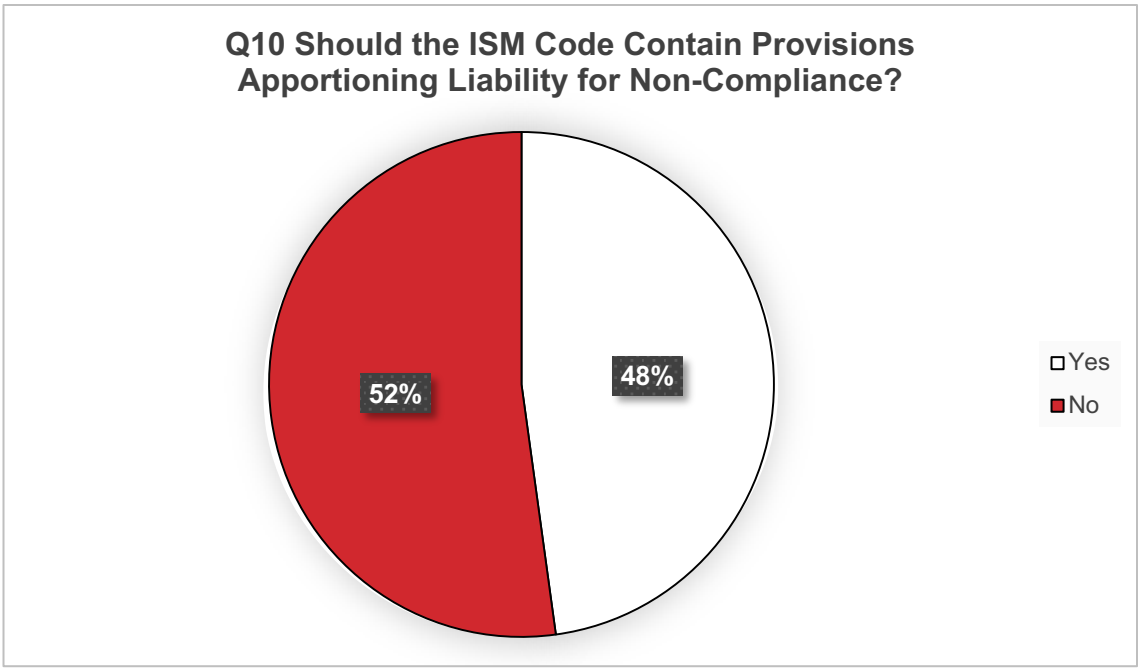

Diagram 7.8: Responses to Question 10

Of the 23 responses, 52% of participants (i.e. 13) agreed that the ISM Code should not contain provisions apportioning liability for non-compliance. The author identified three reasons why participants held this opinion, and categorised them accordingly.

Ten participants (three maritime specialists, three academics, two FSA employees, one on-shore manager, and one seafarer) were of the opinion that the Code should not contain provisions apportioning liability because 'the Code was not intended for liability'. One maritime specialist stated that:

> "where there is apportioning of liability there has to be apportioning of blame, and that seems to fly in the face of the original safety management concept."

The participant suggested that there should be no liability associated with non-compliance of the Code due to the Code being "introduced with a 'no blame' culture." However, the majority of the participants whose answers were included in this category of response, agreed that, whilst the focus of the ISM Code should be on establishing and harmonising minimum standards for on-board safety, the Flag State should incorporate the Code into domestic legislation, and enact relevant provisions relating to liability and punishment for non-compliance accordingly. Whilst this argument is indicative of popular opinion, as revealed by the research, it does not address the issue of liability and punishment for those who fail to comply with the Code and a death (or casualty) occurs as a result; only liability and punishment for the non-compliance itself. In this respect, breaches of the ISM Code in the UK are treated in a similar way as breaches of the Health and Safety at Work etc Act 1974 are, in that the company and/or individuals are punished only for the breach in safety; not for the consequences of such breach.[870] In the case of death(s), this is far from satisfactory, as discussed in the previous chapter.

Three participants (one academic, one FSA employee,[871] and one seafarer) were of the opinion that not only would it be inappropriate for the Code to contain such provisions, but such provisions are in fact unnecessary. They referred to current 'enforcement methods' as being sufficient to deal with non-compliance. Whilst the author agrees that measures currently in place (such as the detention of non-compliant ships and the withdrawal of ISM certificates, both of which would render the ship inoperable and thus

[870] By virtue of the 2014 ISM Regulations.
[871] The same FSA employee also provided a response that was considered under 'the Code was not intended for liability' category.

unable to trade), can help ensure compliance on some level, especially with regards to acting as a deterrent, research has proven that these measures are rarely used.[872] Furthermore, when a disaster does occur and death results, the measures are wholly disproportionate as a form of punishment, and they clearly come too late.[873] It would be more accurate, therefore, to say that enforcement measures currently in place can be effective at encouraging ship companies to implement the ISM Code (or deterring them from non-compliance), and punishing those companies that do not comply, but they are not effective at encouraging individuals, such as seafarers, to comply. Nor are they an appropriate form of punishment when non-compliance or non-implementation leads to casualties or fatalities.

One participant (an academic) was of the opinion that the ISM Code should not contain provisions for apportioning liability because of the effect it would have on seafarers. They stated that 'criminalising seafarers' in this way would be "over-punitive and financially unrealistic." Whilst this may be the case with seafarers being issued with heavy fines, the participant did not consider fines appropriate for the individual convicted (in terms of the individual's position within the company), nor did they consider other forms of punishment. Furthermore, they failed to consider the punishment of the company, which was part of the question being asked.

Ten participants (four maritime specialists, two academics, one lawyer, one FSA employee, one on-shore manager, and one seafarer), representing 48% of the responses, however, believed either that 'the ISM Code should include provisions for apportioning liability' for non-compliance with the Code, or that 'the Code can already be used to apportion liability' on some level.

