A CRITICAL ANALYSIS OF VICTIMS' EXPERIENCES AND STATE RESPONSES TO A CORPORATE KILLING

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Contents:

Abstract

An explicit starting point for this research is to give a voice to the experiences of the victims of safety crime. The accounts of such victims are missing from the criminal justice arena and academia. This research will attempt, in part, to fill the gap in the following ways.

First, the longstanding separation between safety crime and 'real' or 'traditional' crime is both reflected and *institutionalised through* state responses to the offences committed by corporations. This research offers a critical analysis of the social, legal and political obstacles that victims of safety crime face.

Second, the *effect of this process on secondary victims*[1] *is* examined. The deaths of their loved ones are, in the first instance, framed as 'accidental'. The families are an obstacle to the corporations, as they seek to hide or manipulate the truth in the pursuit of their innocence. This is enabled by legal and political processes, which make justice an almost impossible achievement. The thoughts of the families and the long-term impact this has on their lives is explored in detail.

The final part of this research is focused on the aims, nature and success of the various groups created in *response* to the reaction of the criminal justice system following a corporate killing. The visibility of the corporate accountability movement, mounted from the late 1980s against the victimisation of workers, raises questions for future research. It concludes with a discussion of how this situation has altered and the potential site for change in the future.

Safety crime in the UK and worldwide, is a regular occurrence, yet popularly and politically, safety crimes are comparatively

[1] As is the nature of a corporate killing, it is the families of the victim who experience official and unofficial responses.

invisible. Through the experiences of secondary victims, who are neither represented nor treated as real victims, this thesis offers an original contribution to the understanding of how this happens, the effects and the response.

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Abbreviations:

ATP	Automatic Train Protection
CBI	Confederation of Business Industry
CCA	Centre for Corporate Accountability
CPS	Crown Prosecution Service
CSC	Construction Safety Campaign
DA	Disaster Action
DTI	Department for Transport and Industry
FACK	Families Against Corporate Killers
FLO	Family Liaison Officer
HASAW	Health and Safety at Work Act
HFA	Herald Free Enterprise Association
HSC	Health and Safety Commission
HSE	Health and Safety Executive
MODACE	Management of Disasters and Civil Emergencies course
NAO	National Audit Office
NICE	National Institute for Health and Care Excellence
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROSPA	Royal Society for the Prevention of Accidents
RTA	Road Traffic Accident
SAMM	Support After Murder and Manslaughter
SJMC	Simon Jones Memorial Campaign
TUC	Trade Union Congress

Introduction

Interests and aims

The aim of this chapter is to introduce the topic of this research. The main research aims and initial questions of each chapter will be outlined.

There is a lack of academic research into the experiences of those bereaved by safety crime. There has been no research published (to the best of my knowledge) which details the actual response *of* the criminal justice system in the UK to a safety crime and how that impacts on bereaved families. Following a safety crime, it is the loved ones of the victim who deal with bereavement, and all that this entails, as well as an official response that, this research will argue, is designed to either minimise or deny them of their victimhood.

To attend to this gap, this research will trace the experiences of the families of victims of safety crime as they are processed through each stage of the criminal justice system. This is a process that enables corporations to maintain their innocence and ensures justice is almost impossible, which causes long-term pain to such secondary victims. Their experiences of the police, Health and Safety Executive (HSE) and the legal system will be sought in order to collect in-depth qualitative data.

In addition, this research will examine the origins, nature and aims of the corporate accountability movement that began at the end of the 1980s. Various groups were created in *response to* the criminal justice system by secondary victims and are a site of struggle for change. Each group that formed part of this movement has been described by their members in a plethora of ways. For example, the members of one group covered in this research, Disaster

Action, described it as an "organisation" (Eyre and Dix, 2014: 11), a charity and a "special kind of family" (ibid: 14). It was created out of a combination of "family and support groups" (ibid: 12), "self-help support and action groups" (ibid: 19), "trusts" (ibid: 27), "associations" (ibid: 28) and "action groups" (ibid: 20). For consistency, I have chosen to focus on groups who share the goal of supporting and working to alter the representation and treatment of the victims of corporate and safety crimes. Each group chosen was highly visible in the corporate accountability movement.

By combining experiences of how secondary victims of safety crime are dealt with, and respond to, the criminal justice system, this research provides a unique attempt to excavate subjugated knowledges and experiences. Their experiences are present in academia but remain as part of a small proportion of criminological literature. It is crucial that this changes, as one bereaved mother asked, "how do you get your voice heard when no one will let you (1)[2]?" It is the responsibility of academic research to document how she and others are silenced, the effects of this and whether this can be challenged collectively.

As a link to contextualise why this research was undertaken (Okely and Callaway cited in Punch, 1998) it is easy to locate and recall where my interest in safety crime began. As part of a module called 'Introducing Criminology', one lecture on white collar and corporate crime explored the death of Sidney Rouse as documented in David Bergman's book, *Deaths at Work* (1991). In 1988 Sidney Rouse was digging a trench prior to the installation of a gas main under a pavement (ibid.). The obvious risk of hitting pre-installed electric cables was negated by the checking of a 'ways' and 'mains' map. However, the ganger supervising Sidney Rouse's work had only been given the 'ways' map (ibid). In good faith, Sidney Rouse worked until his spade struck an underground electric cable. The subsequent electric shock subjected him to suffer 80% burns. Sidney Rouse was taken to hospital where he

[2] See Appendix 6 - 8

died after a week, his sister reflected, “The worst thing about it was to see him in hospital for over a week. He was in a terrible condition” (ibid: 7). Following his death, an inquest returned a verdict of ‘accidental death’, the Crown Prosecution Service (CPS) decided not to prosecute the corporation for manslaughter and the HSE also decided not to prosecute for health and safety offences (ibid.). Bergman evaluated that these decisions were taken as a result of “a defective and ineffectual inquest”, due to “an entrenched and arbitrary bias” and because of “a lack of political will to enforce legislation” (ibid: 8). Consequently, Sidney Rouse’s sister did not see any justice in the months and years after her brother’s death.

As an undergraduate, I was shocked at the Sidney Rouse’s unnecessary death and the frivolousness with which it was treated. I thought of my father and partner who worked hard in similar work and how I had assumed they were protected, but after that hour long lecture, I knew they were not. No matter how I tried to reconcile it, I was unable to view what happened to Sidney Rouse as an accident. It was one introductory lecture in a series that semester and whilst most of my peers chose to return essays based on serial murder, I focused on corporate and safety crime. Somewhat unsurprisingly, I was penalised for writing more than 10% over the required word count on the essay I returned on the topic.

The aims of this research originate from questions that have perplexed me since that introductory lecture; what is complicated about convicting corporations that is simple when convicting individuals? Why is it not instantly recognisable as a crime? Why are criminologists largely preoccupied with such a narrow definition of crime to the exclusion of safety crime? Who is guiding whom? Why, when I asked solicitors which section of law I could work for that prosecuted corporations for criminality was I greeted with a puzzled look when there is an area of law dedicated to *helping* corporations? My interest did not originate with trying to find fault in the state or to join a ‘moral crusade’ (Shaprio,

1983) but out of curiosity, to find answers to questions I had not realised were questions prior to that introductory lecture.

The context of the social movement

Some of those questions had been taken up by a number of groups from the late 1980s. These groups were created in response to both public disasters, such as the sinking of the Herald of Free Enterprise and deaths of individuals at work, such as Sidney Rouse. Their significance will be contextualised below.

In what Eyre and Dix (2014) referred to as a 'decade of disaster', the 1980s saw a number of tragedies, which included the Bradford fire, the Lockerbie air disaster and the sinking of the Marchioness. The amount of fatalities, the traumatic nature of the deaths, the testimonies of the victims and the plight of the families all meant such disasters were prominent in the media. The widespread use of dramatic images of the Hillsborough football stadium crush and the wreckage of Pan Am 103 spread across Lockerbie meant such disasters became part of public consciousness. In the aftermath, the families of those who died and the survivors found themselves facing problems "thrown up by...mismanagement" (ibid: 19). In response, groups such as SciSafe, the Derbyshire Families Association and Herald Families Association were created (ibid.). Groups representing the victims of disasters highlighted the lack of justice in each of their cases.

Unlike in public disasters, the loved ones of those killed at work were and still tend to be, isolated families. In the 1980s individuals fought their own cases, seemingly as 'one offs'' with the exception of disasters such as Piper Alpha and Bhopal. Just as the families of victims of disasters share a common bond, so do the families of people killed at work. They are disadvantaged because they are fragmented across time and spread geographically and in order to reach others in similar situations, such individuals need representation. In the early 1990s, groups active in the area of worker safety began to mobilise, groups that included the London

Hazards centre, the Construction Safety Campaign (CSC) and the Centre for Corporate Accountability (CCA).

In 1994 David Bergman wrote, "Health and safety campaigners have for many years argued that the criminal justice system has failed to treat deaths and injuries at work – unlike deaths in almost any other setting – as the possible outcome of serious crimes" (1994: 3). By the early 1990s, there was a wealth of evidence available which pointed to the inadequacy of the law in dealing with workplace deaths. This began to be highlighted by the aforementioned groups. For example, in 1994 the Hazards Campaign reported that whilst over 200 people had been convicted of manslaughter in an average year, only one person had ever been found guilty of manslaughter following a death in the workplace (ibid.).

Along with the publication of statistics in the 1980s and 1990s, details of individual cases began to gain a degree of visibility. A notable example is the case of Paul Elvin who was fatally electrocuted when an aluminium pole he was carrying touched overhead cables at Euston Station. In 1995, his mother, Ann Elvin published *Invisible Crime*, which she describes as "The true life story of a mother's fight against the government's cover-up of workplace manslaughter" (1995: 3). She documents how for six years, her and her family fought for justice because her son was "murdered legally" (ibid: 5). Ann Elvin's aim in publishing *Invisible Crime* was to "give [her son] the right to truth" and the hope that "other families fight back" (ibid.). The book includes the details of the case, copies of the original relevant documents and information for families to use to fight their cases.

When a number of groups were established by those bereaved following a violent death in the mid-1990s, Rock (1998) noted it represented "the beginnings of a new social movement and a new identity" (1998: x). Similarly, a movement calling for the accountability of corporations began to gather pace in the late 1980s, thanks to the efforts of the families, the workers and

representatives of some of the groups mentioned above. It was in 1988 that the term, 'corporate manslaughter' was first used in the Guardian newspaper, reflecting a growing public awareness of the crime (Tombs and Whyte, 2003).

The uncovering of crimes committed by corporations and state agencies has continued up to the present day. For example, it is pertinent that throughout the duration of this research, the full scale of injustice suffered by the families and individuals associated with the Hillsborough stadium disaster has come to the fore publicly. After a long campaign of more than one group, high profile fundraising, academic publishing and activism, the truth was finally recognised publicly in a reopened inquest in 2016. Phil Scraton's book (first published in 1999), *Hillsborough, the Truth*, sums up how the aftermath of Hillsborough starkly demonstrates how: "the 'law' fails to provide appropriate means of discovery and redress for those who suffer through institutionalised neglect and personal negligence" (Scraton, 2009: 17). Scraton dedicates the book to the bereaved families and survivors writing:

> …it was your determination that persuaded the Government to appoint the Hillsborough Independent Panel and facilitate the disclosure of all documents held by relevant organisations involved…your continuing struggle for justice in the face of adversity and desolation (2016: 10).

As in the case of Hillsborough, there is no doubt that groups created to support and campaign for change can have a real impact on the status quo. This research will examine the groups that mobilised in response to corporate killing as part of the longstanding effort to have safety crime recognised since the 1980s and 1990s.

Recognising safety crime in Criminology

Safety crime originates from an attempt to categorise different types of corporate crime, categories which are usually based on the type of law that should deal with the offence and the nature of the victim involved (Slapper and Tombs, 1999). In *Corporate Crime* Slapper and Tombs note four sub-categories of corporate crime. This research focuses on the second category, crime that arises out of "the employment relationship…crimes against employees…by employers" (ibid: 45). In outlining this sub-category, Slapper and Tombs cite the work of Carson (1980, 1982), Bergman (1991, 1993, 1994), Pearce (1990b; Pearce and Tombs, 1993, 1997), Slapper (1993), Wells (1995) and Box (1983), all of whom use characteristics of what they term "health and safety crime" (Slapper and Tombs, 1999: 46).

In 2007, Tombs and Whyte wrote *Safety Crime*, dedicated to the subject of the "violations of law by employers that either do, or have the potential to, cause sudden death or injury as a result of work-related activities" (Tombs and Whyte, 2007: 1). This they defined as safety crime, cementing the importance of the sub-category, refining two features. Firstly, the authors emphasise the 'safety' rather than the '*health* and safety' element identified in *Corporate Crime* in 1999. Tombs and Whyte reason this is because the victims of safety crimes are "immediately apparent", for example, when a worker is killed in a factory as a result of their employer violating the law. This is in contrast to many victims of health crimes who are created over a long period of time, for example the latency period of mesothelioma caused by exposure to asbestos is 20 to 50 years (The Mesothelioma Center, 2017), which "makes the burden of proof a difficult one for victims" (Tombs and Whyte, 2007: 4). This complicates both the enforcement of health crime and its measurement, and although the authors note it is still as socially important as safety crime, to study it requires a different approach, certainly from the study of safety crime (ibid.). Secondly, using the Health and Safety at Work Act (HASAW 1974), Tombs and Whyte extend the remit of safety crime to include members of the public who are affected by

the “decisions and omissions” of companies as well as direct employees (Tombs and Whyte, 2007). This covers many more victims, such as those associated with ‘disasters’, for example, the members of the public killed in the Lockerbie air disaster.

The principle aim of this research is to document the ways in which safety crimes are rendered invisible and to highlight the effect of this process on the families when they lose a loved one following a safety crime. The study of victims is crucial for criminological research and analysis, Rock argues:

> Criminal encounters should be treated as the centre of evolving webs of actors and audiences, actions and reactions, relations and meanings, that can fan out to affect the worlds and lives of people around them. Only then would it be possible to begin charting the larger social and psychological significance of crime (Rock, 1994: 8).

In the experiences of safety crime in this research, the victims have died, which makes Rock’s call pertinent. When referring to victims, this research will examine safety crime through the experiences of surviving family members, not the victim *per se*.

How safety crime is rendered invisible will be explored throughout this research in terms of social, legal and political obstacles. These strands have been chosen to reflect the position of safety crime as a social construction that “owes more to legal, social and political…modes of thought and balances of power than to any features of the events themselves” (Tombs, 1993: 332). It is a suitable categorisation to examine the process of invisibility, moving from the death of the victim to the response of the families after the legal procedure has ended.

As cases such as Ann Elvin have demonstrated so clearly, following a safety crime, families are denied the right to find out

the truth about why and how their loved one died. By documenting how the families are denied the truth they desperately need, this research seeks to answer key research questions, which are as follows:

1. What social, legal and political obstacles does safety crime face that prevent it from becoming defined and treated as a crime?
2. How are the victims and families of victims of safety crime treated by law and key institutions of the criminal justice system including the police, inquest, Health and Safety Executive, Crown Prosecution Service?
3. What effect does this have on the families of victims?
4. Under what circumstances do families of victims seek to develop more general campaigns, with what aims, and with what degrees of success?

Chapter summary

In order to answer the questions posed above, the research will be organised as follows:

Chapter One will provide a literature review on safety crimes via the historical origins of white collar and then corporate crime. Starting with a discussion of the emergence of white collar crime, it will move to focus on the development of corporate crime where the role of the corporation became explicit and included crimes as well as omissions of legitimate, formal, organisations (Pearce and Tombs, 1998). This research will narrow its range further to focus on the effects of safety crime, a sub-section of corporate crime, where employers have made omissions such as not keeping employees safe by failing to train them adequately or failed to prioritise health and safety in the face of the available evidence (Slapper and Tombs, 1999; Tombs and Whyte, 2007).

In accordance with the first strand, socially, safety crime is costly and prevalent, but there has been little consideration paid to the victims. Part of this is due to the success of deflecting the existence of the number of victims that already exist, removing them from mainstream law and order and denying them legitimate victim status. This process will be explored, detailing work that

has been carried out to illuminate the extent of corporate and safety crime. There will then be an examination of the inclusion and exclusion of it as a subject in academia. A lack of victims also implies a lack of offenders. How corporations have deflected criminal status, including who has the power to define this, will be reviewed.

To examine the legal obstacles a safety crime, a sub-section of Chapter One will look at the law that governs corporations. It will attempt to show that whilst it exists, the law is designed not to work (Punch, 2009), since many corporations that are charged, are acquitted. The reasons for this are discussed, followed by a review of The Corporate Manslaughter and Corporate Homicide Act (2007).

The main response of the state to the threat of, or following a safety crime, is regulation. In a climate where "elf and safety" is laughed at and seen as ridiculous (Jones, 2014), the origins of such regulation will be outlined. The context and development of the HSE will be detailed beginning with the Factory Acts. Key events such as the Robens Report will be noted together with the impetus for the Health and Safety at Work Act (1974). The relevant developments of the law will be examined.

The law that controls and prohibits corporations has matured at a much slower rate than those which protect it. Punch (2009: 52) concluded that although we assume laws are created to convict, laws such as those purported to control corporations are never intended to be "enforced or are unenforceable". As Bergman (1991) noted, from 1982 to 1991 one director was charged with manslaughter in spite of 4217 deaths during the same period. The statistics have changed since 1991, details of how and the extent to whether this has improved will also be discussed.

With every victim of safety crime, there is a family of that victim. Critical victimologists focus on the construction of the victim, which is where this research is to be placed. The hierarchy of

victimisation will also be explored in Chapter One through the concept of the ideal victim before going on to focus on the state as a perpetrator of harm to the families of victims of corporate and safety crime. The 'ideal' victim (Christie, 1986) who is deserving of support is unrepresentative of victims in general, yet policy and services continue to perpetuate this myth and prioritise the treatment of this stereotypical victim, ignoring the reality.

The final strand examines the political obstacles. In the final part of Chapter One, this is explored with a discussion of who is most affected by safety crime and how individuals have reacted by creating or joining groups to support others and campaign for change. Together, these groups create a social movement that pose a challenge to the dominant discourse and, in similar ways to the feminist movement, seek to change social policy. Research that has examined the impact of such a social movement on the Corporate Manslaughter and Corporate Homicide Act (2007) will be detailed.

Prior to the original research, Chapter Two explores research methodology. Issues with researching crimes of the powerful will be detailed, moving on to researching corporate and safety crime before narrowing to victims of safety crimes. Such research is a sensitive topic. The considerations of this will be explored. Epistemology and ontology will be discussed followed by details of the qualitative research methods used. Sampling techniques and ethical issues will also be discussed in this chapter, ending with personal reflections of the research process on a sensitive topic. This precedes the research itself in the two chapters which follow.

The research and original data is split across two chapters, Chapters Three and Four, which will repeat the strands identified and explored in Chapter One.

Chapter Three will focus on the way the families of the victims of corporate and safety crime are treated including an examination of the social and legal obstacles they face. There has been a lack of

research carried out on the reactions of victims to corporate crime (Stitt and Giacopassi, 1993). Using testimony gathered from families themselves, it will highlight how they are treated by official state agencies. This chapter will show how the families need for the truth is complicated, concealed and manipulated by state institutions, including the police, the HSE and the courts. The dominant oppressive social structure and the institutions that represent and act on behalf of the state will be critically explored (Harvey, 1990). This visibility of the victims of safety crime is counter to the construction of acceptable reality and because of this, the victims suffer, unnecessarily (ibid.; Scraton and Chadwick, 1991). It will evidence how the families are encouraged to see the death of their loved one as an 'accident' rather than criminal and how this suppression ensures justice is never delivered by the legal system. The narrative of 'accident' for example, leads the police to treat the immediate victim, not as a victim of a crime but as victim of misfortune. The police consequently fail to investigate, which disadvantages the stages that follow (the court and HSE investigation).