One participant (a seafarer) argued that, although the ISM Code does not contain provisions specifically apportioning liability, a ship company's SMS and policies/procedures do apportion liability. Two participants (one maritime specialist, and one lawyer) expanded upon this point; making the observation that national courts can use the ISM Code to measure standards and to apportion liability if the ISM Code has been incorporated into domestic law. The maritime specialist stated that whilst courts *should* (emphasis added) be using the Code to determine whether breaches of

[872] As discussed in Chapter 3 of this thesis.
[873] See Chapters 4 and 6 of this thesis.

maritime safety amount to criminal acts, they are in fact not doing so. Although the lawyer seemed to contradict this by stating that the courts in their home country are using the Code in such a way, it is clear from the research, and recent judicial decisions from the lawyer's home country itself, that this is clearly not the case.

Three of the participants (one academic, one maritime specialist, and one FSA employee) claimed that the way in which the ISM Code is written, and the way in which it is used by national courts, allows for and encourages ship companies to shift its liability to the seafarers. The author's research would certainly support the participants' opinion that this is becoming common practice within the international maritime community.[874]

Four participants (two maritime specialists, one academic, and one on-shore manager) were of the opinion that the ISM Code should be amended so as to apportion liability to both the ship company and the individual. The academic and one of the maritime specialists further argued that if an investigation into an accident/disaster revealed that a "corporate level of sloppiness and non-compliance [with the Code]" was the root cause, then both the company and the individuals concerned should be held accountable under the Code and punished accordingly.

The other two participants' responses were concerned more with amending the Code so as to focus on apportioning blame to the ship company when there is an accident/disaster; suggesting that any investigation into an accident/disaster should start with the ship company (a focus on the body corporate) and its management (a focus on the individuals who make up the body corporate), and the Code should be the means of determining whether breaches in safety standards were the cause.

As previously stated, due to the nature of the survey, generalisations cannot be made. Furthermore, the statistics obtained from the analysis of the responses for Question 10 means that a trend cannot be identified. However, there does appear to be a general consensus (amongst the participants) that there should be some form of liability for both the ship company and the individual for non-compliance with the Code, and there needs to be more focus on the ship company's role in the non-compliance (especially when there is an accident/disaster). This would appear to support the author's research and

[874] See the previous chapter.

the thesis hypothesis. However, due to the survey limitations, this 'support' cannot be relied upon too heavily, and therefore the author has accorded appropriate value to it.

QUESTIONS 11 & 12

Questions 11 and 12 were designed to capture quantitative data relating to participants' perceptions of ISM implementation within the international maritime community. For Question 11, participants were asked as to what standard they thought that ship companies were implementing the ISM Code, compared to when it was first introduced. For Question 12, the same question was asked with regards to the implementation of the Code by seafarers.

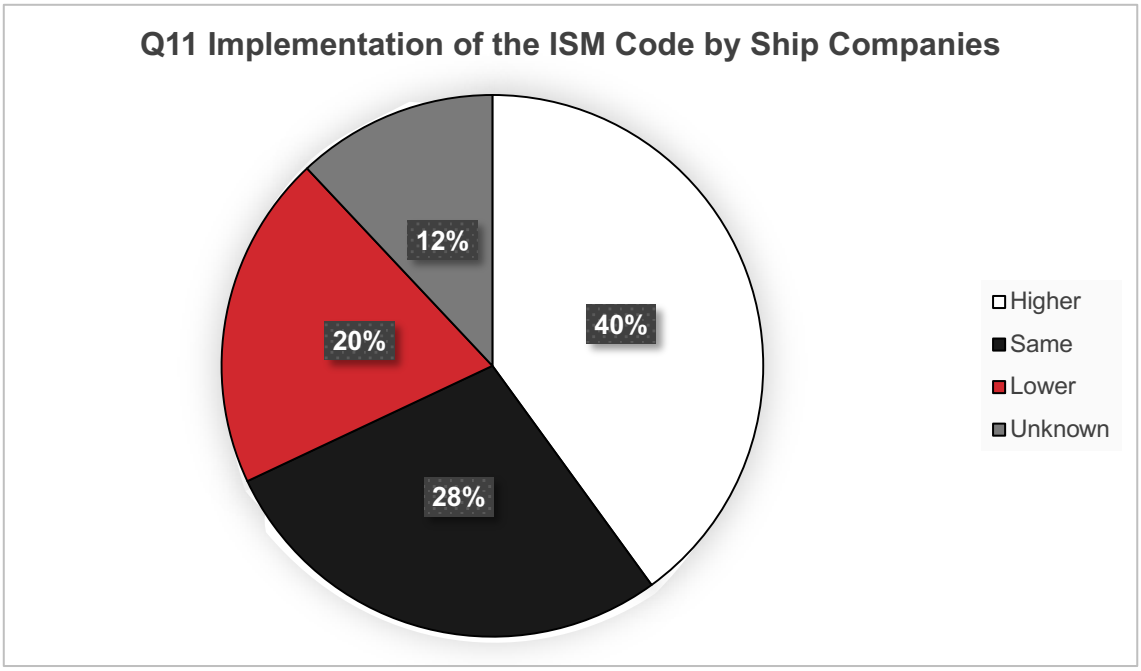

Diagram 7.9: Responses to Question 11

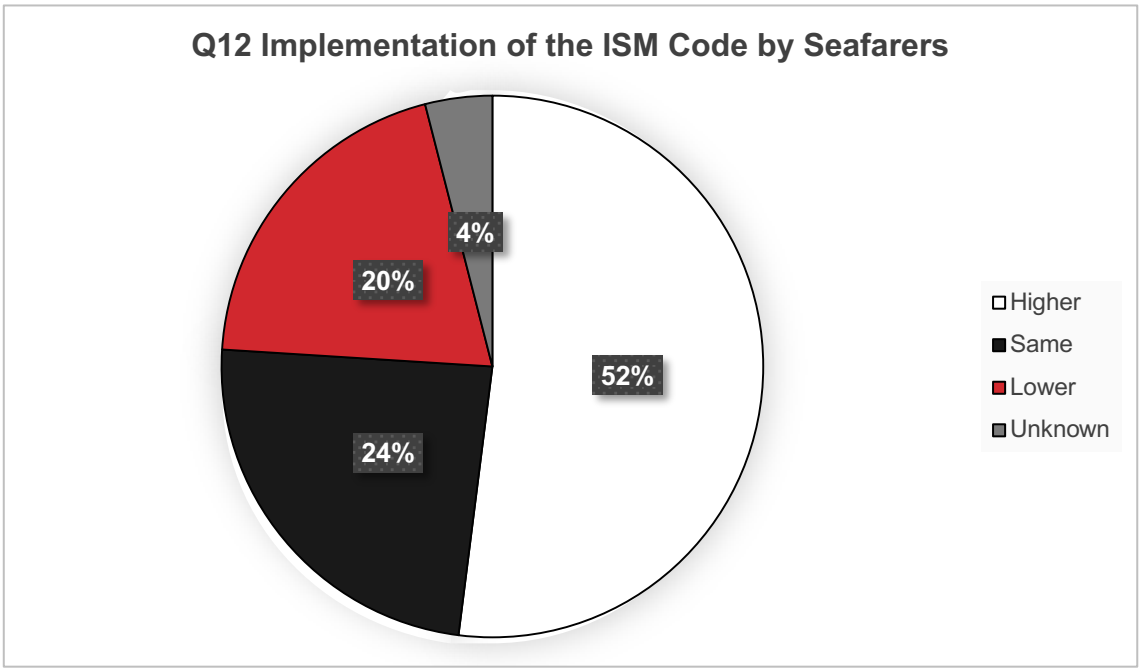

Diagram 7.10: Responses to Question 12

From the statistics obtained, the (slight) majority perception amongst the participants was that the standard of ISM implementation by ship companies has not improved since the Code initially came into force; with 48% of participants (representing 54.5% of the responses[875]) believing that there has been no increase in the standard, compared to 48% of participants (representing 45.5% of the responses) believing that there has been an increase. There is a greater perception amongst the participants that the standard of ISM implementation for seafarers has improved since the Code initially came into force; with 52% of participants (representing 54% of the responses) believing that there has been an improvement, and 44% (representing 46% of the responses) being that there has not.

Therefore, at this point, it can be said that the results for Question 11 support, to some extent, the author's theories and the thesis hypothesis, but the results for Question 12 do not. Due to the author's earlier research concerning the issue of ISM complacency, it was expected that there would be a general perception amongst the survey participants that the ISM Code was being implemented by seafarers at a lower standard than when the Code first came into force. Whilst the purpose of the survey was not to generate new theories, and generalisations cannot be drawn from it due to its limitations, the survey was intended to test the author's existing theories, as devised and developed

[875] i.e. discounting those who provided 'unknown' responses.

from earlier research, and to ultimately support, refine and advance the thesis hypothesis. The results for Question 12 demonstrate the limitations of the survey, and this may be an issue worthy of consideration for any future research projects, as perceptions relating to ISM implementation may ultimately affect the community's safety culture.

SECTION C: CORPORATE MANSLAUGHTER

QUESTION 13

Question 13 was the most important part of the survey with regards to testing and supporting the author's theories and the thesis hypothesis. It was worded so as to capture whether participants thought that the introduction of individual liability for corporate manslaughter would be effective at ensuring compliance with the ISM Code; not whether or not they thought individual liability *should* (emphasis added) be introduced.

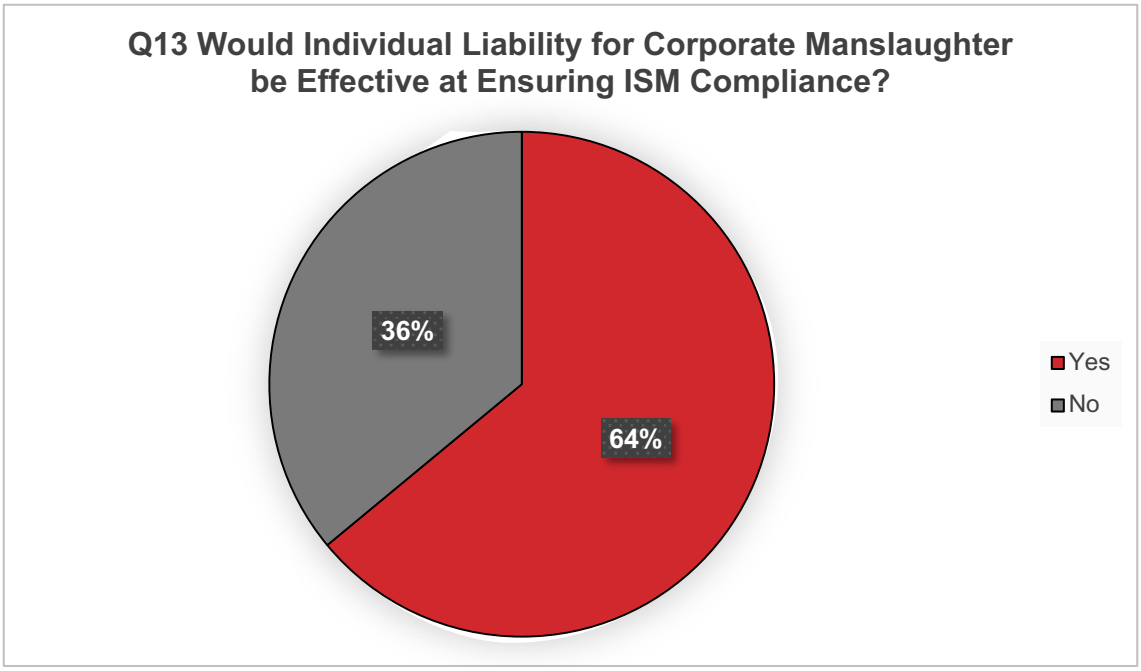

Diagram 7.11: Responses to Question 13

With 16 participants (representing almost two thirds of the survey) answering in the affirmative for this question, the thesis hypothesis was well supported by the responses. This level of response had been anticipated, but some of the responses from certain categories of participant had not.

Firstly, due to existing literature indicating a strong resistance by seafarers to any legislation that increases the 'criminalisation of seafarers', the author had expected most, if not all, of the seafarers in the survey to state firmly that individual liability for corporate manslaughter would not be effective, and even if it would be, that it should not be introduced. However, three of the four seafarers that participated in the survey were of the opinion that individual liability would be effective, and in deed they welcomed it as a means of encouraging ISM compliance and holding to account those whose non-compliance results in death(s). It is suggested that this issue should be examined further by organisations such as the IMO and the EMSA.