By highlighting this inequity, this chapter will document the power imbalance that occurs between the families and the corporation. A typical sign of this is the families are often unable to pay for legal representation whereas the corporations can afford to pay for multiple solicitors. The truth is obscured by the corporations and the families are almost powerless to resist. Denying and suppressing the truth is dependent upon the success with which the corporations and their legal representatives can find fault with the victim themselves. The way this is achieved de-humanises the victims in their absence and after their death. The victim is constructed as a culpable victim; a victim who is at fault for their own death and partially blameworthy. Regardless of the differences between the deaths, or the apparent strength of some cases, the entire process works to incapacitate justice and silence the families of the victim. What happens when the families attempt to counter this will be explored. By documenting the experiences of the families, this research analyses how the law

operates to provide many opportunities for the corporation to protect itself at a personal cost to the families.

Chapter Four will examine the final strand, the political obstacles. The families are silenced and are refused acknowledgement in the criminal justice process, which has long-term effects. Each family discussed in this research had their own informed ideas about what would have constituted justice. Their thoughts are detailed before moving on to look at how many families strive for justice through joining or creating groups with others. The methods they used to achieve this will be explored. This part of the chapter will build on testimonies from those who did so to propel their own cases further, as well as those who created and joined groups to support other families. Further, this chapter will include a discussion of the success of the various groups, judged firstly by the individuals involved and secondly, by any recent changes in law. It will examine the role and worth of such counter resistance when corporations and state agencies seek to preserve their status at the expense of both individuals and any social movement.

A discussion combining the previous four chapters will be offered in Chapter Five. This revisits the original research aims to consider how the invisibility of safety crime and its victims is achieved in spite of the mounting evidence that corporations commit criminal harm affecting many people. It is in the experiences of the families that the consequences of denying the existence and legitimacy of safety crime are demonstrated. The analysis of the original data will show how their suffering is tangible and that it changes their lives irrevocably. This chapter will argue that harm could be avoided or at least lessened, were the victims and the secondary victims acknowledged or treated humanely. Here, an argument will be constructed that combines the strands identified in the literature review to discuss the question of invisibility. The final part of this chapter will include an examination of whether any changes are likely as the nature of the corporation continues to grow in power and influence. This analysis will be used to determine the obstacles to, and prospects

for, a more just treatment of the victims of safety crime in the future.

The conclusion will summarise the findings of each chapter, paying particular attention to the social, legal and political obstacles that are faced following a safety crime. This chapter will ascertain how this research could add to existing literature and note areas for future study.

Chapter One

Revealing the victims of safety crimes

Introduction

This chapter is concerned with exploring the existing literature associated with white collar, corporate and safety crime. The issues raised will be explored in three strands; through the social, legal and political obstacles faced following a safety crime. Of course, these are simply one way to organise the material and, in reality there may be considerable overlap between the categories, which mutually reinforce each other.

The theme of this chapter is the invisibility and legitimacy of victims, combining two core and related strands. Firstly, the subject of safety crimes will be traced to its origins including an analysis of the development of the law. Secondly, the subject of the victim will be approached, particularly in relation to the contribution of critical victimology, before the two are combined in a discussion on the victims of safety crime; those people who are the principal focus of this research.

Situating the victims of safety crimes

The entire focus of this thesis arose from the exasperation I felt after reading one small handout which detailed "The case of Sidney Rouse" (Bergman, 1991). It appeared agonisingly obvious what had led up to Sidney Rouse's death yet even in the absence of the necessity for a complicated 'manhunt', no person or corporation was held to account. It struck me that, as a consequence of this inaction, *everyone* who worked, especially manual workers, were more at risk than I had thought

them to be. Why had I assumed everyone was safe and being protected? How was it possible that they were not? This chapter uses the existing literature to attempt to understand why the offences such as those committed against Sidney Rouse are not treated as crimes and why people are seemingly unconcerned that they are not.

Criminology, defined by the state

There has been a collective failure of criminologists to challenge political definitions of real crimes and legitimate victims. Thus "continued neglect or indifference" by social scientists towards victims "also may play a part in denying legitimacy to them and their suffering" (Shover *et al*, 1994: 96). Criminology has largely ignored the victims of the powerful and instead it has historically focused on the "problem of crime" as represented by those people who are imprisoned and regularly in contact with the police (Muncie and McLaughlin, 2001). It has "cast its gaze 'downwards'…thus, the vast majority of criminal justice is uncritical" (Tombs and Whyte, 2003: 9). For example, the questions that have been asked (or are not asked) by self-report and victimization surveys "do not start off asking the most important question of all: 'what is serious crime?' Instead they take serious crime as a pre- and state-defined phenomenon" (Box, 1983: 6) rather than exploring that "definitions of serious crime are essentially ideological constructs" (ibid: 13).

The propensity to accept state definitions of crime meant that up to the 1970s, criminology had largely omitted "significant areas of social and political life that had a direct bearing on the nature of, and response to, criminal and deviant behaviour" failing to include, "important political and cultural processes, including the question of the state" (Coleman *et al*, 2009: 1). Criminological explanations preferred to explain crime by

focusing on pathological reasons that located fault in the individual. This became the "favourite explanatory imagery of mainstream positivistic criminology" (Box, 1983: 4).

Those criminologists interested in looking at offenders that are not state-defined, were largely absent for a large part of the twentieth century, which Geis and Goff explained was as a result of the:

> conservative tinge of the political climate [and] the priorities of sociology [that] went through a period in which highly quantitative, supposedly value-free empirical investigation was prized (Geis and Goff, 1983: xxx).

This continued into "the 1960s and early 1970s when the stars of interactionism and phenomenology were in the ascendant" and "practitioners of traditional criminology…seemed obsessed with discovering why powerlessness, in one of its many guises, produced so much serious crime" (Box, 1983: 4,-x). What was crime and who was criminal was accepted as scientific fact, unchallenged.

Whilst Hirschi and Gottfredson claim "no topic in criminology can be discussed without the spectre of white-collar crime hanging over it" (1987: 949) it is still the case that crimes committed by the state receive little critical analysis in criminology which has focused on "homicide, rape, burglary, robbery…Criminology, for its part has remained distinctly disinterested in the topic" (Hillyard, 2003: 201). An illustration of this is that:

> most ‘Introduction to Criminology’ textbooks feature a chapter on how corporate crime, state crime and human rights abuse are under-researched, to then just go back to talking about drug-addicts and violent teenagers (Krause cited in Tombs, 2015: 66).

The lack of inclusion of state crimes in widely used criminological texts has implications for many undergraduates who consequently believe “state crime does not exist” (Hillyard, 2003: 206) or is of little importance. A number of academics seek to redress the imbalance and insist “There *are* alternatives. The *raison d’etre* of critical research is precisely to establish such alternatives” (ibid: 272, emphasis in original). Critical research should be concerned with making known what has been made invisible. Referring back to victims, it should:

> explore the relationship between patterns of victimisation and broader questions of social structure and power, by exploring, in more depth than do positivist or radical victimologies, the interconnected links between social class, gender, race and crime (Davies *et al* cited in Croall 2010: 16).

The section of critical criminology relevant for this research places the state at the centre of its analysis aligning with those academics who are interested in:

> materialist, Marxist-based interpretation of power, and by extension, the processes of criminalization and control emanating from the state and its institutions (Coleman *et al*, 2009: 1).

The consequent analysis does not accept national institutions, instead it questions definitions of the state as well as the role it plays or purports not to play. Indeed, there is “the need to grasp

the *reorganization* – as opposed to the relative disappearance – of it and its institutions" (ibid: 13, emphasis in original).

The state managed version of the 'crime problem' is used to create "policies of deceit" deliberately ignoring that which is most damaging to "British society" (Walters, 2003: 211). As a counter to such priorities of the state, critical criminologists, who place the state at the centre of their analysis and evidence that:

> Government penal policy and judicial sentencing practices do not emerge out of a vacuum; rather they both reflect changing patterns of social relationships, particularly between the powerful and their sub-ordinates (Box 1983: 207).

This entails rejecting "government research agendas that ignore… crimes committed by the…wealthy in society" and refuses to endorse "policies that aim to regulate the already over-regulated in society" (Walters, 2003: 209). The state is always at the centre of the study of crimes of the powerful, analysing both the state's relationship with the least powerful whilst also dissecting "the relationship between state and capital" (Tombs and Whyte, 2009: 115). Snider (2003) develops this and argues for an academic commentary that challenges the existing order and tries to appear in the policy decisions that are, or are not, made.

Studying crimes of the powerful is a commitment to creating change and to use the platform that academics have set to challenge inequalities between the powerful and the powerless. An important part of the work of critical criminologists is dedicated to "recognising the nature of particular struggles/moments" using the "voice granted to academics" to

engage in “interventions” in order to challenge accepted definitions of crime (Hillyard, 2003: 272).

Similarly, Tombs (1992) and Tombs and Whyte (2003) call for academics to use the position they have (in classrooms and workplaces) to call for change. They take inspiration for confronting the crimes of the powerful from the position occupied by feminist criminologists. Feminists were revolutionary in challenging dominant discourses from the 1970s, when they engaged in social change with a “desire to strive for so-called objective and neutral knowledge” (Smart cited in Ballinger, 2016: 12).

The inclusion of alternative definitions of crime into undergraduate courses has expanded the literature dedicated to the study of crimes of the powerful. Nonetheless, it continues to be overlooked by criminology as a discipline. Ruggiero (2015: 132) claims it is neglected because ignoring it “contribute[s] to the reproduction of the power structure in society”. Tombs and Whyte state this:

> represents a gaping hole within mainstream criminology. It is a gaping hole which can be justified neither theoretically nor empirically (Tombs and Whyte, 2003: 267).

When criminology fails to research crimes of the powerful, they unintentionally reveal their bias in favour of the powerful (ibid.).

Rather than being recognised as part of a valuable movement seeking to redress a shortcoming of criminology, Pearce emphasises there is:

> [a] disturbing aspect of current academic practice…that differing but rigorous interpretations of the nature of the social world and of theories and theorists are often simply *ignored*, at times crudely parodied, or simply, and contemptuously, dismissed (2003: xi, emphasis in original).

In short, crimes of the powerful are not a mainstream concern of criminology and those who choose to focus on it as a topic face being "ignored…footnoted and passed over" (ibid.: xii).

However, the concerns of the crimes of the powerful have been taken up by a number of criminologists who have attempted to redress the imbalance. These will be detailed below, moving from the 1970s to the present time.

Studying crimes of the powerful

As indicated earlier in this chapter, criminology has been preoccupied with conventional definitions of what is crime, although alternatives to traditional criminology have developed in the past 60 years. The National Deviancy Conference (NDC) in 1968 led to the publication of a variety of seminal texts that "developed the critical themes…identified by those participating" (Coleman *et al*, 2009: 1). These texts set a new agenda and posed questions on the construction of deviance. Questions which include who is deviant? Who has the power to make such constructions? Who benefits? A number of those texts will be summarised in the paragraphs that follow.

In 1976, Frank Pearce published a Marxist analysis, *Crimes of the Powerful*. In it, he challenges assumptions that criminals are only those people who are processed by the police and found in prisons. In *The Rich Get Richer and the Poor Get Prison*, Jeffrey Reiman (first published in 1979) disputes representations of who is defined as criminal by traditional criminology. He proposes that the criminal justice system reflects crime via a 'carnival mirror', fighting enough crime but never eliminating it in order to legitimate the current social order and detract the focus from wealth inequalities. Tombs and Whyte consider that:

> Both Reiman and Pearce showed how, in different ways, the state projects through the law, an imaginary order in which 'crime' is invariably something that is the responsibility of the poor (2003: 104).

With a focus on the state Hall *et al* published *Policing the Crisis* (1978). The authors draw attention to the "contradictory relationship between the state, law and capital" and propose ideas of an "anti-statist strategy" (Coleman *et al*, 2009).

In the following decade, Steven Box explicitly focused on crimes of the powerful that had been largely invisible from criminology, the criminal justice system and the courts with the publication of *Power, Crime and Mystification* in 1983. Box claims the attention of criminological study should be on "understanding most serious crimes…located in power, not weakness, privilege, not disadvantage, wealth, not poverty". On the final page, he calls for change and concludes, "We have for too long ignored crimes of the powerful, allowed the poor to be imprisoned scapegoats, and encouraged criminal justice personnel to act subversively" (1983: 223).

Whilst crimes of the powerful as one topic were largely neglected until the publication of Tombs and Whyte's edited volume, *Unmasking the Crimes of the Powerful*, there was a significant development of subjects which consistently stated "there is more to crime and criminals than the state reveals" (Box, 1983: 15). Integral to this, this includes the study of white collar, corporate and safety crime.

White collar crime

Whilst Morris "pointed the finger at the 'criminals of the upperworld'" and "Writers in other disciplines…were aware of the depredations of the powerful" it was Edwin Sutherland who "brought these general views together in a single package" (Geis and Goff, 1983: xxxi). In an address to the American Sociological Society in 1939, Sutherland, "altered the study of crime throughout the world in fundamental ways" (ibid: ix).

Both Sutherland and Cressey recognise that many criminologists are satisfied with identifying social problems such as poverty as the cause of crime permitting them to suggest solutions to crime which do not challenge either the "social order" or involve "hurting anyone's feelings" (Sutherland and Cressey cited in Melossi, 2008: 138). Such criminologists avoid the scorn and derision by peers that Pearce (2003) referred to. However, theorists who rely upon crime as related to poverty are now, "only able to do so by remaining essentially silent on the white-collar crime issue" Hirschi and Gottfredson, 1987: 950).

Sutherland urges criminology to look upwards through the socio-economic classes in search of corporate offenders. He conceptualises white collar crime, defining it as "a crime committed by an individual in his [sic] occupation" (Sutherland,

1983: 7). Revolutionarily claiming that theories prior to the definition of white collar crime were based on evidence from a "biased sample of all criminal acts" (ibid: 6). In *White Collar Crime* (1949) Sutherland rejects many other criminological theories in the belief that "social and personal pathologies are not an adequate explanation of criminal behaviour" (1983: 5). The most important factor is the "social and interpersonal relations…associated sometimes with poverty and sometimes with wealth, and sometimes with both" (ibid: 7).

Pertinent for this research, Sutherland observes:

> The white collar criminal does not conceive of himself as a criminal because he is not dealt with under the same official procedures as other criminals and because, due to his class status, he does not engage in intimate personal association with those who define themselves as criminals (ibid., 1983: 231).

Sutherland's legacy expanded the scope and study of criminology in ways that can never be reversed and following his work, a number of academics applied the notion of white collar crime. These include Clinard (1952), Cressey (1953), Newman (1953), Nader (1965) and Geis (1967) (cited in Snider, 2003). Although ground breaking at the time, it was not until the 1970s, during an economic recession and mass unemployment that consideration of white-collar crime resurfaced (Slapper and Tombs, 1999). In the late 1970s and early 1980s, Clinard and Yeager (1980) updated Sutherland's research. And in the 1970s The National Institute of Justice at Yale University were awarded grants which "became known as the 'Yale Studies in White-Collar Crime'", although Snider noted the studies carried out looked at corporate crime (Snider, 2003: 57).

By the end of 1990s, almost fifty years after Sutherland's presidential address at the sociological conference, the study of white collar crime had become, irrevocably, a part of criminological literature. Out of this, corporate crime emerged as a distinct category.

Corporate crime

The distinction between white collar and corporate crime has furthered the endeavour of critical criminology in its critique of the existing law and highlighted its inadequacies (Slapper and Tombs, 1999). Corporate crime itself "developed out of Sutherland's original claim and its allied conceptual ambiguities" (Snider, 2003: 51) when he referred to an "offender active in the corporate world" (Melossi, 2008: 139). Different from white collar crime, the study of corporate crime makes the role of the corporation in the crime explicit, moving away from the examination of the role of the individual. Whereas aspects of white collar crime such as occupational crime focuses on that which "victimize business", Snider argues that corporate crime is "a much more counter-hegemonic concept" because it refers to "illegal acts done by business to benefit business, committed with the intention of increasing profit levels" (2003: 52).

Corporate crime was described by Michalowski and Kramer in the US in 1990 as involving the challenging of "powerful political and economic interests" (Michalowski and Kramer cited in Tombs and Whyte, 2003: 37; Tombs and Whyte, 2015). Corporate crime includes crimes as well as omissions made by legitimate, formal organisations (Pearce and Tombs, 1998). The most suitable definition for the purposes of this research defines corporate crimes as:

> Illegal acts or omissions, punishable by the State under administrative, civil or criminal law, which are

> the result of deliberate decision making or culpable negligence within a legitimate formal organisation (Pearce and Tombs, 1998: 107-110).

This definition includes all of the corporations registered in the UK under the Companies Act and discounts those corporations created with the intention of breaking the law. It also includes those who can and are punished by regulatory means, which Sutherland recognised (Tombs, 2005). This is relevant to the cases in this research.

In attempting to explain corporate crime, theories used to analyse traditional crime have been applied, theories such as Merton's strain theory and Durkheim's theory of anomie. Box (1983) uses the aforementioned theories to explain that when corporations are unable to maximise profit using legal means they are more likely to employ illegal means. As "a goal-seeking entity", the corporation is "inherently criminogenic" because it exists in an "unpredictable environment" where "opportunities for goal achievement are sometimes limited and constrained" (ibid: 35). Contrary to those living in poverty, those with wealth, experience "release from moral and social binds" (ibid: 40). The risk of committing crime is higher at times of recession and when competition increases, for example, as detailed in Clinard and Yeager's (1980) study when corporations 'innovated' to increase profit margins. Corporations are well placed to hide their criminality in layers of structure (Croall, 2016).

Hirschi and Gottfredson (1987) drew similarities between the common and the corporate criminal maintaining a general theory of crime is possible because all crime is a "way of some people satisfying their desire to maximise pleasure and minimise pain" (cited in Slapper and Tombs, 1999: 115).

Choosing not to look at offenders, they start by looking at the criminal act itself (Hirschi and Gottfredson, 1987). For them, fraud is "in the pursuit of self-interest" and requires "less effort" at a rapid rate" (ibid: 959). Slapper and Tombs (1999) accept this statement but criticise Hirschi and Gottfredson (1987) for not conceptualising the process which leads to a corporate crime.

Sykes and Matza's (1957) techniques of neutralization have also been applied to corporate crime and focus on "*how* good people come to do bad things" (Slapper and Tombs, 1999:118 emphasis in original). They argue that employees of corporations can act illegally when they can justify and neutralise their behaviour. Punch highlighted that a corporation may not "fully consciously take a decision that would directly lead to the avoidable death and suffering of multiple victims" but that:

> the decision is cloaked in a risk analysis that calculates the negative side-effects of activity…completed within 'normal' and mostly legal business practice, however reprehensible and unethical some commentators may find it (Punch, 2000: 251).

An example of this is in the well-known Ford Pinto case. Dowie (1977) details how leading up to the sale of the Pinto, Ford was facing strong competition, which forced the reduction of production time and did not allow for modifications to be made. Even after Ford engineers identified the fault which led to 500 deaths, it has been claimed the deaths were caused by the failure of a coordinator to recall the defective cars because his "personal ethics were subordinated to the clinical decision-making processes of the company" (Slapper and Tombs, 1999: 121).

Continuing to look at business practices, in 1996 Punch examined "the social and moral dilemmas faced by managers at their work within organisations" and why they turn to breaking the law (1996: 3). Punch showed "the discrepancy between the popular image of business as a highly respectable activity…and what can happen behind the scenes" (cited in Tweedale, 2003: 71) focusing on the "structural and cultural determinants" which lead managers to break the law and cause death and injury. He evaluates that "many incidents of corporate deviance are complex and intricate events that are difficult to unravel in terms of direct responsibility and blame" (Punch, 2000: 253).

Using an interactionist approach, Nelken (2012) describes 'de/non-labelling' that happens to corporations because unlike the poor, they have the power to resist the deviant label. Firstly through the way their activities are labelled as less serious, secondly in their ability to pay for representation in court and finally how the criminal justice system agencies are reticent to investigate and prosecute. Nelken points to "the necessity to draw both on structural and interpretive approaches in order to provide a convincing account of the emergence and implementation of the law" (Nelken cited in Slapper and Tombs, 1999: 125). In analysing the creation and implementation of the Factory Acts, Carson (1974) supports that corporations do not get labelled and avoid their activities being considered as criminal, what he describes as a "peculiarly systematic form of 'non-labelling' at the operational level" (Carson, 1974: 386).

Research carried out into corporate crime has revealed such criminals are not vastly different from more traditional criminals. They are recidivists and their crimes are serious and widespread (Clinard and Yaegar, 1980; Braithwaite, 1984). They commit crime for their own interests when they have the opportunity and cannot exert self-control (Gottfredson and

Hirschi, 1990). Corporate criminals are devastated when they are treated like traditional criminals because they consider their actions are simply part of usual business conduct (Geis cited in Gobert and Punch, 2003). Corporate criminals are rarely identified publicly however, as corporations do not see themselves as criminal and are able to deflect legal criminalisation and successfully resist the label of 'criminal' because mainstream representations of what crime rarely focuses on their activities (Gobert and Punch, 2003).

For Sutherland, differential association explains the criminal behaviour of corporate criminals as "learned in association with those who define such criminal behaviour favourably and in isolation from those who define it unfavourably" (Sutherland, 1983: 240). Crime is committed when the favourable definitions outweigh the unfavourable. Differential association theory is criticised as difficult to use to predict crime as it requires knowing the "most minute details of [the offender's] life-history", although this is a criticism which could be levelled at many other types of social research (Melossi, 2008: 141).

Commentators who build upon Sutherland include Young (1971), Box (1971), Cohen (1972), Mathiesen (1974) and Fitzgerald and Sim (1979), all of whom draw upon Marxism "to place the state as an analytical entity on the agenda of critical criminology" (cited in Coleman *et al*, 2009: 1). Similarly, Reiman develops a "Marxist 'response' to Sutherland's critique of the class-based nature of criminal justice" (Tombs and Whyte, 2003: 104).

For writers such as these, theories other than Marxism fail to understand the phenomenon because:

> to understand…is to seek to understand capitalist economies, and…how it is that fundamental class inequalities are reproduced by law and by politics (Tombs and Whyte, 2015: 3).

Box (1983) claims the public are socialised to see crime through the eyes of the state, rather than fears based on reality. He notes the public find it easier to understand traditional crime rather than the seemingly small thefts that occur every day in business (for example, comparing theft to price fixing). This is caused by the structure of capitalism where "a prioritization of profit leads to chronic levels of corruption" (ibid: 63). The importance of placing the economy at the centre of such analysis can be seen in arguments which were made by the oil industry when it insisted the industry itself should be governed by the Department for Energy rather than the HSE (Carson, 1982). Individuals within the oil industry asserted the HSE were not fit to govern them because the industry was so different and because of the great needs of the UK economy, "justification which asserted by implication that the economic centrality of oil could be accorded greater prominence within a separately administered regime for safety" (ibid: 210). The requirements of the economy took priority over the obligation to safeguard the workers.

There is not only a distance put between the law breaking and the offender (which has major implications that are detailed further in chapter four) but also a social distance (Punch, 2009). Any deviancy is perpetuated for the good of the business, which makes the perpetrators honest within the structure of a capitalist society that encourages the pursuit of competition and the rationalization of deviancy (ibid.). In part, this is based on the class and age of corporate offenders and their ability to disassociate themselves from the criminal act (ibid.). Distance is purposively put between breaking the law and the offender, both literally and metaphorically, in what Punch refers to as a

'cognitive dissonance' (ibid: 29). The high incidence of corporate crime may do little to change this reality. Gobert and Punch (2003: iv) note that the public are not "overly bothered" about corporate crime, even though factually, its effects are larger than that of street crime. Such perceptions impact upon those working in agencies, for example, the police, are hesitant to view employers as potential criminals (Alvesalo and Whyte, 2007).

In 1999, Slapper and Tombs published *Corporate Crime,* which legitimised and cemented the importance, necessity and existence of corporate crime. They chart the scale, costs and consequences of corporate crime, explain why it exists and the response of the state. As well as an academic text, it is an "attempt to engage on both practice (policy-making) and political levels" (Slapper and Tombs, 1999: 21). In it, the authors map the different types of corporate crime, identifying the four most frequently used sub-categories of corporate crimes, financial, offences against consumers, crimes against employees and environmental offences. This research is concerned with the third category, crimes against employers where employers have not kept employees safe by failing to train them adequately or failing to prioritise health and safety in the face of available evidence (Slapper and Tombs, 1999). This is specifically referred to as safety crime.

Safety crime

As defined by Tombs and Whyte, (2007: 1) safety crime is similarly defined as corporate crime affecting workers and members of the public, it is, "violations of law by employers that either do, or have the potential to, cause sudden death or injury as a result of work-related activities". Safety crimes may be violations of the Health and Safety at Work Act 1974 or

those “beyond that proscribed by criminal law [and] that which has been processed through the legal system” (ibid: 3).

A number of high profile disasters are included in this definition of safety crime. Cases such as Piper Alpha where regulations were ignored or flouted, leading to the deaths of 167 people (Tombs, 1993). In Carson’s 1982 examination of safety crime, he details the economic context which led to the expansion of the oil industry. He examines how corporations resist regulation and how the law responded to a number of deaths on the rigs in the race for oil in the 1970s and 1980s. Carson locates the “personal troubles endured” by workers in the context of “global forces” related to national interests (Carson, 1982: 296). He asks readers to “share a little of the shame” he felt about the other price paid by workers in the pursuit of oil. Importantly for this research, he detailed the context and its effects on the workers:

> with its chronicle of offshore workers greeting official casualty statistics with bitter laughter, of injured employees remaining uncompensated, not to mention unemployed, and of drilling companies even declining to suspend work when someone was killed (Carson, 1982: 47).

Negligence by corporations also kills members of the public. 188 members of the public and workers died in the sinking of the Herald of Free Enterprise off the coast of Zeebrugge. (Wells, 2001). In the Paddington rail crash, 31 passengers were killed, one of many rail crashes in the 1990s that Wolmar concluded was due to managers’ “appalling lack of concern about safety…treating recommendations of inquiries as if they were irrelevant” in a “culture of almost venal ineptitude and perhaps even deliberate dishonesty” (ibid.: 143).

Whilst the immediate aftermath feature survivor accounts, there is a relative lack of voices heard from those not killed in disasters but individuals who are killed at work. These victims form a huge proportion of those affected by safety crime. Hazards (2017) estimate between 1,174 individuals were killed between 2015/2016. However, the testimonies of such victims are rarely researched or included in official accounts and the majority of the victims of safety crimes do not make headline, national news.

Many victims of safety crime are unaware of their potential victimisation or even that such a crime exists (Tombs and Whyte, 2007). Part of the project of safety crimes has been to examine how it has been rendered invisible and remains outside the study of traditional criminology and criminal justice. Researchers of safety crime have shown it does exist and further, that it is prevalent and harmful (Tombs and Whyte, 2010). There is a break in the literature for the accounts of these victims, gathered through the experiences of families of safety crime victims, which this research seeks to redress. 25 years ago after a review of pre-existing literature Croall (1992) called for more research both into its causes and effects and why official agencies treated white collar crime differently to conventional crime. This research, is, in part, an answer to that plea.

Navigating the criticisms

Part of that which prevents safety crime being accepted within traditional criminology are claims that it is not a legitimate area of study (Meier cited in Slapper and Tombs, 1996). Any academic argument that seeks to represent safety crime as real crime must first defend its position against dominant representations of what crime includes, including many of the arguments outlined previously in this chapter. Many academics

have mounted such a defence and continue to do so. These contestations must be acknowledged too, as arguments which add to its comparative invisibility. Since safety crime is a relatively recent concept, the criticisms have been levelled at white collar and corporate crime. Although such criticisms can also, retrospectively, be levelled at safety crime as a sub section of corporate crime.

Notable contestations of Sutherland's inclusion of white collar crime include Tappan (1977) who criticise the term and its existence for not truly studying crime, sidestepping the definition itself and disagreeing that it is in actual fact, a breach of a legal norm. According to Tappan, whether an act is criminal or not is dependent upon the decision of a constituted authority, the said authority has duly named the norms with "rigour and precision" and speaks to the interests of the community (1977: 279). Tappan argues crime can only be defined by that authority in order to avoid 'value judgements' (1977: 281). He brands the conduct of those who focus on alternative definitions of crime as dangerous, warning against the use of law, as some white collar crime is economically beneficial and attempts at deterrence are ineffective.

Arguments continue as to whether white collar crime should be included in a criminological analysis, "whether it should include activities which are 'lawful' but 'awful' (Passas, 2005). Sutherland himself (1983) provides a defence as to why white collar crime should be included in the study of criminology. He reasons that criminology already relies on those not dealt with strictly by the criminal justice system, for example, researchers use agencies other than the criminal courts to research crime and interview the unprosecuted in self-report studies. Sutherland recognises:

> that a large number of offences that could be punished in law were not in fact punished – they went undetected or, if detected, were not acted upon or, if acted upon, were then subject to forms of enforcement action different from normal criminal processing…he defined an offence in terms of what was *punishable*, rather than those that had actually been *punished*, by law (Tombs and Whyte, 2015: 132, emphasis in original).

Whilst the study of corporate crime can be a move away from studying exclusively what is deemed to be criminal by the courts and beyond established boundaries of what is crime and criminology, focusing only on conventional crime leads to a distorted view of the world. This is neither reflective of the truth, nor rational (Hillyard *et al*, 2003). The criminal justice system portrays itself as unbiased and since it appears to remain static through every change in government, it can pass as "politically independent" (Lacey *et al* cited in Ballinger, 2016: 2). Relying purely upon the law to define the limits of criminological study severely limits its scope and turns lawmakers into definers of crime with no recognition of space between crime and the law. It suggests that law is unchanging and a finished product, rather than a social construct and whilst Croal argues "definitions of harm may be too wide…the criminal law is inadequate a base for inclusion" (2010: 6).

Shapiro (1983) agrees with Tappan (1977) branding Marshall, Clinard and Yeager, Edelhertz and Overcasr and Ermann and Lundman as "Corporate Crime Crusaders" (Shapiro, 1983: 304). She states that definitions of crime should not make value judgements and since all conduct cannot be criminal that which is, must be defined by the law. While some acts might be harmful, it does not necessarily follow that they are criminal. Consequently, Shapiro criticises research into corporate crime for being a moral crusade, focusing on harms rather than law and forfeiting sociological good sense.

In response to ongoing criticism, Pemberton suggests taking a social harm approach as a "means to escape the 'conceptual straitjacket' imposed by the concept of crime" (2008: 73). In *Beyond Criminology: Taking Harm Seriously* (2004), Hillyard *et al* cemented social harm as an approach which criticises "criminological reasoning" as being "used to bolster states, providing rationales for the extensions of state activities in the name of a more effective criminal justice" (Hillyard and Tombs, 2008: 21). Whether radical or critical, "the very fact of engaging in criminology…legitimise some object of 'crime'" (ibid: 23). The concept of organizational deviance is proposed as another alternative. Stressing that "…many commercial activities which are not legally 'crimes' are nonetheless regarded, by widely respected organizations, as harmful and as issues worthy of investigation or requiring stronger legislation" (Green and Ward *et al* cited in ibid).

The position of this research is that it is inadequate to use the law as a basis of all criminological study as the law is an interpretation of experts, judges and solicitors; entirely agreeable decisions are not reached and inconsistencies remain within the circle and subculture of experts (Snider, 2003). The law is not based on calls from the public, indeed there is no evidence that the legal system reflects the importance the public attach to crimes (Almond, 2009b). It is also pertinent that, "Accountability is minimal and research into judicial practices almost non-existent in this country" (Lees, 1996: 249). Exaggerated in the absence of checks and balances, the criminal justice system does not reflect the reality of crime but has a part in creating the reality (Reiman, 1998).

Further, what is and is not criminal is a construct of social, cultural and historical situations. Wells (2001) argues that crimes have to be discovered because they are a construction of behaviour that already exists, crime is:

> a problematic category used routinely to describe a set of behaviours that, beyond a central core, are highly contested. Legal definition alone cannot adequately recognise the historical development, social relationships, practices, ideologies, and interests that determine what, at any given moment, is designated criminal (Zedner cited in Aas, 2008: 22).

Wells (2001) argues that labelling certain crimes as less important and therefore unworthy of examination on the premise of how they are responded to is, "historically and culturally contingent" (ibid.: 7). The absence of debate about corporations, their power and responsibility "tells us more about ourselves as human beings and citizens, with our fears and insecurities, than it does about criminal law" (ibid.: 168). Since the "law remains the most generally accepted standard by which 'right' and 'wrong' are judged" (Slapper and Tombs, 1999: 18), this research argues for an "inclusive definition which allows an analysis of law and its enforcement" (Croall, 1992: 9), integrating the state into every analysis.

The enquiry of this research agrees with Carson that the criminal justice system should be open to public debate and if:

> saying this consigns me to the company of those whose criminology was once castigated for being based on a 'mindless and atheoretical moral indignation', I can only say that I hope there will always be room for some moral outrage in criminology and sociology alike (Carson, 1982: 301).

By examining "bourgeois legal categories" (Slapper and Tombs, 1999: 19) the inherent bias of the law in favour of the corporation can be studied and compared against the rights of the victims and the consequences they are forced to endure. To that end, the following section will look at the development of

the existing law which relates to safety crime before linking safety crime to critical victimology.

Invisibility: social, legal and political obstacles

The response of the law to safety[3] crime

In 1999, in *Corporate Crime*, and Slapper and Tombs conclude:

> invisibility is sustained by the lack of attempts within criminological theory to account for its incidence; and this in turn allows inadequate conceptions…of appropriate and feasible modes of regulation and sanction to remain relatively unchallenged (Slapper and Tombs, 1999: 227).

Slapper and Tombs highlight the "social processes which contribute to…under-reporting" and that "the costs of corporate crimes exceed those associated with street crimes" (ibid.: 68, 79). Data is not simply a social construction, what is not counted is as important as what is counted (Tombs, 1999). Quantitative data on the deaths and injuries caused by safety crime has been historically difficult to find, which Box (1983) acknowledges is a difficult task. Efforts have continued to accurately represent the harm of safety crime[4].

Whilst statistics on crime are published in the media and utilised politically to demonstrate the success and failure of governments, those relating to safety crime are rarely debated or published with comparable interest. Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

[3] From this point, the term safety crime will be used where appropriate, even when previous studies themselves may have referred to corporate crime.
[4] see Hazards, http://www.hazards.org/index.htm

(RIDDOR 1995), employers have a legal duty to report deaths and injuries, which are recorded, collected and published by the HSE annually. The HSE have claimed this data is 'virtually complete' (HSC, cited in Slapper and Tombs, 1999: 68). Tombs and Whyte (2007) however note this claim was questioned officially by the Robens Committee, a government committee created to review Health and Safety at Work (Robens, 1972: 135).

In 2012/13, the HSE reported there were 148 deaths in Great Britain. This official figure is a small proportion of the figure taken from data that excludes: workers killed at sea; in work-related road traffic incidents; suicides as a result of work-related stress; deaths of merchant seafarers and members of the public killed by a work activity (Hazards, 2015). Hazards, an independent magazine took the above into account and calculated the real number of deaths lies between 1,027 and 1,474 (ibid.).

It is difficult for safety crimes to move away from being branded an 'accident' akin to random "acts of God" (Wells, 2001; Bittle and Snider, 2006). Much research in this area has confirmed that the state only encourages this in its daily response (and non-response) to corporate criminality (Bergman, 1994). The day to day response of the state can be seen in the administration of the laws that affects corporations, which is very different from than those which affects individuals. While:

> a reconfigured law and order agenda has been central to the generation of successive moral panics around the behaviour of the powerless, the failure to mitigate the harms generated by relatively powerful social actors such as corporations can be characterized as an exercise in the creation of *un*-panics (Davis cited in Coleman *et al*, 2009: 6, emphasis in original).

The way the law responds is an important statement of what is considered immoral by society. It is the only line of defence for the majority of victims who look to it to deliver justice. When the criminal prosecution halted after Hillsborough, the families were unable to take their case any further due to the expense involved, "It was *impossible* for families to take a private prosecution. An intolerable weight was placed on the generic inquest" (Scraton, 2009: 144, my italics).

Those who have money are better placed to mount a private prosecution and similarly, wealthy people can avoid detection and prosecution as part of corporations in ways that poor people cannot (Reiman, 1998). Rather than prosecution, safety crimes have been dealt with publicly after the event via inquiries. As Snider (2003) states, rather than seeking to apportion blame, the aims of the inquiries are to establish truths, what went wrong and how to avoid a repeat of the event in the future often focusing on science. Consequently, criminal corporations avoid blame and condemnation and benefit from laws that are vague and confused (Box, 1983).

Perpetrators of safety crime benefit from a measure of 'social capital' (Punch, 2009: 51) since the judges are unused to facing people who they have more in common with. Consequently they are more likely to bestow 'light' punishment upon those accused. Sutherland (1983) compares this historically to medieval society when the most powerful secured immunity due to the 'benefit of clergy'. Those in the criminal justice system admire and respect members of corporations and are unlikely to see them as criminals (Punch, 2009). Box emphasises that not only are corporate criminals able to evade condemnation, they are enabled to "condemn the condemner…law has no place in business" (1983: 56). When those involved in the courts are informed with the perception that offences committed are not really crimes, it affects

subsequent sentencing decisions (Croall, 1992). Tombs and Whyte (2009) agree that corporations have been morally elevated to a position where they can define their own status. As Box observes, "the greatest opportunity lies in [the ability of corporations] to prevent their actions from becoming subject to criminal sanctions in the first place" (1983: 59).

Corporations are not arrested by the same agencies, their crimes are not counted by the Home Office and they are not treated in the same ways as conventional criminals. These are crimes that have avoided being associated with clear criminal liability and instead are categorised as offences that are based on the breaking of regulations, irrespective of the nature of the deaths or the circumstances that led up to the deaths (Gunningham and Johnstone; Wells cited in Almond, 2009b). Much of this classification is determined by the state. Academic research explores how the state is not an obstacle to safety crime, but facilitates it.

This context and intent has been examined by a number of scholars as part of the reason why corporations are able to remove themselves from the crime (Almond, 2009b). In the Challenger disaster, the pursuit of success was prioritised over awareness of the risks being taken (Vandivier cited in Erman and Lundman, 2002). As one employee stated, "we're just drawing some curves and what happens to them after they leave here, well, we're not responsible for that" (ibid.). Not perceiving safety crime as real crime, further encourages corporations to commit crime in the pursuit of success. Risk taking is encouraged in return for large gains, and there is an irrational sense of optimism that leads to dangerous and fatal decisions (Gobert and Punch, 2003). A punitive response must exist to counter the profit-making aims of corporations rather than excusing safety crime as being the result of a few, errant individuals (Pearce and Tombs, 1990).

A punitive response has never been realised. The history of the official legal response to safety crime is important in the discussion of its invisibility. This will be explored in the following sub-section.

The role of the state

Through a variety of political, legal and ideological processes – processes which are always ongoing, requiring a great deal of state work – corporations have been, and are, more or less empowered *within states* in ways that allow them to cause large-scale social harms with relative impunity (Tombs and Whyte, 2015: 93, emphasis in original).

Michalowski and Kramer contend that safety crime "can be *initiated* and *facilitated* by states" (cited in Tombs and Whyte, 2003: 110, emphasis in original). Similarly, McCullagh agreed "it would appear that the law is an ally of corporate power" (McCullagh, 2016: 103). Safety crime is seen "as essentially tangential and marginal by-products of generally socially responsible, law-abiding entities" (Tombs and Whyte, 2015: 2-3) rather than committed by criminals.