Secondly, the author had expected that most, if not all, of the academics and FSA employees would have thought that the introduction of individual liability would be effective at ensuring compliance with the ISM Code, as well as welcoming it as a positive contribution to an enhanced safety culture within the international maritime community. However, only one of the three FSA employees, and only four of the seven academics, supported the author's theories. Whilst four academics represent a slight majority of the participant category, the author had expected a larger majority.

The remaining categories of participant responded in a way that was anticipated by the author, a breakdown of which is provided here.

Category of Participant	Yes	No
Academic/researcher	4 (16%)	3 (12%)
Maritime specialist/practitioner	5 (20%)	2 (8%)
Seafarer	3 (12%)	1 (4%)
FSA employee	1 (4%)	2 (8%)
On-shore management	2 (8%)	0
Lawyer	1 (4%)	1 (4%)
Total	**16 (64%)**	**9 (36%)**

Table 7.7: Breakdown of Responses to Question 13

When analysing responses, three trends emerge for those participants believing that the introduction of individual liability for corporate manslaughter would be effective at ensuring ISM compliance.

Firstly, four participants (one academic, one maritime specialist, one on-shore manager, and one seafarer) were of the opinion that individual liability for corporate manslaughter

would be a welcome move in improving maritime safety because it would increase the exposure to liability of those at senior-management level, and so encourage them to focus their attention more on safety and ISM compliance/implementation, especially the person responsible for coordinating safety within the ship company; the DPA. The maritime specialist added to this point by arguing that, although the author had stated as part of Question 13 that ships' masters were to be considered 'senior management' and therefore liable,[876] masters should not be liable for corporate manslaughter, as it may be more appropriate to prosecute them for manslaughter. The participant cited the prosecution of Captain Schettino for manslaughter to illustrate their point and to support their argument. However, as noted in the previous chapter, there are often evidentiary issues with proving the standard for (gross negligence) manslaughter, and the sentencing is often inappropriately harsh (i.e. too high in terms of the custodial sentence imposed).

Secondly, four participants (three maritime specialists, and one academic) agreed that individual liability would be effective, and they discussed how the ISM Code might be used by the courts to prove the offence of corporate manslaughter. This discussion can be appropriately summarised by quoting the academic's response to Question 13:

> "Liability always increases consciousness of action and responsibility that motivates individuals to get things done the right way. […] The standard set by the Code should allow any court to determine whether the Code has been complied with and to determine the relevant penalties [including for corporate manslaughter]."

As this is essentially what is being proposed by the author in the thesis hypothesis, as discussed and outlined in the previous chapter, the thesis hypothesis is once again well supported.

It should be observed that one maritime specialist stated that, whilst individual liability for corporate manslaughter should be effective (in theory), it may be difficult for courts to "find the person (or persons) ultimately responsible for the breaches in safety and resulting death(s)." However, this concern has been addressed fully by the author in the previous chapter and therefore the author does not consider it to undermine the thesis hypothesis.

[876] The reasons for this are discussed in the previous chapter.

The third issue that proved valuable for the author's research and understanding was that which was raised by two participants (one maritime specialist, and one FSA employee). They stated that individual liability would ultimately prove effective at ensuring ISM compliance, but not initially. They argued that there needed to be a widely-publicised conviction and imprisonment of an individual within a ship company who had the power to affect safety, in order for corporate manslaughter to positively affect ISM implementation. One participant went on further to say that, in their experience, when a situation arises where individuals within the ship company are exposed to criminal liability in this way, either a plea bargain is reached or the case is dropped due to evidentiary issues. The problems surrounding plea bargains in maritime cases is discussed in the previous chapter. If the author's Proposed Act (or a similar piece of legislation) were to be enacted, it is hoped that the issue of plea bargaining would be addressed by any relevant guidance produced for the courts and the CPS.

Of the nine participants who did not feel that individual liability for corporate manslaughter would be effective, two reasons were identified from their responses.

Three participants (two academics, and one maritime specialist) stated that they could not see a link/relationship between individual liability and the implementation of the ISM Code, in that they "don't think that people anticipate this sort of liability within their relationship vis à vis the State in relation to their ISM responsibilities." Whilst there may be some merit in this 'observation', the discussion in the previous chapter addresses this, as well as that above regarding the need for actual prosecutions and the need for them to be widely-publicised. Therefore, the thesis hypothesis is not contradicted or undermined by this opposing view.

Three other participants (two academics, and one maritime specialist) did not necessarily oppose the author's theories, but they were of the opinion that there may be better ways of ensuring ISM compliance. They argued that the focus of individual liability should be through *existing* (emphasis added) health and safety legislation because individual liability for corporate manslaughter would leave senior crew far more exposed to liability than on-shore management. This, they argued, would be unfair, as well as being ineffective at achieving the goal of ensuring/encouraging compliance with the ISM Code. However, as already noted in the previous chapter, the

Health and Safety at Work etc Act 1974 is insufficient to deal with serious breaches of safety that result in death(s).