This is reflected in the types of laws that are created each decade. What is defined as serious is of interest to those who make a profit and gain from the 'controlling' of crime (Tombs and Hillyard, 2000; Hall, *et al*, 1978). Nothing is static, each government in England and Wales has highlighted different problems and focused on strengthening existing laws or creating new ones, some of which are created easily and quickly. What is criminal is ever changing, for example, every year between 1997 and 2008, Labour created 3,600 new criminal offences and 44 Parliamentary Acts (Tombs and Whyte, 2010). One was related to safety crime.

The creation of effective laws to prohibit and sanction acts of safety crime is not forthcoming, whether in name or action. This continues to create large gaps between the numbers of people killed by corporations and the numbers of families who see those corporations punished in court. These families are people who are greatly affected by that loss. It should be clear that for many criminologists, the lack of legal response does not mean safety crime does not exist, or that it is unsuitable for study. It does mean that the law and the construction of the victim is a crucial part of how safety crime is rendered invisible, which the following section will examine.

Is the law designed not to work?

> Whatever the state does by way of provision of services and economic intervention has to run the gauntlet of the economic imperatives dictated by the requirements of the system – and what emerges as a result is always very battered (Miliband cited in Carson, 1982: 212).

If the numbers of convictions are an indicator of the usefulness of a law, the common law corporate manslaughter law was certainly inadequate. Between 1965 and 2003, there were five prosecutions and two convictions under the offence compared to the 20,000 deaths at work in the same period (Tombs, 1993; 2003). The existence of the law is not an obstacle to all perpetrators of safety crime:

> Law is like a cobweb: it's made for flies and the smaller kind of insects, so to speak, but lets the bumblebee break through. When technicalities of the law stood in my way, I have always been able to brush them aside as easy as anything (Daniel Drew cited in Sutherland, 1983: 57).

Law is conservative and laws specific to corporations is historic and inept at responding to the complex corporations that operate today (Punch, 2009). Law governing corporations has not innovated at the same rate as the corporations have (Clinard and Yaegar, 2011). Punch calls the law *'lex imperfecta'*; designed not to work (2009: 66, emphasis in original). Prosecutions are avoided, investigations are cursory or are prolonged and the eventual punishments are woeful (ibid.). Corporate manslaughter was first seen in a British court in 1965 [in *R v. Northern Strip Mining Construction Company*] but not again until 1991 in *DPP v P&O European Ferries (Dover) Ltd* (Tombs and Whyte, 2003).

In response to the fact that not even one death at work was referred to the police between 1974 and 1990, despite an estimated 9,050 deaths at work, Slapper (1999) explored the reasons why cases of people killed at work were not being prosecuted for manslaughter. After examining 40 cases, Slapper found that 38 had no more than a routine inquiry by the police. Coroners too, took a limited view of deaths at work, 38 out of 40 returned either 'accidental' or 'death by misadventure' verdicts (ibid.: 98). Slapper concluded that of these, 32 had the potential to be adversarial, potential that was never realised.

If the activities of the criminal justice system reflect the incidence of crime, it should be supposed that corporate manslaughter did not take place between 1974 and 1990. However, academic research demonstrates that safety crime exists and that it is widespread. Further than this, perpetrators of safety crimes are not vastly different from perpetrators of traditional crime. The principal difference is the way the law responds (or fails to respond) to a death caused by a corporation. This response is built into the creation of the law that relates to corporations.

The corporation became recognised as a legal person after the East of India resolution in 1641 and as they increased in size following the industrial revolution. From the nineteenth century onwards, corporations were able to cause more damage to person and persons (Stone cited in Wells, 2009; Wells, 2009; Glasbeek, 2009). To ensure financial recompense via compensation for victims, a corporation could be held vicariously or criminally liable by the civil courts, receiving so called 'damages' (Slapper 1999; Gobert 2008).

The development of case law relating to corporations is comparatively recent, historically the criminal law has been focused upon individuals. Whereas the law regarding the legal nature of corporations to enable them to carry out business transactions is well established, but the application of law to control them requires continued justification (Glasbeek, 2009).

In order for the state to prove an offence has taken place it has to establish "that the offending conduct involved an *individual who intended to engage in it"* (ibid.: 125, emphasis in original). Individuals have the required intent and ability to commit crime with their own mind and by their own hands, what is called *mens rea* ('guilty mind'). Malice and recklessness are based on the notion of the autonomous individual taking a conscious decision and when m*ens rea* is absent, gross negligence or recklessness remain (Punch, 2009). A corporation does not have a will, guilty or otherwise and so therefore, it cannot be guilty of a crime (Slapper, 1993). Since corporations do not speak as a whole and do not give consent or make commands, prosecutions of corporations struggle to succeed (Wells, 2009).

In order to prosecute corporations, the prosecution has to establish vicarious liability. This requires a larger test and as is

the way of case law, the English legal system developed its response through various verdicts, which began, notably in a "trio of cases" in 1944; *DPP v Kent and Sussex Contractors Ltd, R v ICR Haulage Ltd* and *Moore v Bresler Ltd* (Slapper, 1993: 52). Slapper (ibid.) details how three cases in the post-war period affected the law creating the foundations for the difficulties experienced using laws when attempting to convict corporations for manslaughter in the 1990s. They established the 'doctrine of identification', a type of vicarious liability that held that a corporation could be found guilty by using the *mens rea* ('controlling mind') of certain employees to ascertain the *mens rea* of the corporation (Gobert, 2008). It was contested as to who the employees who constituted the 'controlling mind' should be (ibid.: 55).

In 1972, (*Tesco Supermarkets Ltd v Nattrass*), Lord Reid perceived the 'controlling mind' should be a person who is in control of the company and not responsible to anyone else for their conduct. After the *Nattrass* case, this was interpreted as unsuitable for application to all managers as not every manager is created equal, and not all have enough influence to be a 'controlling mind'. The focus should instead be on those who exercise power in the corporation, which can be traced via a paper trail of documents and memos and included the board of directors (Gobert, 2008). This became known as the 'controlling officer' test (Slapper, 1999: 55). As a result of the search for appropriate *mens rea*, this meant that the larger the corporation, the less likely anyone would be held criminally responsible by a court (Gobert, 2008), a precedent that is yet to be resolved. Any secondary victim seeking justice after the death of their loved one at work would have unknowingly entered a criminal justice process that was almost impossible to navigate successfully. (Many would argue this is unchanged.)

Up to the 1980s, the issue of safety crime had lain dormant to a large extent. This was a consequence of big business where Margaret Thatcher's 'individualism' ruled, buoyed by the thirst for economic wealth, the start of the privatisation of public services whilst simultaneously rolling back the welfare state and reducing the power of the unions. Thatcher and a New Right influenced Conservative government, reformed crime control policy and located safety as the responsibility of individuals alongside sustained de-regulation (Sim, 2000). A number of high profile tragedies in the 1980s and 1990s grabbed the public's attention. As well as viewing the devastation of the immediate aftermath, the public were made aware that no person or corporation was held accountable for any of the hundreds of deaths that occurred across the various tragedies during this relatively short period of time. Public awareness was raised, in part, by the various groups created by survivors and family members of those who died that emerged from the high profile tragedies. One of the most high profile cases was the sinking of the Herald of Free Enterprise in 1987.

After 193 passengers were killed when the Herald of Free Enterprise sank off the coast of Zeebrugge, the Sheen Inquiry (1987) that pre-dated any legal response, summed up that the practices of the owners were "infected with the disease of sloppiness" (Report of the Court, cited in Slapper and Tombs, 1999: 151). Fault across Townsend Thoresen (which became Peninsular and Oriental, P&O) was clearly identified and in a preliminary ruling the court accepted that corporate homicide could be proven (Slapper and Tombs, 1999). In the court case, the prosecution used the 'doctrine of identification' and attempted to prove a 'controlling officer' was guilty of manslaughter in order to convict the corporation (Slapper, 1999: 55). As the Sheen Inquiry concluded, it was the faults of many in the corporation that ultimately led the Herald of Free Enterprise to sink. The prosecution attempted to combine the

mistakes of the employees to prove that P&O was guilty of reckless manslaughter (Wells, 2001).

This was referred to as the ‘aggregation principle’, which attempted to establish the required *mens rea* to combine the actions and guilt of those identified. However, Lord Justice Bingham, (as he was to become) dispensed with the ‘aggregation principle’ and the existence of the corporate mind. He stated that “A case against a personal defendant cannot be fortified by evidence against another defendant” (*R v. HM Coroner for East Kent ex parte Spooner* (1989) 88 Cr. App. R. 10 at17). Consequently, the Department for Public Prosecution (DPP) dismissed its charges against the remaining individuals (Slapper and Tombs, 1999). By rejecting the ‘aggregation principle’, Lord Bingham foretold that few corporations in the future would ever make it to court (Tombs and Whyte, 2007).

Wells (2001) states Lord Justice Turner made the wrong decision at the time for the following reasons. Firstly, he did not allow all of the witnesses to take the stand and side-lined evidence which contradicted that more than one person could have the foresight to realise the risks of sailing with the doors open (the test for 'objective recklessness'). Lord Justice Turner based this on the foresight of a member of the public rather than the defendant. The jury was not permitted to decide whether the risk was reckless based on the available evidence (ibid.). Secondly, the judgement on whether Townsend Thoresen were a prudent company was based on the interviews of employees (past and present), which Wells (ibid.) likens to judging the morality of a person charged with robbery via witness statements from the perpetrator’s family and friends. Lord Justice Turner concluded the risk could not be said to be ‘obvious’ as the Herald of Free Enterprise had sailed without tragedy for seven years previously. As is the nature of safety crime, offenders are able to present the offence as a ‘one off’

(Croall, 1992). Wells (2001) compares this to the analogy of a child who survives crossing a road without looking and therefore they continue to take the risk because they were not run over the first time. Whilst no person or body was held to account, this case was a significant step in the acknowledgement that a corporation could be guilty of manslaughter (Slapper, 1999).

Wells highlights why so many corporate manslaughter cases in the 1980s and 1990s failed:

> if there is one lesson from the P&O and other corporate killing sagas, it is that corporate defendants are highly motivated and well-placed to exploit the metaphysical gap between 'the company' and its members (2001: 126).

This gap can be manipulated to make finding fault very complicated, requiring a high burden of proof. After the Hatfield rail crash in 2000 which killed four people, an investigator working to pursue a manslaughter charge against executives in charge at the time said there was a need to find a letter that stated “do not repair this track, we can’t afford it, yours sincerely, the Fat Controller” (Wolmar, 2001: 156).

Hatfield was one of many high profile rail crashes in the 1990s, which highlighted the inadequacy of the law. In the Southall rail crash the prosecution sought to argue that one director did not need to be implicated and that the liability of the company could be proven through their management policies. This line of argument failed when the judge rejected it outright, reaffirming the narrow identification principle that a corporation could only be prosecuted via the guilt of a single human being (Wells, 2001).

Wells concludes that any law relating to corporate manslaughter is to "be treated as an important historic species, to be preserved in their embryonic form, never allowed to develop a bite" (ibid.: 113). The law exists to prosecute corporations in a written sense; it can be referred to but it is rarely used to prosecute. Tombs and Whyte (2007) highlight the discrepancy in the law as in 2006 and 2007, seven manslaughter prosecutions were brought against corporate bodies under charges of gross negligence manslaughter compared to 564 work-related fatalities in the same period (Almond, 2009). The law has barely ever reached the Appeal Courts to be tested, which is important since, as Wells (2001) describes, the law is subjective and corporations are not held morally to account, along with children under ten years of age, the insane and animals.

In spite of very public failures to prosecute and subsequent condemnation, the law continued to find corporations innocent. There were only two successful manslaughter convictions in the UK between 1989 and 1999 (Pearce and Snider, 1995). Punch sums up: "It is criminal how often the system fails to deliver justice" (2009: 53). The law fails and the absence of conviction leads to further rewards for perpetrators. Gobert and Punch (2003) illustrate how the Chairman of the Roy Bowles Transport Company was awarded an Excellent Order of the British Empire award (OBE) for services to the Road Haulage Association. Despite the fact his company had been found to have been involved in systematic rule breaking which had led to an employee falling asleep at the wheel killing two people on the M25.

The 1990s saw a political and public response to such high profile safety crimes. Bittle notes that:

> a well-publicised corporate disaster was followed by pressures on government to introduce new legislation to hold corporations and/or corporate executives to account for their wrongdoing (2013: 46).

Safety crimes were highlighted by New Labour when they were seeking and then trying to maintain, power. Following the Ladbroke Grove train crash which killed 31 people in 1999, John Prescott visited the Paddington site and promised an inquiry would take place to "get the bottom of everything that happened" (Tran and Pulham, 1999). He also met with victims groups, such as The Marchioness Campaign Group where he promised to launch an inquiry (Wolmar, 2001; Tombs and Snell, 2011). But his promises were not automatically sustained, as Snider states, "cultural permission to proactively scrutinise the practices of dominant economic actors is short lived following corporate disasters" (2009: 27). The Marchioness campaign had proof of Prescott's claims, which they later challenged him with, perhaps leading to the launch of the inquiry in 2000.

The law that permitted immunity for corporate criminals is strengthened with each act of non-enforcement. As mentioned previously, cases such as Paddington, Southall and the Ladbroke Grove train crashes, together with the sinking of the Marchioness and the near collapse of Piper Alpha Platform, highlighted publicly the inadequacy of the law from the 1990s. People began to take notice of the gap between wrongdoing and the failure of the law. In that sense, criminality failed to be concealed (Wells, 2001). At the same time, other Western countries were experiencing similar discontent that corporations were escaping legal redress (Bittle, 2013).

In 1994, the Law Commission produced a consultative paper, followed by a report in 1996 on an involuntary manslaughter

law that detailed a new offence of corporate killing. In 1997, Home Secretary Jack Straw promised a law that would provide for conviction of directors of companies where it was claimed that individuals had lost their lives as a result of dreadful negligence by the company as a whole. Consultation by the Home Office in 2000 stated the new offence, named the Corporate Manslaughter and Corporate Homicide Act (2007), would be designed to secure more convictions reflecting the seriousness of the offence. Labour made the proposed Act part of their 2001 manifesto and after much consultation, it became law in 2007.

Does the Corporate Manslaughter and Corporate Homicide Act (2007) reflect the seriousness of the offence?

The intention of the legislation was to make it easier to prosecute larger companies than had been the case in the 1980s and 1990s (Tombs, 2013). For this to happen, the fault had to be located in the failure of how a corporation managed its business thereby, dispensing with the 'identification principle' (Gobert, 2008). The new offence dropped the use of the identification doctrine and replaced it with a 'management failure' model that relates blame to the actions of senior managers.

The offence is aimed at work-related fatalities, which is reflected "by the high threshold of liability inherent in the requirement that death occur as a result of a gross breach of care" (Almond, 2009b: 158). The Act established a senior management test where "a substantial element of the management failure must be at a senior management level" (Corporate Manslaughter and Corporate Homicide Act, 2007: 15). The sentencing guidelines that emerged on February 2010 reneged on those detailed in the 2007 draft as they dropped the proposal to link the level of fine with the turnover of the convicted company. Instead the level of fine was established

according to the 'seriousness of the offence' and factors contributing to this such as how far the injury could have been predicted and how common the breaches were.

The Law Commission and Home Office did not provide any evidence for the conclusions that led to the Act. They were said to be influenced by various interest groups, which led Almond (2009b: 148) to describe the new offence as a "penal populist" measure rather than one that was going to succeed. Similarly, the Act is described as:

> full of dead ends, controversies, broken promises and governments succumbing to the siren voices of the Confederation of British Industry (CBI), Institute of Directors, and other employers and their organisations (Tombs, 2013: 2/3).

The new law made the conviction of directors impossible:

> An individual cannot be guilty of aiding, abetting, counselling or procuring the commission of an offence of corporate manslaughter…an individual cannot be guilty of aiding, counselling or procuring, or being part in, the commission of an offence of corporate homicide (Corporate Manslaughter and Corporate Homicide Act 2007: 15).

Any person wanting to convict an individual manager or director must use the old common law (Tombs and Whyte, 2007). As a piece of legislation, the Act:

> steers a path between the government's symbolic need to do something about "companies that kill" whilst not unduly harming business interests: a

> juxtaposition that points to a "deeper set of tensions" regarding legal attempts to control corporate behaviour (Almond cited in Tombs and Whyte, 2015: 154).

The Government's own Regulatory Impact Assessment project predicted the Act "will not generate more than 10 to 13 successful prosecutions per annum" (Field and Jones cited in Doyle and McGrath, 2016: 158).

Hadjikprianou notes:

> The cases filed so far involved companies that did not have complex management structures and thus their convictions or acquittals cannot be used as a case study on the Act's effectiveness…it has been argued the outcomes of those cases would probably have been the same even under the '"identification doctrine" (2016: 46-47).

The cases that have reached the courts thus far have not tested the law for its intentions and it remains symbolic (Omerod and Taylor, 2008; Tombs, 2013).

The new law was actually utilised by the defence in one recent case. The legal team representing the corporation appealed to the court to drop the corporate manslaughter charge lodged against the directors following negotiations where it was agreed that in return, the corporation would plead guilty to a charge of corporate manslaughter under the 2007 Act. Tombs (ibid.: 7) refers to this as "bait" and that "one form of liability is being exchanged for another." The people involved, who were once opposed to a corporate manslaughter law by way of argument that corporations are fictional bodies unable to have a state of

mind and therefore be prosecuted, are now empowered to do the opposite. The recent judgement argues that directors and managers should not be punished in favour of prosecution of the corporation (Glasbeek, 2009).

In publicly finding corporations innocent of wrongdoing, treating safety crimes as different from other crimes has been purposeful and effective. Wells says this has "[At] its base a class assumption about the types of person who commit crimes of violence reinforced by a proposition that legislative offences are 'different' from 'real' crime" (2001: 118). It is a failure of the legal system to contribute to a meaningful public dialogue about corporate wrongdoing (Almond and Colover, 2010). Equally scathing, Glasbeek notes:

> The irony is that the liberal-democratic polity prides itself on its adherence to the rule of law and on the care it takes with the application of criminal law – to ensure even-handed treatment and, thereby, the legitimacy of the system. But it still tolerates this apparent privileging of the corporate sectors. […] (2009: 125).

Instead, corporations continue to be dealt with overwhelmingly by regulatory agencies and governed by regulation that began at the time of industrialisation. Its origins and subsequent development will be detailed in the following sub-section.

Does Health and Safety law adequately detect and prosecute criminals?

Health and safety is often referred to in the media with the now popular phrase, 'health and safety gone mad'. Such a view is pervasive both through various forms of media and contemporary political rhetoric, and in a common sense that is

temporary and full of contradictions (Carson, 1974, 1979, 1981). The perception of health and safety as 'bothersome', related to 'red tape' and in direct opposition to entrepreneurialism insidiously supports the continual reduction of regulation (James *et al*, 2012). This further aids the invisibility of safety crime and increases the consequences for the secondary victims.

Under the guise of reform that repeats the same measure, governments have almost consistently found reason to reduce regulation. From the language to the sanctions given to them, it is divisive that regulatory enforcement agencies were/are not in the "business of catching criminals" (Carson, 1974: 138). The law should not interfere "with the pursuit of legitimate business goals" (Croall, 1992: 67).

The entire nature of regulatory bodies and regulations has successfully diverted safety crime away from any connection with mainstream criminal justice and the negative associations with criminality (Croall, 2003). The term itself "business regulation" stands outside of criminal law and "crime control" (Croall, 1992: 143). Regulation is the most significant part of the law, and the privileging of safety crime, occurs in relation to regulation. Whilst regulatory responses do not show the same moral disapproval that comes with police investigations (Hawkins and Thomas, 1984), regulation reveals social order; what it permits, what it prohibits (Pearce and Tombs, 1989). Too much regulation damages certain interests and too little, threatens the legitimacy of the state (Barnett cited in Pearce and Tombs, 1994: 435).

As demonstrated in the previous section, criminal law has been largely evaded by corporations who have caused injury and

death, and instead its breaches are dealt with by regulation. Moreover, in the *practice* of enforcement, the most common finding of studies of regulatory enforcement is that a co-operative regulatory approach is dominant: regulators seek to enforce through persuasion – they advise, educate, and bargain, negotiate and reach compromise with the regulated (see Pearce and Tombs, 1998: 223-246). The ways in which the corporation is able to be subject to such regulatory approaches was developed through a number of measures taken in history that began with the 1833 Factories Act.

Carson details the development of the laws and legislation relating to health and safety. He documents how the large factory owners were motivated to introduce legislation to control the smaller companies who were perceived to be contributing to over-production and thereby reducing their profits. Well established and large factory owners considered the smaller firms as exploiting the lack of regulation and laws and making profits from poor working conditions (Croall, 1992). Reformers who took on this issue called for the option of punishment, including imprisonment, to be included. This was resisted when a line was drawn between the stereotypical criminal and gentlemen factory owners:

> does the Inspector suppose that it is no punishment to a man, we will say nothing of a gentleman of education in society equal to himself, to be dragged into a court of justice, tried and condemned, and to have his name entered on a register of convicts? (Parl Papers cited in ibid.: 131).

Carson (1974) notes the battle that was fought to decide whose view should be endorsed, became symbolic the moment a Commission was set up to clear the names of the factory owners. It was agreed that inspectors should continue to

communicate with the factory owners to make the law more acceptable, this is the legacy that led to the enforcement agency being unconcerned with the search and conviction of criminals and instead with consultation (ibid.). Punishment should be "employed only against wilful and obstinate offenders" and "with regret" (Carson, 1970: 396). The early factory legislation failed because the criminal justice system was seen by all who could utilise it, as an inappropriate measure for the harms committed by factory owners (Carson cited in Wells, 2001). Instead 'bargaining' was introduced as a legitimate tool to be used between the factory owners and trade unions, all "distasteful connotations…[were] neutralised (Tombs and Whyte, 2010; Carson, 1974: 137). Here a relationship was cemented between the government and corporations, which only strengthened in the decades that followed. Carson noted in 1982 that, "'Our companies' was the constantly repeated phrase used by one senior Department of Energy official when referring to the offshore oil industry" (1982: 175).

Pearce and Tombs (1996: 435) refer to a 'corporate liberal discourse' that emerged in the first half of the twentieth century. Progress was focused on the short-term; that accidents should be accepted as inevitable in times of progress, only mediated with compensation. Risk assessments were created in the 1960s for the use of chemical companies in order to secure insurance. They were soon co-opted by corporations in response to issues of health and safety (Keltz cited in Tombs, 1995). Regulation via risk assessment allows corporations to show they are competent and know what is required of them when they agree to regulation, once again treating the employees as sources of risk (Pearce and Tombs, 1989; Tombs 1995).

The Robens Report (1972) set out statutory duties for employees and employers, rendering them both liable as well as reducing the importance of criminal law in favour of regulatory

measures. Compiling a criminal case against corporations took time and it was considered that this time would be better spent by inspectors in consulting with employers on how they could better comply with regulation (Tombs and Whyte, 2010). The premise of the recommendations of Robens was that accidents at work were the result of the apathy of the employees and not recklessness (Wells, 2001).

Tombs (1991) explores the notion of the 'accident prone' victim describing it as a myth that enables the employer to claim there is nothing they can do to prevent accidents. It is "a functional *misrepresentation* of the causes and nature of such accidents" (Tombs, 1991: 72, emphasis in original). Nevertheless, the narrative of worker apathy was accepted officially and Robens recommended that the government focus on safety awareness and accident prevention, diverting the potential causes away from the responsibility of employers (ibid.). The recommendations of the Robens report were consolidated into the Health and Safety at Work Act (HASAW), enacted in 1974.

HASAW (1974) is a criminal statute, which includes criminal offences for criminal infringements of the law that lead to potential injury, danger and death; safety violations are crimes whether or not they result in death and injury (Tombs, 1993). The HSE was created out of this in 1975 to report to the Health and Safety Commission (HSC), created in 1974 (and disbanded in 2008).

Following HASAW (1974), there was a "vicious cycle of non-enforcement" where the HSE could not maintain the self-regulation that had been recommended (Tombs 1990: 335). Prior to HASAW in 1970, there were 300,000 factory inspections (Nichols and Armstrong cited in Tombs and Whyte,

2013b) but in 1975 there were 481,000 ‘visits’ by HSE agencies (Dawson *et al*, cited in ibid) reflecting a reduction in the operation and scrutiny of corporations under the HSE.

De-regulation has been the aim of every successive government and has only been slowed by European Union legislation (Tombs, 1995). This has meant that the regulatory body created to deal with safety crime has been unable to respond effectively.

In the first half of the 1980s the HSE was “virtually emasculated” by Robens’ self-regulation (Tombs, 2000: 193). In the second half of the 1980s, public disasters led to new demands for regulation and the HSE had an increase in funding, which on reflection may have been a symbolic, political measure (ibid.). The Conservatives cut health and safety enforcement by 25% in 1996, which Monbiot (2000) links to a 20% increase of recorded deaths the following year. Even as a party created out of trade unions, Labour continued to stress they were also no threat to business interests (Miliband, 1973) and continued to paralyse the HSE. In 2000, *Revitalising Health and Safety,* was published, a shift to a “market-based” system of regulation, where the costs and benefits were weighed up to justify a lessening of enforcement (Tombs and Whyte, 2010: 30). The Labour government continued to make reductions in spite of the results of the House of Commons Work and Pensions Select Committee Inquiry published in 2004, which recommended that additional resources should be utilised to double the number of inspectors in the HSE.

The following year, the Cabinet Office published *Less is More: Reducing Burdens, Improving Outcomes,* again explicitly citing regulation as an excessive affliction. This report proposed that new regulation should only be introduced in exchange for

regulation that already existed (ibid.). It was extended to be 'One in, One Out' – in 2013 (Department for Business, Innovation and Skills cited in James *et al*, 2012: 5). As a government agency, the HSE accepted each reform proposal, including that they should negotiate with corporations and use prosecution as a last resort. Evidence suggests they preferred to use negotiation over prosecution as in the nine years between 1996 and 2005, 86 directors were convicted of health and safety offences, only 11 were jailed (Tombs and Whyte, 2010).

With fewer inspections, and no minimum requirements, the HSE was criticised in The Better Regulation Executive and National Audit Office report (BRE/NAO) in 2008 for not targeting inspections (Tombs and Whyte, 2013). When the Coalition formed in 2010, the Business Secretary, Vince Cable, continued to press an anti-regulation, pro-business agenda and promised to take "radical steps…against red tape" (Horton, 2010). It was announced that within the following five years, HSE funding would fall by 35% (Tombs, 2016).

In the same year as the Coalition came to power, Lord Young was appointed for the review, *Common Sense, Common Safety*. Moving seamlessly between health and safety to compensation, the review sought to find evidence for the 'compensation culture' but was forced to conclude:

> The problem of the compensation culture prevalent in society today, is, however, one of perception rather than reality (cited in James *et al*, 2012: 19).

Employment Minister Chris Grayling continued to attack the health and safety culture, claiming it was 'stifling growth', and proposed a reduction in inspections by 65,000 and a reduction

in proactive inspections by one third (DWP, 2011). In 2011, Grayling invited people to submit their views over five months on existing health and safety law in the 'Red Tape Challenge' (Health and Safety Executive, 2011). This was repeated in 2012 when the public were invited to suggest what regulation should be changed, abolished or extended (Tombs, 2016).

In 2011, the Lofstedt Review examined whether regulation could be reduced or tailored for small corporations. It concluded that regulation does not require major change and supported the current regime of HASAW (1974), stating regulation has positively reduced the harm caused at work since its creation (ibid.). The report was utilised to reduce regulation further and supported the concept of 'low-risk' that James *et al*, (2012) stated would have a real effect creating victims by increasing the risk and numbers of deaths, injury and illness at work.

Historically then, the state appears reticent to refuse the needs of corporations and profit, and tries instead to attract its influence, investment and confidence (Snider, 1993). Regulation stifles growth, as can be seen when the oil industry when they were "Anxious to be fettered by nothing more than its own technological limits, the offshore oil industry sees statutory safety controls in general, and harmonization in particular, as impeding its spontaneous progress" (Carson, 1982: 203). The clash between regulation and advancement continues to be justified. In 2011 Prime Minister David Cameron took opportunities to bemoan health and safety and continue the ideological assault on the need to regulate and the legitimacy of regulators. He linked 'broken society' and human rights to "the obsession with health and safety that has eroded people's willingness to act according to common sense" (Cameron, 2011). He weighed up regulation with the effectiveness of business as being diametrically opposed and

urged the HSE to arbitrarily cut regulations by half (James *et al*, 2012).

Cameron perpetuated a myth on health and safety at Conservative Party conference in Manchester, attempting to combine humour with imperialism, “Britannia did not rule the waves with arm-bands on” and citing it as a reason children were not getting work experience (Cameron, 2011b). Cameron called his party to action in 2012, "This coalition has a clear new year's resolution: to kill off the health and safety culture for good” (Tombs, 2016: 123). As the Deputy Prime Minister, Nick Clegg agreed:

> For too long new laws have taken away your freedom, interfered in everyday life and made it difficult for businesses to get on (Prime Minister’s Office ibid.: 124).

The government continue to favour a ‘risk based’ approach, reassuring that higher risk businesses will continue to be monitored, in return for reduced inspections elsewhere (Tombs and Whyte, 2013). The result is that the average workplace should expect an inspection less than once every 38 years (James *et al*, 2012). A corporation needs only to pretend to cooperate with inspectors and regulation, in what McBarnett and Whelan refer to as ‘creative compliance’ (cited in Gobert and Punch, 2003: 17). Many do so successfully, for example, Union Carbide’s slogan prior to the 1980s was ‘Production at a cost: safety at any cost’ (Pearce and Tombs, 1993).

Irrespective of party allegiances, governments have continued to reduce the scope and effectiveness of the HSE (Tombs, 2016). It has been largely accepted that free enterprise is good

and should not be attacked by the state or controlled with regulation – an ideological assault. If it is good for business, it is good for society and the state should withdraw (Michalowski and Kramer cited in Tombs and Whyte, 2003; see also Tombs and Whyte, 2009). Seen as a threat to business, regulation of any kind breaks the relationship between the state and the markets (Gordon *et al*, 2004). Regulation is an opportunity to avoid or minimise injury and death, but only within the limits of capitalism (Tombs and Pearce, 1989). Regulation is not to be eradicated but it must be minimized to near paralysis. Instead corporations are congratulated on even poor safety records, as Carson noted at a "commercially organized seminar" in the oil industry "when members were told that the offshore safety record was not a good one" it was not the corporation who rose to defend this allegation" but the government safety body who emphasised the industry "come further in seven years than any other comparable one has in three times that time'" (Carson, 1982: 176).

Any success of regulation is hollow, the fines are relatively low in relation to profit the corporations make. The 'record' fines work to "…strengthen [capital's] legitimacy through the symbolic effects of an apparently class-neutral law and its enforcement" (Tombs, 1995: 354). For example, Balfour Beatty were fined £150,000 for the death of Michael Mungovan, which pales in comparison to their turnover of £2 billion in the first six months of 2004 (Monbiot, 2005). By holding corporations to account for breaking regulatory codes under HASAW 1974, the fines are paltry, what Slapper (1993) compares to the equivalent of a parking fine levied at an average member of the public.

Corporations are being prosecuted less and for fewer offences. The past 30 years have seen many changes to regulation and the HSE, which are unlikely to be reversed in the foreseeable future

(James *et al*, 2012). Prosecutions have reduced from 1999/2000 to 2011/2012, falling by 54% where convictions have reduced by 52% (Tombs and Whyte, 2013). The regulators created to control risk-taking and law-breaking are unable to be effective. The HSE are now incapable of preventing major incidents, as shown by their track record, which has meant that businesses are not discouraged from taking risks that lead to the loss of life and injury for thousands of workers (Gobert and Punch, 2003).

The tension between regulation and policing aids this invisibility (Tombs, 2003). The HSE do not have the funds or ability to enforce the laws that do exist and so are pushed to rely on encouraging compliance rather than demanding it (Monbiot, 2004). Any consultation that precedes less regulation excludes those directly affected; the workers. For example, unions were not consulted prior to the Lofstedt Review (DWP, 2011). In contrast both the Chamber of Commerce and a right wing think tank were also consulted whose interests were openly in the free market (James *et al*, 2012). The views of the workers are therefore side-lined yet they are the individuals who are affected by the emasculation of the HSE and following a corporate killing, it is their families who suffer.

In *Blood in the Bank*, Slapper (1999) concludes 24 out of 40 deaths featured in his research were the result of the pressures of making profit, not ignorance but unwillingness or inability to pay the costs to ensure the work was safe. The HSE themselves say that between 70% to 85% of workplace deaths are preventable, compared to less than 20% that result in prosecution for health and safety offences (Slapper and Tombs, 1999). In an environment of de-regulation and reduced legitimacy of the HSE, the number of unsafe workplaces will only increase.

The government's desire for economic wealth at any cost is at odds with care for the employees and leads to cost calculations (Carson (1974, 1981). This can be seen in cost calculations, for example, on the railways. A safety system (ATP) was proposed in the 1990s but rejected on the basis it would cost £10.9 million per life to install and was subsequently dismissed by the Transport Secretary who said it would only prevent 3% of fatalities (Wolmar, 2001). Such cost calculations are subjective, despite being held up as scientific and actuarial. Statistics can underestimate the benefits and exaggerate the costs, using the previously example, Hall recalculated that a third of lives would have been saved had ATP been implemented (cited in ibid).

Formal enforcement action is rare, and overwhelmingly involves the imposition of notices of varying severity. Prosecution is a 'last resort', and is seen as a failure within the enforcement agencies themselves (Hawkins, 2002). Almond relates this to the level of wrong and harm, i.e. the case must be seen as winnable (Hawkins cited in Almond, 2009b). The effect of this general *modus operandi* on the part of regulators is to prevent the vast majority of corporate offending ever being recognized, recorded or treated as crime – and if there is no crime, there can be no victim of crime (Tombs, 1999). Yet victims exist, victims who have been harmed by the loss of their loved one as a result of safety crime and then by their invisibility. The following section will draw together safety crime with the victim and draw comparisons between the victims of safety crime and the other invisible victims.

How is the victim constructed?

Critical criminologists have argued that "criminology has enjoyed an intimate relationship with the powerful" determined by "its failure to analyse the notion of crime…handed down by the state" (Foucault; Cohen; Garland cited in Hillyard and

Tombs, 2008: 15). They assert that the state and the power it wields is central to any critical criminological analysis. Here the state colludes with corporations and as a perpetrator. Similarly as an analysis of patriarchal power, feminists challenge the power of the state as inbuilt into the criminal justice system and raise awareness of offences which were primarily related to females, such as domestic violence and rape. Lees refers to the way "male norms are institutionalized at every stage of the criminal justice system" (1996: xx). This is important because the consequences are for women who find themselves in court seeking justice; here they lack a "voice" and are "overlooked in the assumed 'rationality' and 'objectivity' of the [court] proceedings" (ibid.).

Feminism criticises the law for neither reflecting nor upholding the rights of females. The courts do not try to be patriarchal in minutiae actions, but patriarchy is woven into the "structure of rape law" so that "the more objective they are in procedure the more effectively patriarchal they are" (Tosh cited in Ballinger, 2016: 24). The procedure is presented as the best there is, couched in historical importance and run with expert knowledge. Agents of the criminal justice process can pursue a discriminatory procedure simply by obeying the rules. The law creates a narrative and is a "process of constructing masculinist official discourse…the voices which fall outside official discourse are disqualified and silenced" (Ballinger, 2016: 23). Victims may be able to offer their account of what happened in a courtroom, they might be *heard*, however by the time they come to speak it is through the lens of the [patriarchal] law (ibid, 2016). Theoretically, victims of safety crime have been compared to such experiences of victims of domestic violence in the 1970s as uncovered and revealed by feminists (Shover *et al*, 1974).

The construction of the victim

Who is considered a victim "cannot be taken for granted", ideas about victims are "optional, discretionary and not innately given" (Whyte, 2007: 446). Who is awarded victim status has changed throughout the last century and prior to the late nineteenth century, the victim as a discrete category did not exist at all (Walklate, 1989). As a starting point for the examination of the construction of the victim and always with one eye to safety crime, it is perhaps appropriate to trace the victim back to the time of the Factory Acts of 1819 and 1864 and to the time when the role of the state had progressed to become 'interventionist' (Tombs, 1995). Images of vulnerable children as victims of business malpractice were used by those seeking to reform the system, which led to better working conditions for workers (ibid.). Kearon and Godfrey (2007) note this was an attempt to reassert moral and normative frameworks within industrialisation and out of this moral enterprise, the ideal offender and the ideal victim emerged, a concept which is crucial for this chapter (Hendler cited in Walklate, 2007). Victims were recognised as a *necessary* part of the criminal justice system but they were not to be protected or humiliated. Proposals were increasingly introduced post WWII in the name of the victim, which recognised this negotiation (Sanders and Young, 2000, Davies *et al*, 2005). A clear link was, and continues to be drawn between crime and a reduction in morality that governments have attempted to redress (Whyte, 2007).

With an interpretation of post WWII ideology on the welfare state, the status of the victim continued to gain in prominence. Mendelsohn introduced the term victimology in 1940, rooted in a functionalist view of society (ibid; Kearon and Godfrey, 2007; Whyte, 2007). Mendelsohn considers that a victim may not be wholly innocent, which fitted with the aims of the government as they drew out the 'deserving' victim for whom the state will

intervene (cited in Williams, 1999). Notably, this can be seen in compensation schemes and comparisons drawn between the deserving and the undeserving poor (Williams, 1999; Mawby and Walklate, 1994). It created a categorisation of who is a victim, choosing to focus exclusively on the victims of unlawful violence to the exclusion of a plethora of others, for example, victims who have served a prison sentence are not entitled to receive full compensation from the government (ibid.; Tombs and Williams, 2007). In the eyes of the state, ex-offenders are not ideal victims and are less deserving of compensation than those who are unconvicted, and thus clear lines are drawn between the two.

The opportunity offered by victim surveys introduced into Britain in the 1970s and 1980s to counter many taken for granted assumptions about who is a victim, failed to fully realise their potential. Victim surveys were widely "criticised for a somewhat narrow focus on interpersonal violence and property crimes such as theft, burglary and robbery" (Croall, 2010: 169). In addition, the omission of certain types of crime from the focus of victimisation surveys, as with official statistics, leads to the exclusion of certain victims from public and political debate. For example, the results of surveys were not used politically to try to protect those revealed as most at risk; the young, male, economically disadvantaged offender (Green 2007). Green (2007) notes this was possible by the hiding of abuse within children's homes and domestically, misrepresenting the realities of crime. Instead, the 'vulnerable' victim (and the threat of being a victim) continues to be utilised politically in calls for punitive penal measures to take from the offender (ibid.). In this, the victim survey is restricted to examining a small proportion of victims, continuing to hide certain inequalities prevalent in society (Croall, 2010: 178). The 'ideal' victim continues to be "connected to the construction of a generally accepted or consensus view of how the criminal justice system should respond to crime" (Whyte, 2007: 447).

Irrespective of who the true victims are, the 'ideal' victim is the victim who "attract[s] public and media attention and sympathy" (ibid.).

Critical victimology opened up the debate to include victims who were not state defined, such as victims of the police, war, prisons and state violence (Mawby and Walklate, 1994). By many, the state was seen as an unsuitable starting point for defining who is and is not a victim with a recognition that the state needs to distract attention away from its own violent, sanctioned violence so it can continue to be the purveyors of increased law and order to restore moral order (Sim, 2004). As with the move away from a positivist approach, this analysis is not without its opposition. It is criticised for ignoring the plight of conventional victims along with the influences of gender, race and age and for simplistically reading of the law and social class (Sumner, 1994). Whilst approaches such as new realism answer this criticism and challenge issues such as intra class and racial crime, Walklate agrees with Sim *et al* (1987) that the left realist faith in the political process without also looking at social regulation and control, is problematic.