QUESTION 14

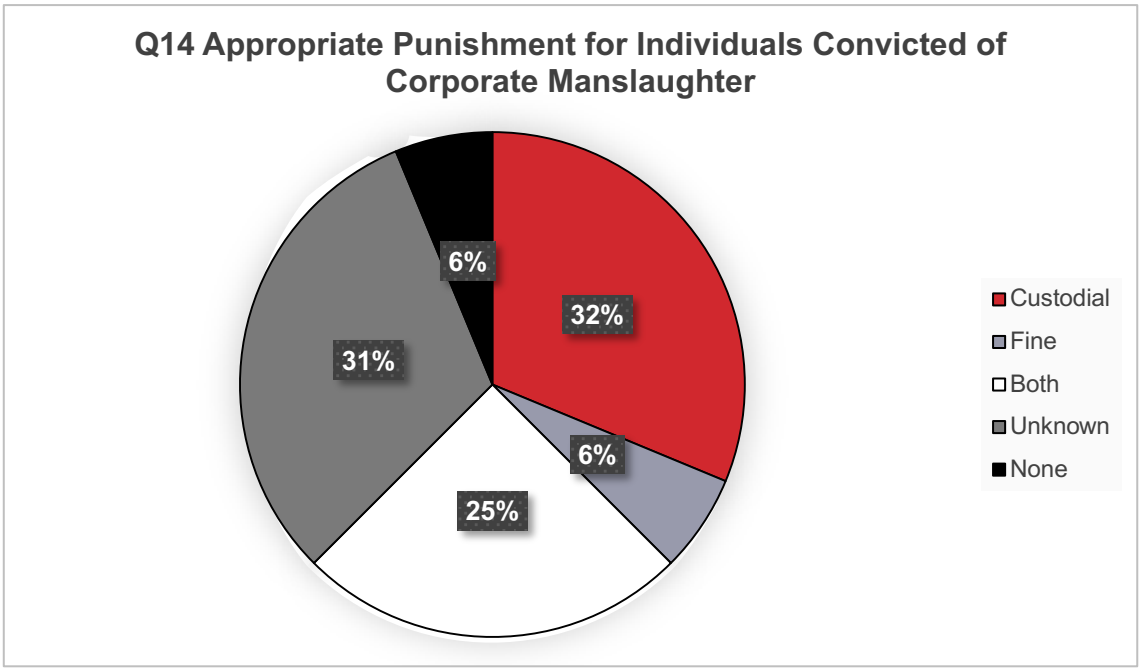

Diagram 7.12: Responses to Question 14

Of the 16 participants who answered yes to Question 13, five were of the opinion that a custodial sentence (only) would be an appropriate punishment for those convicted of individual corporate manslaughter, one was of the opinion that a fine (only) would be appropriate, and four were of the opinion that both a custodial sentence and a fine would be the most appropriate means of punishment. Five of the 16 stated that they did not know, or did not provide an opinion for Question 14.

One response presented as an anomaly to the data due to the participant believing that, although individual liability for corporate manslaughter would be effective at ensuring ISM compliance, and they in fact supported the introduction of it, they did not believe in punishing those who "accidentally" caused a person's death, as in the case of manslaughter (corporate or otherwise), but only those who intentionally caused the person's death, as in the case of murder. As a result, only 15 of the responses were deemed appropriate for consideration in the analysis of Question 14.

For the five participants who were of the opinion that a fine would be the best form of punishment for those convicted of an individual offence of corporate manslaughter, there was a broad range in terms of the amounts suggested; the lowest amount was £1,000 and the highest was £500,000. There was one suggestion of £5,000 and two suggestions that referred to fines based on a percentage of the ship company's profits, i.e. the individual's employer would be liable to pay the fine, which would suggest some form of vicarious liability. One participant (a maritime specialist) suggested that an appropriate level of fine would be:

> "A percentage of gross profit – e.g. 100% of gross profits for the year in which the incident occurred or an average of the previous five years."

Another, also a maritime specialist, suggested that:

> "The company must be fined at a level that ensures that it won't make the mistake again, but is not putting people jobs at jeopardy due to collapse of the company or a lack of liability insurance. So, the level of fine would depend on the structure and size of the company."

This latter suggestion is certainly well argued and well supported by the legal and academic community, and is in line with the Sentencing Council guidelines, as discussed in the previous chapter.

For the nine participants who were of the opinion that a custodial sentence would be an appropriate form of punishment, eight specified a term in number of years and one merely made a comment that if a member of senior management was identified as being liable, they should receive a custodial sentence, but no figure was provided as part of this response. Therefore, eight numerical values were considered as part of the data analysis.

Numerical Value (Years)	Number of Responses
20	1
10	3
7	1
5	2
0.5	1

Table 7.8: Breakdown of Responses Relating to Custodial Sentences for Question 14

The most popular responses were 10 years and five years, and the average was calculated at 8.43 years.

After considering the various responses received for Question 14, the author chose to amend the sentencing levels proposed in the previous chapter, in order to take participants' suggestions into consideration, as well as the author's evolved understanding.

Culpability Level	Original Starting Point	Original Category Range	New Starting Point	New Category Range
High	14 years	10 years – life	**10 years**	**8 – 15 years**
Medium	7 years	4 – 10 years	**6 years**	**4 – 8 years**
Low	2 years	1 – 4 years	**2 years**	**0.5 – 4 years**

Table 7.9: The Author's Revised Proposed Table to Use When Sentencing Individuals for Section 2 Offences

These new sentencing levels, it is suggested, though not making any significant changes to the medium and low levels of culpability, do make a significant change to the high culpability level by, most notably, removing the possibility for a life sentence being imposed (as is possible for convictions of gross negligence manslaughter). This, it is suggested, would better reflect the nature of the proposed offence; imposing a harsh but appropriate punishment, whilst also acknowledging that the mental element of the proposed offence is not at the same level as manslaughter or murder.

QUESTION 15

Question 15 asked participants if they had any suggestions for better alternatives for improving ISM implementation. The author identified five main suggestions from the responses received.

One suggestion related to the 'training' of seafarers and on-shore personnel. Four participants (two academics, and two seafarers) argued that "better implementation [of the Code] means well-trained, well-motivated, carefully-selected employees." It was suggested that this training would come in the form of the individual's initial training at seafarer schools/colleges, and then regular follow-up training to be organised/delivered

by the ship company. This would be akin to the education, training and continuing professional development of lawyers. It was also suggested that organisations such as the Nautical Institute should take a more active role in the deliverance of this training, as well as the auditing of other training providers.

The most popular suggestion related to ISM 'auditing', and was put forward by five participants (two maritime specialists, one academic, one FSA employee, and one seafarer). It was stated that the internal auditing by ship companies needs to be improved throughout the maritime community, including more regular reviewing of the SMS, "so that it remains a living and relevant document." This would involve raising awareness as to the importance of regular reviews, so as to encourage the adoption of a safety culture, as well as providing financial incentives for doing so. One participant suggested that "the introduction of heavy fines for ISM-related deficiencies found during [external] audits" would serve to "attract the attention of [ship companies] and force them to increase their standards." When combining these two suggestions together, a strong recommendation is proffered, and a one that is worthy of consideration by PSC regimes (as it would need to be implemented at the regional level).