Relying on the state to define crime and trusting the outcomes of the criminal justice system to define who is a victim means many victims are excluded. Of particular relevance to this research, in the 1960s and 1970s, feminists called for more examination of female victims, which were largely missing from the male dominated criminological agenda; to "name that which had gone without a name" (Mawby and Walklate, 1994: 10). As an alternative discourse, feminism tackles myths about rape and raises awareness of the political significance of rape (Lees, 1996). In the second half of the twentieth century, the criminal justice system was revealed not only as unreflective of the victims that were being created but also as being a perpetrator and causing additional pain to females (Shapland

1985). By highlighting the experiences of the female victim in the criminal justice system, feminists demonstrate how woefully inadequate the process can be at recognising certain crimes and in the delivery of justice (Davies *et al*, 1995).

The experiences of female victims are not reflected in official statistics, fewer than 7% of rapes recorded by the police in England and Wales result in a conviction (Temkin *et al*, 2016). With the use of victimisation surveys, writers were better able to qualify what they had long suspected, that rape was in fact a regular occurrence and that the perpetrator was more likely to be men known to the victims rather than a stereotypical "fiend" (Davies *et al*, 1995: xii). How the criminal justice system avoided representing these truths is examined in Lees' 1996 research, which shows how the criminal justice system relies upon various rape myths in its interpretation of the truth. (These myths include the failure to resist, that sex offenders are different from ordinary people, kissing as consent and rape is an easy allegation to make (Tempkin *et al*, 2016.)) The success of cases in court is dependent not upon the act itself, but how the event is framed within the criminal justice system. The uses of rape myths used by defence barristers in court undermine the credibility of the complainant, deny victimhood and crucially, "make her appear unworthy of the protection of the law" (ibid.: 2). Lees comments:

> The image of the law is one of impartiality, objectivity, rationality and neutrality. Traditionally, the law is supposed to treat all who come before the courts equally, regardless of class, race, sex or creed. This is far from the case (1996: 130).

The truth is not something static, presented and dissected by the neutral agents of the court determined to hone in on the facts. Instead its inept response to cases of rape, blocks justice,

damages and creates future victims. Victims of rape are disadvantaged due to the nature of offence committed against them and the defence counsel has:

> at his fingertips a history of misogynist thinking to draw on about women's mendacity, untrustworthiness, spitefulness, impurity, provocation, wildness, unpredictability, irrationality and general unreliability…the idea that all women are 'whores' who cannot really be raped as they want it anyway (ibid.: 261-262).

Victims of rape do not measure up against the 'ideal' victim and numerous cases fail at the court, if they ever reach that stage. Much progress has been made and changes in the law have occurred as a direct result of academics and groups involved in campaigning and the raising of awareness. Previously, some examples of rape (notably, marital rape) were viewed separately to other types of rape. Lees' (1996) book categorised rape into two sub sections, choosing to prioritise the study of rape by strangers, acquaintances and ex partners over rape committed by husbands or cohabitees. Though this was justified by the authors on the grounds of other recent and pre-existing research which covered inter-marital rape, the categorisation itself would be unlikely to be repeated twenty years later. Those at the 'coalface', for example members of campaigning groups, may recognise such discrepancies as Lees notes that in response to her decision not to study rape within relationships "Rape Crisis centres were critical…and failed to understand our need to limit the scope of the research" (ibid.: 8). This demonstrates how choices about what is studied and what is not studied changes over time in accordance with our own preconceptions about what is really a crime and the categorisations that are made. This is never fixed or complete.

In summary, the law may present itself as neutral, but it operates based on a number of assumptions about who is and is not a victim. Victimhood is developed through "a process of publicly validated construction" (Winter, 2002: 179), which involves communicating with others, flexible meanings and transitions; in short, it is a moral career (Sykes, 1992). Whether an event is perceived as criminal and how it navigates through the criminal justice system has major implications for victimhood. Critical victimology has highlighted the need for the state not to take centre stage in defining who and who is not a victim, led by feminists in their demands for justice for female victims and for them to be seen and treated as genuine victims.

How do the victims of safety crime compare to the 'ideal victim'?

Whilst crime happens and victims are created every day, up to now this chapter has argued that although these occurrences are worthy of study, there is an alternative victim who has been rendered invisible. People like Sidney Rouse are invisible both from the Victims Charter and victims' movements (Mawby and Walklate, 1994), which is important because it exacerbates their suffering in similar ways to that of rape victims. Fattah argues the fate of victims of safety crime is "sadder" than "victims of conventional crime" because "they lack any means of redress and usually have no recourse against the perpetrators of the abuse" (Fattah cited in Levi and Pithouse, 1992: 230). This section will draw together victimology with criminology for an examination of how the victims of safety crime are invisible and who they are likely to be.

When examining who is and who is not a legitimate victim, the concept of Christie's (1986) 'ideal victim' is useful. Christie (ibid) outlines an ideal victim as weak (sick, old, young), carrying out a respectable activity where they are devoid of any

blame and attacked by an evil perpetrator who is unknown to them. The ideal victim would attempt to defend themselves before being overpowered. They are able to claim the status as an ideal victim, afraid of being victimised and have not deliberately put themselves at risk (ibid.). This is summed up as a 'little old lady' who is fearfully walking the street in the daytime after caring for her mother when she is randomly attacked by someone who is a stranger to her. She is overpowered, though she resisted. As an elderly member of society, this victim is in a position where their case will be heard and will not threaten dominant interests. Few real victims measure up to the ideal victim, including the victim of safety crime.

Firstly, the victim of safety crime is not often weak in a traditional sense of the word – they are often of working age and below retirement. However, on the second point, as wage earners and workers, they are carrying out a respectable activity, one which is expected and applauded. Secondly, the offender is not often an individual and in the sense that Christie (1986) was writing, they are not big nor viewed traditionally as bad. Thirdly, the offender is known to the victim and further, the victim has signed a contract to be in a relationship with the offender as an employee. The victim may or may not have resisted the crime, but indirectly, it is unlikely that at the time of the crime, the perpetrator will have been face to face with the victim. Related to the final points of Christie's (ibid.) 'ideal' victim, a victim of safety crime is not powerful enough to state their case as a victim, it is unlikely they would have been frightened of victimisation on a daily basis and finally, widespread recognition of their status as a victim would be a challenge to dominant interests. The following section examines the victim of safety crime in more detail using both Christie's (1986) 'ideal' victim with Croall's (2016) recommendation that the processes of victimisation should be explored through links between social factors.

The victims of safety crime are comparatively less powerful in terms of social class. They tend to be working class where the lowest paid workers are the most exploited (Whyte, 2007). Within the working class, those aligned to a union are statistically safer, a concern when at the time of writing, unions cover less than 20% of Britain (Ewing *et al,* 2016) and the casualization of labour is increasing. Workers who are subcontracted and those on zero hour contracts have increased risk of becoming victims of safety crime due to their "relatively subordinate economic position" (Whyte, 2007: 455). The corporations themselves are under pressure to deliver and know unless the workers meet the requirements of the contract, they will lose profit, as one worker put it:

> 'Well, I've got pressures; I've got to get these jobs done. If your company won't do it, we'll soon get another company to do it'…And you have got fairly experienced men in these positions, but their professional judgement is far too often, I think, clouded by the commercial pressures (Carson, 1982: 76).

Victims are, "more likely to work in smaller rather than larger workplaces, or to be self-employed or on short- or fixed-term contracts, to be non-unionised, and receiving low levels of pay" (Tombs, 1999: 91). Victimisation is, "known to reflect wider social inequalities, with the poor and least powerful being more severely affected" (Croall, 2016: 71) so that "the impact of some, if not most, white-collar crime falls most severely on the poorest" (ibid: 71/70). This is true of the secondary victims who are likely to match the social class of the person killed.

With regards to minority ethnic groups, migrant workers are more likely to be exploited (Croall, 2016) and lower employees are more likely to be seriously and fatally injured (Tombs and

Whyte cited in Croall, 2010). One exception to this is with regard to financial crime when the rich are more at risk due to the need for money to invest in the first place (Croall, 2016). Here, the more affluent are more likely to be informed about the dangers of risky investments or products and employ independent financial advisors who spread their risks and are less likely to buy cheap and dangerous goods. As consumers, it is the more affluent who are able to resist the location of dangerous chemical plants or industries and can move away if they are unhappy. "In short, they are protected by their economic, political and cultural capital" (Croall cited in Croall, 2010: 12). Whereas the "least affluent have fewer choices, less information and are less able to 'shop around' for higher quality goods and services" (ibid.). The same can be said of workers who rely upon a steady wage and are either living in or on the edge of poverty. However, hazardous chemical and waste plants are situated closer to black and minority ethnic communities and have a disproportionate effect on those inhabitants (Lynch *et al*; Pellow; Pinderhughes cited in Croall, 2010).

Related to age, victims of safety crime are more vulnerable when they are older to food poisoning, aggressive sales and commercial crime (Croall, 2007). When they are younger they are at risk of being harmed by toys, as students at the hands of landlords and in the misleading practices of mobile phone companies (ibid.). In these instances they could be described as 'weak' in the manner of Christie's 'ideal' victim, however research has not focused on the experiences of victims of safety crime in relation to age, who by definition are at working age and therefore tend not to be either very old or very young.

Examining gender and victimisation, Szockyj and Frank (1996) highlight how women are in a lower status than men and experience secondary victimisation at the hands of a patriarchal political system that does not help them; "In a society in which

opportunities and expectations are differentiated by gender, it is only to be expected that the distribution and nature of victimisation are gendered as well" (1996: 11). They examine women as producers and reproducers and conclude that women are more vulnerable as consumers conforming to beauty norms and as mothers and as second class employees. In one example and an interaction between gender and class, the Dalkon Shield, marketed as a contraceptive, killed 33 women and following doubts on its safety, sales were shifted to developing countries (Mintz cited in Whyte, 2007). Perhaps again linked to class, women are also less likely to be members of unions (Szockyj and Frank, 1996). Croall (2007) illustrates how women are also victimised through the function of their socially ascribed characteristics and structural location within patriarchal societies. In their position as wives and mothers rather than workers, historically, women are less likely to be victims of safety crime. More men are affected by safety crime because of their dominance in manufacturing occupations (Tombs and Whyte cited in Croall, 2010). Following the death of a worker however, it is the females who are most likely to suffer the short and long term effects of a sudden death when the breadwinner and father is removed. It is generally females who are tasked with navigating and securing victimhood as secondary victims of safety crime, a role which has been unexamined within academic research.

The experience of victims of safety crime is further exacerbated by the nature of the victimisation as the victim has to realise they are a victim (or their families do), that it was not a random act and be in a position to search for evidence of this from the corporation itself (Szockyi and Frank, 1996). The nature of the corporation as a perpetrator takes us to the next two categories.

Victims of safety crime have been seen as fully aware of the risks entailed in certain jobs, that in exchange for higher pay,

they accepted potentially grave circumstances. Carson found this in his research when a Texan oil rig superintendent told him: “the offshore worker is paid his money and can take his chance” (1982: 76). This fed into the “emergence of a stereotype of the offshore worker as someone who…recklessly embraces immense hardships and incalculable risks in the pursuit of quick rewards” (ibid.: 45).

By agreeing to take more money, ‘danger’ money, the risks are minimised and further, this appears to automatically presume they are the type of person to take additional and potentially fatal, risks. In Carson’s research, a senior department official remarked: “We are talking about the type of lads who chase money…a certain type of labour which hasn’t shown itself in the past to be very careful about how to do things” (ibid.: 45). Carson noted that this was supported by other regular contributors in the industry who claimed that:

> ‘fatigue, cold, hunger and, not surprisingly, boredom are major factors contributing to the accident rate’…This rather leisurely image of the bored worker whose attention momentarily wanders, to his own or others’ subsequent detriment, is not quite in line with the impression of the offshore work situation gained in the course of this research…On the contrary, the picture painted was one of hard, long and continuous labour” (ibid.: 72).

The perpetrator may be big as corporations grow in size and scope. The fragmentation in the way labour is organised, diffuses responsibility and means that identifying a single offender is problematic (Croall, 2016). The potential offender is not seen as ‘bad’ but as a respectable business person who is known to the victim, which can lead to the blame being redirected at victims (Rock, 1998). Rather than being vilified as potentially criminal, successful business people are

(increasingly) idolised in the press; courted as self-made and aspirational, they are far removed from the anti-social, unemployed, gang members, drug addicts associated with criminality (ITV, 2012). Instead, the victims are easily blamed (Croall, 1992) and the 'therapy' culture that pervades Western society means the general public scrutinise personal characteristics of the victims and offenders. This in turn diverts attention away from pre-existing social and economic injustices (Spalek 2006). This also fits with the positivist approach of analysing how the victim caused their own victimisation, highly useful for the perpetrators of safety crime who are also in a position to conceal and manipulate the scene of death (Whyte, 2007).

Victims of safety crime may not protect themselves against a perpetrator, as in Christie's conception of the 'ideal' victim (1986). Parallels can be drawn with rape victims who are expected to struggle, ignoring that women "are socialised against aggressive behaviour" (Lees, 1996: xvi). Workers are structurally in an inferior position and by entering into a contract, they are employed to carry out duties on behalf of the corporation. They are rarely able to negotiate how, where they work or how much they are paid (Whyte, 2007). The EU described the relationship as one of subservience (Ewing *et al*, 2016) where only membership to collective organisations such as trade unions offers any chance to alter the working contract. Richard Walker was aware of the dangers he faced as a diver in the North Sea on an oil rig as this extract from his diary entry made on the day of his death testifies, "Poor topside management. Guys here are nuts…and dear God I want out" (*Glasgow Herald* cited in Carson, 1982: 296). This diary entry was made on the day of his death when he was suffocated 490 feet under water, his body recovered after eighteen hours. In his diary, he endeavoured to secure different employment because:

> It leaves my stomach twitching…Oh God, please help me to exercise my talent and will to pull out of it. I don't even know if I'm gonna get out of here alive. I never know" (ibid.).

It is clear that Richard Walker was desperate to move employment and in spite of fearing death, he did not walk away from the job. Should he be blamed for voluntarily walking into his own death? Related again to female victims as illegitimate, "As Faludi (1991) points out, women [the victims] are blamed for the very problems they face" (Lees, 1996: 94).

When the victim is dead and physically unable to make their own case, the accounts that remain are "constructed for a purpose…to diminish the defendant's culpability and inflating that of the victim to blur moral differences" (Rock 1994:25). Any victim, who has died, may be blamed for their death (Rock, 1998) and be de-humanised as much as possible in the court. After their death, their needs are neglected. The numbers of those affected have not been collected or counted accurately and instead a discourse is encouraged which makes the issue of health and safety a joke and causes additional problems for the families of those affected when a loved one is killed at work (Slapper and Tombs, 1999). The accident prone victim is blamed for their own demise, their actions are scrutinised against what we are all told we *know* about deaths at work; that it is not criminal and should not be treated as such (Tombs, 1991). If health and safety is over cautious and a national joke, any person who dies at work *must* have been flouting the rules. In the same way we *know* that women cry rape against innocent men, so any rape victim must first be viewed as a potential liar.

Similarly, victims of safety crime face a larger offender pitted as authority, which they are taught not to question from an early age (Bowles and Gintis, 1999). In many cases of safety crime,

for example, a death from being crushed or a fall from a height or an explosion, victims do not have the chance to defend themselves from a perpetrator. As workers, they are vulnerable to the demands of the employer as felt keenly in the production of oil in the 1970s and 1980s when demand was high, "…it costs a lot of money to operate an oil or production platform, so there is pressure all the way down the line" (Carson, 1982: 74). In the case of safety crime, it would be more appropriate to find out whether employees doubted the safety of their workplace and changed their behaviour or took measures to leave, similar to that of victims who refrain from walking alone or install burglar alarms. The preoccupation with crime as a single event obscures the nature of corporate offending that can only be explained in context.

The victim of safety crime faces a multitude of barriers that block their ability to claim the status of ideal victim (Christie, 1986). Offending and victimisation is part of a process rather than a single event (Croall, 2016). Following a safety crime, "[The victim must] overcome…[the presumption] that the injury is a just a random happenstance…in order to be treated as a crime victim" Szockyj and Frank, 1996: 8). Walklate (1989) recognises that in respect of safety crime, the success of framing incidents such as Piper Alpha as a 'disaster' and beyond control encourages a failure to point out criminal activity as a factor, which affects the subsequent handling of events. Referring back to Lees' research, the courts:

> often present issues only from…the defendant's standpoint, which is then treated as the only objective, rational position to hold…the complainant is scapegoated as a 'slut' or as unrealisable, and her account of what happened is rarely reported, while the defendant's version is often given as incontrovertible fact…men are often represented as the true victims of false allegations (Lees, 1996: 93).

Being denied victimhood as a status leads victims out of the criminal justice process, families of victims have been persuaded that 'accidents happen' and consequently go on to settle for compensation. For example, it is estimated that 5,000 people were killed immediately in Bhopal in 1984 and 8,000 people have been affected and 80,000 in the years that followed (Pearce and Tombs, 1989). Nevertheless, only 3,329 victims were officially recognised and considered fit for compensation (Pearce and Tombs, 2012).

The victim of safety crime requires identification of a corporate offender, which is not an ideal offender and in doing so, is a threat to other important interests (Christie, 1986). There is a gulf between the power of an employee and employer, with an inherent conflict between the two (Ewing *et al,* 2016). In cases when the victim dies, they have no rights whilst the powerful perpetrator may be protected by the criminal justice process (Rock, 1998). This imbalance of power is most palpable in the globalisation of work where corporations relocate production to take advantage of migrant workers (Croall, 2010). The perpetrator, the corporation, benefits from having a clean criminal record and are already in the favourable position of being seen as making a positive contribution to society just by way of being in business. Once again drawing similarities with Lees' observation in the case of rape:

> For a man, his occupation and lack of previous criminal record are the two main factors deemed to be relevant. Quite apart from the personal bias of individual judges, then, sexist assumptions are already built into the way the rules of evidence on character and credibility are interpreted and applied in court (Lees, 1996: 130).

Whyte (2007) states it makes sense that safety victims are hidden because seeing them would problematize crime as a result of declining moral standards; they are unknown because they are not counted. However the reverse is not true as businesses are encouraged to be seen as victims, for example, the Home Office regularly organises a Commercial Victimisation Survey alongside the British Crime Survey (Shury cited in Whyte, 2007). An attack on business is hailed as an attack on the whole community, victims together. Perhaps indicating business has become part of the 'victimised state', which Sim (2004) notes is over-represented in comparison to the victimisation of the most powerless and disadvantaged members of society.

Finally, being killed at work is statistically more likely than being killed at the hands of a common murderer, but no surveys, similar to those carried out by Left Realists, have been completed into the fear of safety crime. This makes it difficult to say with any certainty whether victims are afraid of being victimised. We are only to fear traditional crime committed by traditional criminals.

Comparison to the 'ideal victim' goes some way to explain why victims of safety crime are viewed as undeserving of the weight of the law. The construction of victimhood is important because only the 'ideal' victim is of use to those who seek to define how the criminal justice system should respond to crime, affecting policy change (Miers, 2000). There is a longstanding separation between safety crime and 'real' or 'conventional' crime is both reflected and *institutionalised through* state responses to corporate offending, excluding its victims from consideration or treatment as real victims of real crime. Most obviously, this separation is signalled in the fact that offences committed by corporations are subject to regulation (not policing) by a diverse range of state and quasi-state agencies. Whilst the sanctions

exist, they are very rarely able to be utilised by the court and whilst the following comments were taken from Lees' work on rape, they could be applied to safety crime:

> The availability of such harsh penalties provides the illusion that the judiciary has taken appropriate action to control rapists, although in practice the maximum penalties are almost never used (Lees, 1996: 240).

Similarly, Croall notes that offences committed in a corporate culture are accepted in pursuit of legitimate organisational goals such as efficiency (2010).