It was further suggested that in order for ISM audits and inspections to be effective at improving maritime safety, Flag State Administrations, or the Recognised Organisations (Classification Societies) acting on their behalf, should be (criminally) liable for their audits/inspections. One maritime specialist criticised some Classification Societies for:

> "feeling that they give a very good service to the ship company (in a marketing sense) by only stating 'non-conformities' and comments, rather than stating 'major non-conformities."

This criticism is aptly supported and expanded upon by the other maritime specialist, who stated:

> "A party which is never held accountable is the Flag State Administration, which supposedly verified and audited the SMS and issued the DOC and SMC, but they are protected by Sovereign Immunity. However, in the majority of cases, the verifications and audits, and even the issuing of certificates, had been carried out by Recognised Organisations – invariably Classification Societies – which should not be able to hide behind any sovereign immunity defence. If it was established that the fatality – or even accident – was a result of a DOC/SMC

being issued for a SMS, which was seriously defective – then the Recognised Organisation should be included amongst those being held accountable and prosecuted accordingly."

Whilst Classification Societies receive full relief (immunity) from legal liability in most States, the UK holds a different position. Whilst the case of *The Nicholas H*[877] decided that Classification Societies are immune from civil liability for the physical loss of a ship where a certificate is wrongly issued, the case of *Perrett v Collins*[878] 'opened the door' for future cases in holding Classification Societies (civilly) liable for personal injury or death resulting from wrongful certification.

In *Perrett*, two companies that inspected and certified an aircraft as being in an airworthy condition and fit for flight, were held liable when the aircraft crashed and injured the plaintiff as a result of it being unairworthy. Whilst this case does not concern ship Classification Societies, the judgment refers broadly to the role of inspectors voluntarily assuming responsibility, and therefore liability, for certifying class. This case could, therefore, be applied in a maritime context, in much the same way as it has been in other industries.[879] However, this case would not extend a Classification Society's liability to criminal liability.

It is suggested that the UK's approach is preferable, but criminal liability should also be extended in instances of death (and personal injury). By issuing ISM certificates, the Classification Society is declaring that the ship company is in compliance with the ISM Code's requirements. It is therefore fair, just and reasonable that it be held accountable when this declaration is given in error, whether negligently or otherwise. If Classification Societies had to accept legal responsibility for their actions, it would increase their credibility and serve to ensure that their auditing is more thorough, thus providing more accurate information on the company's implementation of the ISM Code, and further encouraging a safety culture.

Another suggestion, made by two participants (both maritime specialists), was that 'naming and shaming' those ship companies who knowingly fail to implement the ISM Code would serve as an effective deterrent because it would adversely affect the

[877] Marc Rich & Co. A.G. and Others v Bishop Rock Marine Co. Ltd [1996] AC 211.
[878] *Perrett v Collins* [1998] 2 Lloyd's Rep 255.
[879] See, for example, *Watson v British Boxing Board of Control Ltd* [2001] QB 1134, where certification was within the sport industry.

company's reputation and, ultimately, its business/trade. This would give ship companies a further incentive to implement the Code fully.

These suggestions all have merit, and they could all potentially work *alongside* (emphasis added) the author's proposed corporate manslaughter offence (as contained within the thesis hypothesis) to effectively improve maritime safety within the international maritime community. Once again, all are worthy of consideration for any future research projects, as well as implementation by relevant regional and national administrations.

QUESTION 16

For the final Question, participants were given the opportunity to provide comments/feedback regarding the ISM Code, its implementation, or corporate manslaughter. Of the 25 survey participants, 16 chose to respond. From these responses, the author identified three main themes, all of which proved useful to the quality of the research.

Firstly, three participants (two maritime specialists, and one on-shore manager) commented that when accidents and fatalities do occur, in most cases the ship company, which is "far better equipped to fight than the master", shifts blame onto the master and so the company escapes liability. One participant described this situation as "hiding the guilty and offering up scapegoats at a low enough level to satisfy legal bloodlust." This quote aptly summarises a concern that is prevalent in the maritime community, and it echoes the author's point made in the previous chapter, as well as that of the Skagerrak Foundation. It is something that certainly needs to be addressed by the maritime community and by Flag State Administrations.

Six participants (three maritime specialists, one FSA employee, one on-shore manager, and one seafarer) stated that they were in full support of the thesis hypothesis. In particular, the seafarer stated:

> "I see no issue in linking [the] ISM Code with Corporate Manslaughter Legislation. […] Corporations and individuals should be liable for human loss. Of course, only the court should have the right to judge if a death at sea is a crime liable under corporate manslaughter or a simple, unavoidable accident. If

> the system is not working, it's not implemented or it's fake, the liability should be extended to the auditors, the issuers of the DOC/SMC certificates."

Furthermore, one maritime specialist stated that:

> "Adding the threat of corporate manslaughter to a ship company's senior management […] would probably make life at sea *much safer*."

7.3.7 SURVEY CONCLUSIONS AND FUTURE RESEARCH

The survey has proved valuable in testing the author's theories and supporting the thesis hypothesis. Participants felt that the ISM Code has had a positive impact on both the international maritime community and the UK maritime industry. Although the majority opinion of the participants was that the overall standard of ISM implementation has improved since the Code initially came into force, and this contrasts with the author's theory regarding ISM complacency, evidence actually suggests that implementation is in fact waning. The thesis hypothesis, on the other hand, is well supported by the survey. A great majority of participants felt that individual liability for corporate manslaughter would be effective at encouraging better ISM implementation and the adoption of a safety culture. Furthermore, participants supported the author's proposal for punishing those individuals convicted of corporate manslaughter with a custodial sentence. The responses received for this part of the survey prompted the author to reconsider and amend the original sentencing levels proposed in support of the thesis hypothesis.

Whilst the survey has proven useful in supporting the thesis hypothesis, due to its limitations, certain issues have emerged that prompt further academic consideration and research. Most notable of these issues is whether perceptions relating to ISM implementation are accurate in terms of reflecting actual standards of implementation, and whether this in turn affects the international maritime community's safety culture. It is further hoped that the author's theories and research are developed into a large-scale research project, which examines the potential for individual liability for corporate manslaughter affecting compliance with the ISM Code and the adoption of an enhanced safety culture within the international maritime community.

CHAPTER 8
THESIS CONCLUSIONS

8.1 GENERAL CONCLUSIONS AND RECOMMENDTIONS

In this research project, the author has critically examined the two significant pieces of legislation that were developed in response to the *Herald of Free Enterprise* disaster and the subsequent failed prosecution of P&O for corporate manslaughter: the IMO's International Safety Management (ISM) Code 2002, and the UK's Corporate Manslaughter and Corporate Homicide Act 2007.[880]

Firstly, the principles and objectives of the ISM Code provide an international standard for the safe management and operation of ships, and there is no doubt that it has had a hugely-positive impact on safety throughout the international maritime community; with a noticeable improvement in safety standards, and a marked reduction in the number of maritime disasters and recorded fatalities. The reason behind the Code's success is that it unprecedentedly demanded a change in behaviour from the community's key players. The success of its implementation depends, to a great extent, on the continued commitment, competence, attitudes and motivation of *individuals* at all levels.

Research shows that where the ISM Code has been embraced as a positive step towards a safety culture, tangible positive benefits are evident. However, whilst there is no doubt that the Code has proven successful, research has revealed that there is now a problem with waning enthusiasm when it comes to the implementation of the Code, which is resulting in complacency. It is this ISM complacency that is adversely affecting the enhanced safety culture that the ISM Code aims to create and maintain.

This complacency with the ISM Code, and safety in general, is allowing for unsafe acts and conditions to exist on board ships, which are going uncorrected by the ship company, and which are resulting in serious accidents and fatalities.[881] In some cases,

[880] Herein referred to as the 'Corporate Manslaughter Act'.
[881] See Anderson's Safety Triangle in the Chapter 1 of this thesis.

the culmination of these unsafe conditions is causing maritime disasters, such as the *Costa Concordia* disaster in 2012.

The author undertook a detailed analysis of two important post-ISM maritime disasters: the *Sewol* and the *Costa Concordia*. Whilst the *Sewol* was not bound by the ISM Code's requirements, the South Korean Government has since recognised the importance of having in place a system of safety management for *all* ships, and not just those engaged in international voyages. As a result, it instigated a program of legislative and political reform in order to enhance safety within the country's maritime industry. Furthermore, the South Korean courts' handling of the culpable parties is to be respected. The ship's operating company, its corporate individuals, and the master and crew were all held accountable, and punished harshly and appropriately for their respective roles in the disaster. The sentences, and the new legislative reforms, serve as an effective deterrent in South Korea for the operation of unsafe ships to *all parties* concerned. This is a welcomed move, and an example of a good and developing safety culture for the international maritime community. However, the situation in South Korea is to be starkly contrasted with Italy's handling of the *Costa Concordia* disaster.

Due to Italy failing to incorporate the ISM Code into its domestic legislation effectively, the inquiry into the disaster, the courts, the prosecution and the defence lawyers in the case, all ignored the Code when judging the actions of the *Costa Concordia*'s owners, and its master and crew. With this ignorance, the opportunity to take advantage of the Code and to demonstrate its value has been lost. This is disappointing when it is considered that one of the international maritime community's expectations from the ISM Code was that it would shape legal decisions in key cases such as this one; ascribing duties, liability and accountability between the ship company and its on-board crew.

The issue of ISM complacency is a global problem, apparent throughout the international maritime community, and it needs to be addressed by the community at the Flag-State level, and with encouragement, support and coordination from the IMO. If Flag States fail to incorporate the ISM Code into their domestic legislation adequately, and/or fail to ensure (through national courts) that it is being implemented by the Flag State Administration and those companies operating ships within the Flag State, then the Code will fail; amounting to a mere symbolic gesture, with no bite in legal practice.

This will only serve to undermine the ISM Code, increase complacency, and thus result in the number of recorded accidents, fatalities and disasters increasing.

However, whilst it is accepted that some Flag States, such as Italy, have failed to incorporate the ISM Code into their domestic legislation adequately, and this is a problem that needs to be addressed by the IMO, these are isolated instances and are therefore exceptions to the norm. Research suggests, rather, that ISM complacency is due to ineffective implementation of the Code by ship companies, and the individuals within those companies, including 'corporate individuals' and seafarers; not the Flag State itself. The main reason why ISM complacency is allowed to increase, research suggests, is due to the lack of 'effective, proportionate and dissuasive' penalties for those individuals who fail to implement/comply with the Code fully.

It was the focus of this research project to consider how potential legislative measures/reforms could be used by the UK alongside the ISM Code to impose an appropriate punishment on those ship companies, and their corporate individuals, when death(s) occur on board ships as a result of their failure to implement/comply with the Code fully.

The UK, as a member of the EU, is obligated to lay down 'effective, proportionate and dissuasive' penalties by virtue of Regulation (EC) No 336/2006. However, the author is of the opinion that the penalties adopted by the UK in the 2014 ISM Regulations fail to satisfy this obligation fully. This failure is even more apparent when having regard to the punishment imposed when a death is caused as a result of a failure to implement/comply with the Code.

Therefore, when considering potential action to the be taken by the UK to improve upon the penalties laid down in the 2014 ISM Regulations, and in order to adopt true 'effective, proportionate and dissuasive' penalties for deaths at sea, the author had regard to the Corporate Manslaughter Act; this Act being enacted in response to a number of disasters where subsequent inquiries found corporate bodies (and corporate individuals) responsible, but where the law was incapable of convicting them for corporate manslaughter. The most notable of these disasters was that of the *Herald of Free Enterprise*.

A detailed analysis of the Corporate Manslaughter Act revealed that, whilst it has had some initial success with regards to convicting companies, this success was slow to begin with, and all of the companies convicted under the Act have been relatively small in terms of management structure and, therefore, it was easy for the Crown to prove the elements of the offence and secure the convictions.