In Greer's (2007) hierarchy of victims, the victims of safety crime rate poorly as they comparatively do not lead to a change in policy or attract the attention of the media. There are some safety crimes that have featured in the press although they tend to be the more sensational cases and not typical of the deaths that occur weekly and routinely across Britain and the world (Shover *et al*, 1974). The media favour a simplistic reading of offender and victim that fits with the' ideal' victim. Safety crimes present as more complicated, slow to resolve and with a dissatisfactory outcome in terms of delivering justice (ibid.).

Since victimhood is a moral career (Sykes, 1992) and requires recognition by the criminal justice system in order to attain justice, the need for research to make victims visible is crucial (Croall, 2016). If victimhood is dependent upon social, legal and political conditions (McGarry and Walklate, 2015), academic research can help to change yet research on the victims of safety crime has remained very much a minority interest among criminologists, despite significant contributions in the field of victimology since the 1970s onwards (Szockyi

and Frank, 1996). As a subject, Rock highlights that it has ignored what does "not bear the names of crime, criminals and criminal justice" (1994: 7), whilst Young notes that safety victims "remain in the shadows, backstage, glimpsed only out the corner of the eye" (2002: 138). Exposure is important can produce change, as demonstrated by the way corporations hide tax avoidance schemes (Neville and Treanor cited in Croall, 2016). As McGurrin and Friedrichs argue, exposing the harms and expanding the conceptualization of crime victims by constructing harmful activities as "criminal" can play a part in combating them (cited in Croall, 2016). Part of this has been exposing the experiences of victims of safety crimes.

What are the experiences of invisible victims?

Unsurprisingly, studies of corporate and safety crime victimisation, then, frequently refer to the associated traumatic and enduring psychological effects associated with the denial of victimhood (Friedrichs, 1996). In particular, Spalek (1999, 2001) documents the ways in which victims of white collar and corporate crimes have been affected. Those researched were victims of financial crime. Spalek (2006) identifies five ways that being a victim impacts on a person, which is detailed below.

Firstly, psychological effects happen as a result of the victim experiencing a criminal harm that violates social norms, it can lead to self-doubt, and a questioning of previously 'normal' behaviour, and leading to self-blame. These factors can affect confidence and lead to a search for meaning from the event. The more a victim blames themselves, the more they may find it difficult to adjust to relationships (Wyatt *et al* cited in Spalek, 2006). Secondly, emotionally, a victim can fear repeat victimisation, which causes stress as this as the past is reimagined; leading to physical stresses such as high blood

pressure and insomnia. Victims can become more isolated and the lack of support can compound frustration and hopelessness. Thirdly, a victim's behaviour might change including how they act and live in everyday life, for example, avoiding areas or using alcohol to cope. Fourthly, the victim could take their own life or attempt to hurt the offender. Finally, financially victims are responsible for the cost of going to court. The factors above also affect their ability to return to work. These factors detailed may be exacerbated by stresses that the victim was already experiencing (such as poverty), the event itself (how severe it was) and lastly, the long-term effects the victims are left to bear. Spalek (ibid.) points to how in reference to white collar crime, research has focused on the social, psychological and financial costs rather than the general human impact.

In the Bank of Credit and Commerce International (BCCI) case, many victims thought their pensions were safe and had their expectations shattered (ibid.) their trust betrayed (Croall, 2016). In their study of female victims of corporate crime, Rynbrandt and Kramer (2001) state there is an "extreme power differential" between victims of corporate crime and "giant corporation[s]" which "immediately places the woman in a vulnerable legal, economic, and social position" (2001: 171). In the Maxwell case too, victims were tired of campaigning and felt a sense of powerlessness as they were pitted against a "far bigger criminal" (Spalek, 1999: 226). The size of corporations is crucial in the increasing prevalence of corporate crime and they are becoming ever larger and feature more frequently in our everyday lives, from sponsoring schools to providing funds for political parties (Tombs and Whyte, 2015).

The position of the victim compared to the perpetrator was detailed in Scraton's (2009) work with the survivors and families of victims of Hillsborough. Scraton (ibid.) illustrated the consequences of not being a conventional victim and how

this affects the response of the state agencies. The victims and survivors of Hillsborough were denied their victimhood, blamed and even harmed by the state and its agencies. Scraton (ibid.) details how a mother of one of the victims of Hillsborough was prevented from touching her loved one:

> Whatever she had done, however much she had pleaded, access would have been denied. The decision was immovable, indefensible…[the mother was] left to carry the burden of that denial and a deep sense of guilt that she should have done more to challenge those who had discretionary power to make arbitrary, *ad hoc* decisions, to change minds narrowed by professional convenience and personal intransigence (ibid: 114).

Contact with such agencies cannot be avoided yet being treated poorly and the serious consequences of this all have to be borne by the individual. Tombs and Whyte state that "in almost every major case of corporate crime corporations escape liability for the burden of social costs: costs that always fall on the most vulnerable" (2015: 15). It is the "poor and powerless" that are "most vulnerable to exploitation and victimization" from white collar and corporate crime, just as they are in conventional crimes (Croall, 1992: 169).

With reference to health and safety crime research Spalek (2006) acknowledges that such secondary victimisation is often greater. It stands outside of progress made regarding the needs of victims in the criminal justice system because they are excluded in discussions of what a victim needs. This is in spite of the many similarities between the two. The findings of corporate crime victimisation have referred to a double victimisation – that is, from the offence and then from their treatment by the 'official response' (Shover *et al*, 1994: 94). Thus, in their study of the long-term consequences of

victimisation to the collapse of a loan company, Shover *et al* conclude that:

> victims with the most extensive contact with the official system for redress of injury often emerge from the experience more disillusioned and more disheartened than when they began (ibid.: 95).

Such official responses deemed ultimately unfair and unjust, amount to an official denial of their status as victims and families of victims of crime (ibid.). There is no such thing as a typical victim response (Williams, 1999). The criminal justice system can worsen experiences, passing victims from one organisation to another (Button *et al* cited in Croall, 2015) rather than being careful about the treatment of families and loved ones of victims.

Secondary victimisation can range from the life changing effects of deaths and injuries, the loss of jobs and economic security to the amounts of time spent attempting to remedy a variety of losses. It can be indirect, families of those who die clearly suffer immeasurably, businesses close and suffer from a loss of trust, "The accumulated effect can be considerable" (South 1998 cited in Croall, 2010).

Developments have been made that have taken a friendlier approach to victims; once victimhood is established, a victim is a victim and is approached as equal to any other, able to access the services required as an active citizen who needs to solve their problems (Spalek, 2006). As Spalek (ibid.) states, there has been an increase in the visibility of the victims of safety crime, from large scale cases such as Zeebrugge and Bhopal. Cases in the US and the UK have shown how corporations can

cause physical and financial damage. Further, the growing accounts of the experiences of victims demonstrate that corporations "encourage, tolerate or engage in illegality" (Gobert and Punch, 2003: 8). Chapter three seeks to add to this research.

The criminal justice system has presented itself as neutral whilst at the same time, acting in many ways which hold the corporation as far superior to the needs of victims of safety crime, irrespective of the harm it continues to cause (Tombs and Whyte, 2015). Ballinger describes the important process and necessity of unearthing "knowledge from 'below'…to reconstruct new configurations of 'truth' which allow hitherto silenced groups to speak for themselves" (2016: 2). A large part of this has been carried out by groups created by survivors and secondary victims. The following section will examine safety crime and social movements.

How do some secondary victims respond to their experiences?

Secondary victims have mobilised collectively to redress this imbalance and victim movements have successfully altered the political agenda in the past. Social movements are important in the project of feminism, which inevitably, is a "political practice" (Faith cited in Ballinger: 2016: 3). Feminists have encouraged social movements as part of a political project to listen to the voices of victims who have been neglected in the past. In doing so it is inclusive and provides a platform so that "voices of the powerless…can be heard" (Ballinger, 2016: 12). Movements have influenced policies and politics whereby politicians fight for their vote, leading to increased rhetoric (Sanders and Young, 2000).

At a time when recorded crime grew exponentially between 1950 and the 1990s, feminism revealed the abuse inflicted upon women and children and victim surveys revealed the reality of victims of rape, sexual assault and domestic violence (Davies *et al*, 1995). Women's groups "began to question the low social status of women and to demand changes in opportunities available to, and discrimination suffered" (Smart, 2013: 26). Whilst the aims of the challenge are unfinished, feminists have been and are still successful in challenging the dominant discourse which has directly helped victims. By identifying and documenting the experiences of women, feminists have altered the experiences of women. Standpoint feminism challenged "dominant knowledge" and created "new knowledge in its place" (Smart cited in Ballinger, 2003: 221). It developed "overtly partisan standpoint positions in order to present critiques of, and engage with, patriarchal power structures" (Tombs and Whyte, 2003: 270).

In the mid-1970s, the US saw the creation of victim assistance and rape crisis projects, which attempted to alter previous secondary victimisation (Roberts and Corcoran, 2001). The first refuge for victims of domestic violence was established in 1972 by Erin Pizzey followed by rape crisis centres (Davies *et al*, 1995). By 1988, 40 rape crisis centres existed (Zedner, 2002). In the 1970s and 1980s, "The judicial treatment of rape [underwent] some changes…mainly in response to the campaigning of groups such as the Rights of Women, the Women's Aid Federation, Women Against Rape and Rape Crisis groups" (Lees, 1996: xiv). The 1988 Criminal Justice Act ensured the anonymity of rape victims, in response to the campaigning of women's groups (Davies *et al*, 1995). However, whilst projects such as Victim Support, a community based service that relied upon volunteers garnered support throughout the Conservative government as an example of 'active citizenship' with self-help (Mawby and Walklate, 1994), other

victim movements, such as Rape Crisis continued to be starved of funding (Williams, 1999).

Nevertheless, governments are now in a position where there is an expectation they should consult with victim groups that exist before enacting legislation (Williams, 1999). Whilst the focus may be on groups that align with the interests of 'ideal' victims who support the political agenda, other visible groups are nonetheless part of demands for social justice and a potential for change (ibid.). A number of victims of safety crime have joined or created such groups as a response to their experiences of victimisation. This will be described in the next section and in chapter four.

> Neither victims nor suspects/defendants have any significant leverage on the agencies and officials about what should happen, when, and to whom…[the criminal justice system] will continue to represent a site of struggle and conflict (Sanders and Young, 2000: 757).

Many victims realise they are not as central to the process as they had imagined they would be. Walklate (1989) reiterated Christie's (1977) observation that the law has taken matters away from the individuals and further, has stopped those affected by crimes from responding in constructive and potentially imaginative ways. Secondary victims and in the case of those family members referenced in this research, have no role in proceedings unless they are called as witnesses, which is highly unlikely (Rock, 1998). The effects of safety crime are largely felt by individuals who are isolated, "their effects are very localised" (Tombs and Whyte, 2015: 35). In response, victims and the families of victims have responded in ways that are unspecified or required by official agencies, they have mobilised collectively.

Disaffected and disenfranchised from the criminal justice process, some families of victims, join or create groups to demonstrate their struggle and try to find ways to make their experiences more intelligible to others uninvolved (Rock, 1998). Pressure groups emerge when social groups feel under represented by the mainstream (Goodey, 2005). Diani (1992) explained there are four characteristics of what a social movement is, relevant to this research.

Firstly, they consist of networks of informal interaction, secondly, they have shared beliefs and solidarity, thirdly, they take collective action on conflictual issues and finally, they take action that is "outside of the institutional sphere and the routine procedures of social life" (ibid: 7). Ultimately, social movements arise when, "members of excluded groups mobilise (or threaten to) to seek recognition and influence" (Williams, 1999: 129). This has become easier now that "Mail, the telephone, cars, airplanes, and now email and the Internet can sustain these ties" (Wellman and Haythornthwaite, 2008: 32).

As victims come together, a bond is forged through their shared experiences as they collectively object to the way they have been treated by official agencies (Williams, 1999). In response, they seek to make their struggles known, "Visibility is a central resource for social movements and a central component for the successful construction of a social problem" (Jenness cited in Williams, 1999: 130). Victim movements are a threat to the political agenda as victims connect to each other and point to "broader social systems of inequality" (Spalek, 2006: 132). Victim movements have taken on causes that are defined as criminal but have not been enforced or treated as such. With little support in government-led policy, they are supported by other groups and aim to challenge official pictures in favour of fundamental change (Elias, 1993).

In the case of safety crime that this research is concerned with, the inequalities continue and victims have to face the government and other powerful forces that have an interest in maintaining the status quo. Corporations can influence the government, repeal laws and oppose proposals for new laws (Box cited in Croall, 1992). This can be seen in the way the Corporate Manslaughter Bill was weakened by the corporate lobbying of businesses (Whyte, 2007). Wells states that such groups can "force the state's agenda, threaten legitimacy, and arouse and channel dissent" (2001: 3). It remains the job of the victims to raise the visibility of victims of safety crime and Whyte (2007) points to various groups as a key factor in forcing safety crime onto the political agenda in the 1990s.

In the political context in the 1990s that continued to promise a new law to deal with a number of high profile disasters, David Bergman published a number of texts that were part of a movement for corporate accountability (Bergman, 1991, 1994, 2000). In conjunction with the London Hazards Centre, Inquest and The Workers' Educational Association, Bergman published *Deaths at work: Accidents of Corporate crime.* The booklet focused on immediate and violent deaths at work: "to propose changes in police and HSE policy, criminal and health and safety law, and the operation of coroners court" (Bergman, 1991: 6). It was part of a movement that demanded change, which led Bergman to create the Centre for Corporate Accountability (CCA), detailed in chapter four.

The debate social movements such as the CCA were involved in, were a time when there "was a genuine possibility to pierce…the de facto veil" (Tombs and Whyte, 2015: 175). Groups which were created, such as Families Against Corporate Killing (FACK), which call for justice for victims of corporate and safety crime, stay "outside the ideological terrain of the state and at the same time" engage "on the terrain of the policy

world or within the current political system" (ibid.: 179). Such groups:

> provide us with often incontrovertible evidence that idealism does not necessarily constrain the effectiveness or political impact of counter-hegemonic struggle (Coleman *et al*, 2009: 17).

The corporate accountability movement was instrumental in the creation of the Corporate Manslaughter and Corporate Homicide Act (2007). The various groups which made up this movement represented the victims, lobbying regularly, for example, calling for sentencing guidelines to remain the same as those detailed in the 2007 draft (Tombs, 2013). They were one set of voices against the pull of the corporations who also consulted with the government and ultimately affected the scope and potential effectiveness of the act. They stood "firmly and unapologetically in opposition to the state's criminal justice agenda" (Tombs and Whyte, 2015: 179).

Whyte highlights "This issue can't be silenced when the victims exist" (2007: 200). Academic literature has not explored the way these groups operate, including their common aims, methods of resistance and levels of success. The work in chapter four seeks to fill, in part at least, this gap.

Conclusion

This research is concerned with a sub-section of crimes of the powerful. It does not seek to be value neutral but to affect the dominant criminological discourse that primarily focuses on conventional crime. Any researcher, who chooses to engage

with or “expose” (Hillyard, 2003: 272) crimes of the powerful, must challenge the requirement of “value neutrality” because part of their work involves “developing “organic” relationships” with groups that oppose the state (ibid: 272). It takes inspiration from the manner in which standpoint feminism challenged “patriarchal power structures” in the 1970s (Tombs and Whyte, 2003: 270). It is part of a body of work that is not part of the reproduction of power in society, preferring instead to establish alternatives.

Developed from Sutherland’s unmasking of the white collar criminal in the first half of the twentieth century, it explores safety crime as a “counter-hegemonic concept” (Snider, 2003: 52). As a term it is contested as a breach of a legal norm, only defined as criminal by authorities if it is to avoid making value judgements (Tappan, 1977; Shaprio, 1983). Safety crime should be included within criminology if the space between crime and what is law is recognised. Laws are a construction of behaviour and a reflection of ideologies and interests at any one time (Wells, 2001; Zedner cited in Aas, 2008).

Researchers highlight the volume of harms that have been inflicted upon individuals as a result of “violations of law by employers… [or] as a result of work-related activities” (Tombs and Whyte, 2007: 00). Criminologists demonstrate that such crimes are widespread and harmful, yet this is not reflected in the criminal justice process where the criminalisation of corporations is avoided.

This chapter provided details taken from existing literature of how criminalisation of corporations is rejected, both in public perception and in the nature of safety crime. For example, there is a large distance put between the victim and the perpetrator

and corporate killing is easily defined as accidental. This is supported by the state who respond to corporate criminality with weak laws and emasculated regulation.

Safety crimes remain relatively invisible. A body of work suggests how this is enabled by the criminal justice system, where such crimes are recorded as something other than what they are, for example, at the inquest, many deaths are inaccurately recorded as 'accidental' (Slapper, 1999). Corporations are able to avoid the label of being criminal, through the eyes of the law and the general public where deaths at work are almost automatically perceived as an accident (Wells, 2001). Such offenders enjoy a "structural advantage which enables them to avoid prosecution, conviction or severe sentences (Croall, 1992: 125). The process of how this is achieved at a micro level has not been explored. The wide-reaching consequences of this have been touched upon in academic literature but have yet to be detailed on a case by case basis. Both will be detailed in chapter three.

Corporations avoid being labelled criminal through the actions of the state who have created laws that rarely prosecute and seem "designed not to work" (Punch, 2009: 66). The corporation has developed and mutated into a form where responsibility is dispersed, which is magnified with the increasing use of sub-contracts. In contrast, legal responses have not adapted and continue to offer woeful sanctions. The common law of corporate manslaughter only rarely overcomes the barrier of establishing the *mens rea* of a corporation. High profile cases such as the Herald of Free Enterprise led to a number of individuals publicly criticising the inadequacy and impossibility of the law. The creation of the Corporate Manslaughter and Corporate Homicide Act (2007) attempted to make it easier to prosecute larger companies (Tombs, 2013). This law does not appear to be too dissimilar from the common

law in its ability to punish corporations. It still remains untested on large corporations. Concerns have been expressed that it has been used to minimise levels of liability (Tombs, 2013). Doyle and McGrath note that Gobert writing in 2008:

> intimated that the symbolic significance of the 2007 Act may 'ultimately transcend its methodological deficiencies' and that the primary value of the Act may very well lie in the very fact of its existence (2016: 164).

It should be clear that regulation is a lesser punishment for corporations who commit crime, yet it remains the job of regulation to punish the corporation, which in the UK requires the involvement of the HSE. The development of regulation is rooted firmly in consultation, bargaining and acceptable laws (Carson, 1979). Governments have almost continually reduced the power of the HSE through regular cuts to funding and unremitting reviews into its effectiveness and usefulness (Tombs, 2000). The *only* consistent political response to HSE and the crimes that it answers to is to de-regulate. The HSE are now incapable of preventing major incidents and are forced to seek compliance rather than demand it (Gobert and Punch, 2003). This has serious consequences for the numbers of victims of safety crime that are created.

The HSE have limited resources to tackle the threat of safety crimes and in their ability to secure justice through health and safety prosecutions. This has consequences for the families of victims who turn to regulation to deliver justice after common law has failed. The ways regulation has been shaped historically and the manner in which the HSE has been affected by government ideology which continually seeks to de-regulate, is well established. The experiences of the families who have been in contact with the HSE, the effects on them and their thoughts

on what constitutes justice have yet to be detailed in academic literature. This will be explored in chapter three.

The desire of criminal justice agencies to treat safety crime as an accident impacts upon victims and the families of victims. They are denied legitimate victim status as the context of their victimisation does not fit with the ideal victim (Whyte, 2007; Christie, 1986). Whilst the ideal victim is utilised by governments in their desire for crime control (Garland, 2001), the safety crime victim is pushed to become invisible. This leads to psychological, emotional, physical and financial harm (Spalek, 2006). Denied by official processes, the state becomes a perpetrator, causing secondary victimisation, leaving the victims to bear the social costs (Shapland, 1984; Tombs and Whyte, 2015). The short and long-term effect on families of safety crime has not been explored.