Furthermore, although the Government's decision to enact the Corporate Manslaughter Act was driven by a public perception of injustice that resulted from the Crown's failure to obtain a corporate manslaughter conviction for P&O, and its corporate individuals, for the deaths resulting from the *Herald of Free Enterprise* disaster, the final Act specifically excludes individual liability for corporate manslaughter in any form. This has resulted in the Act being ineffective, both as a form of punishment and as a form of deterrence for individuals. The Corporate Manslaughter Act therefore fails to deliver on the Government's promise to enact effective legislation that appropriately punishes those responsible for corporate manslaughter, and that serves as a sufficient deterrent for those companies who fail to meet proper standards of safety.

The author has argued that legal reforms to the Corporate Manslaughter Act are necessary in order to prevent corporate individuals from hiding behind the 'cloak of organisational liability'. In acknowledging that the Corporate Manslaughter Act falls short in meeting the public's expectations, the author has outlined proposals for the inclusion of secondary individual liability in a 'Proposed and Improved Corporate Manslaughter Act', as well as considering 'effective, proportionate and dissuasive' penalties for the offences proposed. With regards to ship companies, these proposed reforms would work alongside the ISM Code in order to harshly and appropriately punish those ship companies and corporate individuals (including ships' masters) for deaths at sea that were caused by the breaching of necessary safety barriers. This interaction between the two legal instruments would consequently serve as an adequate deterrent and so ensure that ISM complacency, and complacency with maritime safety in general, is replaced with an effective safety culture in the UK maritime industry.

For the final part of the research project, the author tested the thesis hypothesis that had developed and evolved through the course of the research. This was achieved through academic consideration of how the ISM Code could have prevented the *Herald of Free Enterprise* disaster in a hypothetical context, and how the author's Proposed Act, and

the penalties proposed in support of the thesis hypothesis, could have been used, had the disaster still occurred, to successfully and appropriately hold the operators of the *Herald* and its corporate individuals accountable for the 192 deaths.

The thesis hypothesis was further tested through the use of a survey. Whilst the reliability on the survey data is limited, the thesis hypothesis was well supported. Furthermore, the majority of survey participants fully supported the author's proposal for individual secondary liability for corporate manslaughter, and the proposed method of punishment in support of the thesis hypothesis. However, participants' responses prompted the author to review and subsequently revise the levels of sentences proposed. The revised levels better reflect the nature of the proposed offence; making a clear distinction between it and those of manslaughter and murder.

This thesis has identified potential provisions relating to primary corporate liability and secondary individual liability for corporate manslaughter. If these provisions were to be included in any reform package of the Corporate Manslaughter and Corporate Homicide Act 2007, it would serve to fill a gap in the law. This gap has existed since the failed prosecution of P&O in 1990.

For the maritime industry specifically, these provisions would encourage more effective implementation of the ISM Code. Such implementation would have a positive impact on safety, by appropriately holding to account those responsible for operating unsafe ships, and any resulting fatalities. In turn, it could reasonably be asserted that this would deter ISM complacency and so encourage the ISM Code's intended safety culture.

8.2 THE LIMITATIONS OF THIS RESEARCH PROJECT, AND POTENTIAL FUTURE RESEARCH

Whilst the author's theories and the thesis hypothesis are well supported by the research (i.e. the hypothetical *Herald of Free Enterprise* scenario case study and the survey undertaken), there are limitations to this research project

Firstly, the UK, with a reputation of being one of the safest maritime States in the world, does not present a huge concern with regards to on-board fatalities and disasters, and therefore the need for reform in the UK could be questioned. However, research undertaken by the author (and others) would suggest that ISM complacency is present in the UK maritime industry and, furthermore, that the culmination of unsafe acts and conditions as a result of this complacency will inevitably lead to a fatality or a maritime disaster.[882] Therefore, the UK's efforts on the international stage should be directed towards lobbying for the improvement of ISM implementation, in the same manner as when it lobbied for the adoption of the ISM Code.

The second limitation relates to the Proposed Act itself. Whilst the proposed reforms to the Act outlined in this thesis would affect the criminal liability of all UK companies (and their corporate individuals), and not just ship companies, this research project has focused entirely on how the proposed reforms would effect change in the maritime industry. However, the author has acknowledged that the proposed reforms would have a desired effect on all industries within the UK.[883]

The third limitation of this research project concerns the question of how reforming the UK's Corporate Manslaughter Act, so as to improve ISM implementation within the UK maritime industry, could affect maritime safety within the international maritime community.[884] The author acknowledges that the incorporation of the ISM Code into domestic law is the responsibility of each Flag State, and it is for each Flag State to decide on the measures it adopts in order to ensure that those ship companies operating within its jurisdiction implement and comply with the Code fully. However, action taken by the UK has, in the past, influenced the development of regional and international law and policy.

The fourth limitation relates to the author's reference to statistics relating to maritime deaths and their relation to maritime disasters. Any disaster will significantly affect the total number of maritime deaths recorded for that year and, therefore, it could be argued that the number of deaths recorded is dependent upon the size of the ship involved in the disaster. However, the two disasters examined as part of this research project would

[882] See Anderson's Safety Triangle in the introductory chapter to this thesis.
[883] See Chapters 5 and 6 of this thesis.
[884] This question was raised by one participant in the survey, as discussed in the previous chapter.

dispel this argument. Furthermore, the apparent trend/increase in maritime deaths, regardless of the number of incidents or the size of the ships involved (where a maritime disaster is the cause of death), is indicative of an increase in non-compliance with safety, and therefore supports the theory that complacency is a causal factor.

The final limitation relates to the testing of the thesis hypothesis. Although trends in the opinions and perceptions of the survey participants have been identified, due to the nature of the survey and the limited number of participants, accurate statistical generalisations are not possible from the survey data. In order to state such generalisations with a degree of accuracy and certainty, a large-scale survey-orientated research project would need to be undertaken, similar to that undertaken by Anderson in 2002[885] or the IMO[886] in 2005. The author would fully welcome and support any such future research projects.

[885] P Anderson, 'Managing Safety at Sea' (DProf Thesis, Middlesex University 2002).
[886] MSC 81/17/1, Role of the Human Element: Assessment of the impact and effectiveness of implementation of the ISM Code (The International Maritime Organisation 2005).