This research focuses on the more mundane nature of safety crime victimisation rather than the atypical criminal incidents that have been featured in previous research (Shover *et al*, 1994). In comparison to media interest when members of the public are killed, these victims have not attracted much publicity (Hutter and Lloyd cited in Croall, 1992). This will be achieved through an examination of how victims and secondary victims are treated by the law and the key institutions of the criminal justice system (the police, HSE, CPS and Coronial system). Their experiences of the social, legal and political obstacles they faced will be detailed in chapter three and four.

Victims who are disillusioned and harmed by their experiences of the criminal justice process have attempted to change the process for future victims. Many victims and families of victims join with others and mobilise to form group who seek to be

recognised and enact change (Williams, 1999). For victims of safety crime, such groups became active in the 1990s and influenced the introduction of the Corporate Manslaughter and Corporate Homicide Act (2007). This research continues to build on the existence of the victim as evidence that the issue of safety crime cannot be silenced (Whyte, 2007). To the best of my knowledge, their impact in the "counter-hegemonic struggle" has never been explored (Coleman *et al*, 2009: 17). This will be detailed in chapter four. The following chapter, chapter two, will explore how the research was undertaken and the reasons for the choice of methods.

Chapter Two

Methodology

Introduction

This chapter starts by discussing the issues that are raised by researchers who choose to study crimes of the powerful making a case for the importance of breaking with traditional criminology in order to challenge unequal power relations. Associated problems of funding and publishing are explored before the subject matter will narrow to examine concerns in researching safety crime.

There are limited opportunities to research corporations. Pre-existing research which has navigated around such limits are outlined. To that end, two main studies are explored in further detail (Spalek, 2007, 1999; Matthews *et al*, 2011). The aims of the research are identified, highlighting one fundamental difference between this research and those findings that already exist; that this is a study of those victims whose experiences are rarely publicised.

Rationales for methodological decisions are evaluated in terms of validity and reliability. The unique nature of the research matter requires an additional section on details of the issues faced when researching victims of safety crime and facing sensitive subjects. This chapter ends with consideration of contemporary issues that may negatively affect future research into safety crime.

Researching the crimes of the powerful

It is fitting with the conclusions made in Chapter One that researching the powerful receives only "token recognition" in criminology (Pearce, 2003: 4). A decision to research the powerful is "A commitment *not* to take the claims of the powerful at face value…to subject them to scrutiny" (ibid: xi, emphasis in original). If "the aim of social research should be to change society for the better" (Henn *et al* cited in Harding 2013: 11) research has a responsibility to challenge powerful groups rather than reproduce unequal power relations. The exclusion of research into the issue has meant so-called radical political agendas have been side-lined (Tombs and Whyte, 2003). Critical approaches then have a duty to look at the alternatives (Tombs and Whyte, 2007).

When attempting to look at the alternatives and to research the powerful as opposed to the powerless, there are unique problems experienced by researchers. Research that focuses on crimes of the powerful is a relatively small area so there is little for researchers to base their own research and choice of methods on (Pearce, 2003). The decision to study crimes committed by those who have control and power over others automatically entail a number of specific difficulties. These principally include context and especially who, or what is being studied (Snider, 2003).

Granting access to carry out research can be problematic for researchers wishing to study the powerful. In order to challenge dominant discourses, the knowledge utilised by institutions and experts must first be scrutinised, which is a difficult task (Scraton and Chadwick, 1991). When "criminology casts its gaze downwards" (Tombs and Whyte, 2007) it focuses on those who are in a position of powerlessness and part of a 'captive audience'. Groups such as prisoners may participate in research in order to be

viewed favourably by those in charge, have the time and can be easily located. In contrast, those in power are not primed to be researched, rather the opposite, they have something to lose and are suspicious and defensive with the added ability to block the efforts of researchers. As Tombs and Whyte write:

> it might be argued that *one of the key features and effects of power is the ability to operate beyond public scrutiny and thus accountability* (Tombs and Whyte, 2003: 4, emphasis in original).

The courtesy that researchers are encouraged to have towards individuals they investigate has been extended to organisations. Indeed, the study of corporations has its own guidelines, adapted from those that are designed to protect the wellbeing of individuals. For example, the British Society of Criminology encourages researchers to be 'sympathetic' (Sim, 2003: 244). There is little guidance on how to respond to a corporation when it is the focus of wrongdoing and deserves little compassion (ibid.).

An alternative method of researching power is to focus on those whom it affects. The wielding of power impacts upon some groups more than others and academic research can be one method marginalised groups use to respond to such threats (Tombs and Whyte, 2003). Researching the powerful by examining those that it harms is a simpler process in terms of practicality and still has much potential for revealing and challenging the changing nature of hegemony (ibid.).

It is true that in essence, no one can tell a researcher what to research and what to leave alone (Punch, 1998). However, this ignores the factors that inform research decisions, for example, the implications on future careers, issues of funding and who will use

the research. This is pertinent when funding for studying the crimes of the powerful is scarce (Snider, 2003).

As mentioned previously, criminologists have tended to focus on a certain type of crime that chimes with common-sense notions, although it is difficult to disentangle who is influencing whom. Historically, areas of law breaking have been ignored by criminologists, who have in turn colluded with the state (Carson, 1974). Tombs and Whyte illustrated how in journal articles between 1991 to 2000, just 3% were focused on corporate crime. This relationship is unlikely to change in the future as university based research is increasingly sponsored by private businesses and leads to consultancy. Neither of these sits comfortably with research aims of crimes of the powerful and notably, safety crime (Slapper and Tombs, 1999). Researchers interested in safety crime are forced to turn to trade unions and campaign groups to engage with, and work towards "a more just and humane social order" (Tombs and Whyte, 2002: 232).

Punch (1996) indicates that as a lecturer in a business school he was only able to "smuggle" some topics into more acceptable courses on Public Policy And Business Ethics and the Management of Crisis. He emphasises that only as an 'independent scholar' did he pursue his self-interest of corporate crime, police corruption and organisational deviance. The increasing cost of university, the need to repay debt and earn money quickly will lessen the opportunities for subjects such as safety crime to be researched (Tombs and Whyte, 2005).

Even when the difficulties of researching the powerful have been overcome and research has been carried out, there remains a further difficulty experienced by those attempting to research crimes of the powerful. Those who seek to publish their research have to do so within a structure that is unfavourable to highlighting the crimes of corporations. The consequences of this are that the research may never be published or that which is

published, may be altered. This was even the experience of Edwin Sutherland in 1949.

Sutherland experienced difficulties both from a publisher, when he was a sociology editor, and from the university that employed him. After producing a manuscript on white collar crime, his publisher, Dryden Press, insisted Sutherland remove the names of corporations he had described as criminal because they had not been convicted and they feared being held liable for damages (Tombs and Whyte, 2003). Indiana University similarly encouraged the removal of the names of the corporations. Sutherland believed this was due to fears the university had of harming business connections (Sutherland, 1983). He agreed to the removal of the names in the initial copy in 1949, the names were reinstated 30 years after his death in the 1983 edition. Similarly, Braithwaite also had to respond to possible libel following his research into pharmaceutical companies in 1985 (Tombs and Whyte, 2003). The way such research is censored and doctored prior to publication is testimony to the nature of power.

As with any other research that has advantages and disadvantages, the difficulties outlined above could be viewed as simply part of the consideration when choosing to research crimes of the powerful. Such unique disadvantages could inform a researcher's decision to instead focus on another topic. Choosing to avoid rather than negate those difficulties in favour of more acceptable or easier research is an acknowledgement of the pre-existing power structures. The choice to study power structures and the inequality that results has been approached previously by theorists within the sociological tradition.

Feminists have taken up similar challenges in the past and revealed inequality that otherwise may have lain dormant

(Walklate, 2007). Such researchers recognised that what is held as common knowledge exists within, and maintains, power structures. It is crucial that this common knowledge is interrogated (Harding, 1991). It is arguably important to challenge those who perpetuate safety crime and question the structures that facilitate it in order to scrutinise the powerful and present alternatives to the dominant discourse.

Researching corporate crime

Once the decision has been made to carry out research that attempts to challenge dominant discourses including safety crime, it is necessary to explore and discuss how this can be done. There are challenges, but rather than simply choosing another subject, the challenges can be overcome with a research plan or methodology (Almond, 2008). Methods for researching safety crime are underdeveloped worldwide and so, many of the problems connected to it remain unresolved (Tombs and Whyte, 2003).

Tombs and Whyte (2007) highlight two main difficulties researchers of safety crime have experienced. Firstly, there is a lack of statistics available on the scope and nature of safety crime. Secondly, the creation of a large quantitative data base is expensive to collate and relies upon extensive funding. It is entirely predictable that corporations will resist research that seeks to uncover wrongdoing, complicating access (Noaks and Wincup, 2004). A way that researchers have navigated such difficulties has been the tendency to study corporations through case studies of well-known, publicised safety crimes or those involving large financial loss or with many victims (Tombs and Whyte, 2007).

According to Tombs and Whyte case studies can provide comprehension of a wide range of safety crimes, which when combined demonstrate the large scope of offending whilst producing a number of themes from which "tentative generalisations can be generated" (2007: 8). Although historically utilised by those researching safety crime, case studies do rely upon some secondary sources, which "raises issues of reliability" (ibid: 9). Those sources, in this research, largely originate from those involved in the groups studied, such as Families Against Corporate Killing. This does not make the data impartial or neutral. However, without observing such groups, which would still be considered subjective, there are few alternative ways of finding out about organisations. The continued study of safety crime owes much to the body of work that highlights the scale of corporate offending and utilises case studies, specific examples will follow.

Punch's work includes a number of case studies. He asserts:

> Individual cases need to be placed in a situational context that does justice to the range of interrelated variables involved. This means we have to a certain extent to rely on detailed studies (Punch, 2000: 253).

He explores a number of high profile cases in his 1996 book, including the contraceptive Dalkon Shield, Barings Bank and Ford Pinto (Punch, 1996). Punch uses case studies for interpretation from themes he identifies but also places them "in a context that raises the industrial and social setting" in order to "provoke discussion and stimulate thought" (1996: 84). The themes are reinterpreted in successive chapters, which make it an organic/ongoing discussion, ultimately permitting conclusions which cut across macro and micro explanations.

Bittle and Snider (2006) also utilise the case study to examine the collapse of the Westray mine in Nova Scotia, linking this case to the development of law and regulation. Slapper examines 40 cases of deaths at work between 1992 and 1994, which he follows up with fieldwork that involved attending 18 inquests. Interviews took place with personnel involved in the process that enabled him to make judgements on whether the case should have progressed as a manslaughter offence (Slapper, 1999). Spalek (1999, 2006, 2007) and Matthews *et al* (2011) utilise qualitative interviews, which will be discussed in further detail later in this chapter.

Researching safety crime

Safety crime research has focused upon its existence and prevalence. Recent safety crime research has used official data in combination with case studies. For example, Tombs and Whyte (2007) look at the following case studies; cases in UK construction, the gas leak at Union Carbide in Bhopal, India, the capsizing of the Herald of Free Enterprise, the Piper Alpha explosion, the death of Simon Jones, a gas explosion in Larkhall, Scotland and the case of the cockle pickers at Morecambe Bay. From here, they identified common themes and highlight key issues (which include, sub-contract, power, regulatory processes, aggressive management and the welfare state). Tombs and Whyte (2007) use press reports, related academic publications and statistics that are available as a matter of public record. They note:

> the sources we draw in constructing our cases, and indeed which we use more generally…are not primarily criminological, indeed criminological sources are often in little evidence here. Studying safety crime means moving well beyond criminology, drawing upon literature in business, management and organisational studies, economics, history, political economy, politics and sociology (ibid.: 8).

Leading directly out of this research, came the decision to explore the experiences of the victims of safety crime.

Researching victims of safety crime

Governments have found it increasingly impossible to ignore the voices of victims, which Rock (1998) states has led to changes for subsequent users of the criminal justice system. As discussed in Chapter One, the likelihood of governments recognising victims depends upon whether their existence supports the intentions of the state. What the state chooses to represent should not lead decisions made by critical victimology, which should instead, question what is real (Walklate, 2007).

Positivist victimology has limited its scope to 'conventional crime', examining the incident rather than the process and by focusing on "street crime" to the detriment of studying crime that happens "behind closed doors" (Mawby and Walklate, 2002: 9). In the search for victim characteristics and victimizing events and desire to maintain "objectivity and value freedom" the work of feminists "has largely been marginalized by victimology" (ibid: 10). Held in high regard by policy makers, according to Mawby and Walklate (2002) positivist victimology has developed the study of victimology in the following ways. Firstly, the term victim is rarely debated but determined by suffering and/or legal response. Secondly, being a victim is static and not understood as possibly refuted, survived or resisted. Thirdly and finally, sudden and unpredictable social change is not discussed. This makes positivist victimology relatively easy to research as the victim is obvious, state defined and it is only the act precipitating the victimising event that needs to be scrutinised.

Radical victimology rejects positivist approaches, turning instead to structural factors, questioning the role of the state in the construction of the victim. Left Realists utilised the crime survey to illuminate who is victim, largely redundant for researchers of economic crime as much victimisation is "indirect and diffuse" (Croall, 2010). Less straightforward to research, radical victimology has been criticised as lacking a body of significant empirical data and therefore not moving away from positivism, failing to create a logical research agenda (Walklate, 2007). In opposition to positivist victimology and attempting to overcome the criticisms of radical victimology, critical research attempts to understand and change practice. Thus it is connected with the aims of this research (Walklate 1989, Mayall *et al* 1999).

Critical victimology is committed to researching hidden processes, which "problematizes both the law and the role of the state" and calls for "imaginative, comparative and longitudinal studies" (Mawby and Walklate, 2002:20). It goes into "more depth than…positivist or radical victimologies" and examines "the interconnected links between social class, gender, race and crime (Davies *et al* cited in Croall, 2010: 10). As a discipline, it examines the development of victims' movements and why they may or may not have succeeded (ibid.).

This research utilises both critical victimology and research on corporate and safety crime, two areas that have rarely been studied together in the wide scope of criminology (Tombs and Whyte, 2003). In 1999, Spalek interviewed 25 individuals who were "adversely affected" by the Maxwell scandal. Again, in 2007, Spalek interviewed 16 customers of Farepak to explore the impact of the collapse to challenge the regulatory principle that customers can avoid their own victimisation. This research on corporate and safety crimes continues in the same nature as Spalek's as one crucial source of data is the experiences of the victims. More

specifically, the focus is on the bereaved following a "work-related death or where members of the public have died where the circumstances raise questions about the working practises of an organisation" (CCA, 2007).

Matthews *et al* studied the "impact of traumatic work-related death (TWD) on victims' families" in Australia (2011: 5). In order to examine the financial, social, and health consequences, they also used in-depth semi-structured interviews using an interview schedule but with no set questions.

The question initially posed was based upon existing literature that had provoked initial interest: *why is safety crime not recognised as a crime? Why are victims denied justice?* During the research process, this question developed, but these aims remained, whilst endeavouring to make the research interesting, relevant, feasible, ethical, concise and possible to answer (Harding, 2013).

The nature of corporations in a social, legal and political context is examined through the experiences of victims, or specifically the families of victims of safety crime who have died. By being principally focused on the victim, this research examines the effects of the theories and policies on the people who become intertwined in this process (Williams, 1999). It highlights that victims of safety crime do exist, that their experiences are real:

> Balancing the lived experiences of people and the immediacy of daily interaction with the often less-visible structural arrangements – the political, economic and ideological management of social worlds (Scraton and Chadwick, 1985: 165).

It is a study of the underdog to highlight the suffering of individuals affected by a powerful offender (Gouldner, 1973). This is an academic concern for victims of safety crime and in doing so, is inherently a relationship with the activists whom it focuses on; the two are difficult to separate (Fattah, 1986).

Contrary to the majority of the cases identified in safety crime research (see Punch, 1996; Slapper and Tombs, 1999; Tombs and Whyte, 2007; Spalek 1999; 2007), the focus of this research is on the individuals and the families of victims of safety crime. It focuses on those individuals who are part of the "mundane and routine" safety crimes, those who are barely visible (Tombs and Whyte, 2007: 10). This is in similar ways to those researched in the work of Slapper (1999) and Matthews *et al* (2011). It aims to provide further evidence of the consequences of the crimes committed by corporations on the individuals who live on after their loved one has died (Tombs and Whyte, 2003). This relies upon data which is sufficiently in-depth to uncover and convey the emotions of the families. The documenting of these emotions are important for the last two aims of the research, as it was partly the upset and anger that was to fuel the creation and membership of support and campaigning groups. As mentioned previously, the main method used to research these groups will be case studies.

The decision to research the experience of the families of the victims of safety crime is a way to negotiate the problems of observing corporate criminality whilst acknowledging but navigating debates over their legitimacy. This research originated out of a desire to seek answers to seemingly indefensible contradictions evident within policy making and practise and therefore requires a specific framework.

Ontology, epistemology, politics and a critical framework

This research has already set out its aims as being a critical inquiry that questions commonly held beliefs and assumptions as a challenge to dominant assumptions (Gray, 2013). The facts that this research seeks to uncover are connected to "the ideology and the self-interest of dominant groups" (ibid.: 27). It is critical epistemology in that the results are made whilst keeping in mind "underlying structures and mechanisms" (Blaikie, 2004).

As discussed earlier, there are similarities between this research and feminist epistemology that seeks to access "deeper reality" the families have "through their deep experiences (of oppression) and through their feelings and emotions" (Gray, 2013: 27). As in the case of feminism, Cain's epistemological strategy is pertinent here to deconstruct the official discourse and to uncover the truth from an alternative standpoint (cited in Ballinger, 2011). First, the dominant discourse of the state is deconstructed. Secondly, the new truth is developed from the perspective of minority groups, which Ballinger argues is better suited to non-traditional research as it does not strive to be independent. Finally, conceptualising takes place in the gap between the "official discourse and the newly generated subjugated knowledge" (Cain cited in Ballinger: 2011: 12). In tackling power, standpoint feminism detects similar experiences that those researched share (Comack cited in ibid.). The purpose of this is to "create social and legal changes that eradicate structural power inequalities between men and women" (Cain cited in ibid.: 13).

As Punch noted, everything is political (Punch, 1998). Indeed, it is difficult to avoid being political as the very nature of critical research questions social relations and power (Harvey, 1990). This research takes a critical approach from an epistemological

perspective where knowledge and critique are linked (ibid.). Adopting an openly partisan position is likely to be at its most effective when developed as part of a social movement:

> Research that has a high degree of organic quality – research that retains a connection to real movements and struggles – is likely to be more effective in challenging power, and in producing an accurate alternative world view (Tombs and Whyte, 2002: 231).

The challenging of dominant discourses is best achieved through working with others. As Sim notes:

> Gramsci attempted to develop a social theory and political strategy that was alliance-led, where personal and political links were forged between progressive social movements and cultural forces so that the 'common sense' that governed the perception and understanding of social issues was replaced with an alternative, hegemonic 'good sense' (Sim, 2003: 255).

It is important that research that seeks to challenge dominant discourses, rather than being overly concerned and therefore paralysed, by the right way to discover knowledge. As Harding notes:

> Worse of all, the sciences' commitment to social neutrality disarmed the scientifically productive potential of politically engaged research on behalf of oppressed groups and, more generally, the culturally important projects of all but the dominant Western, bourgeois, white-supremacist, androcentric, heteronormative culture (Harding, 2004: 5).

Rather than being disarmed, critical social research is:

> close and detailed because it aims to show how oppressive social structures are legitimated and reproduced in specific practices (Harvey, 1990: 210).

Contextually, it aims to examine how what is going on at the abstract level affects the families and the victims (ibid.). The location and existence of power flexed in the institutions shows itself in the results below and the way the families are affected (Mills cited in ibid.: 57).

In keeping with the critical tradition, it aims to contribute to existing theory and to try to explain the experience of the families of victims of safety crime that are absent (Blaikie, 2004). It seeks to ask, "whose interests are served by [ideological forms]?" (Harvey, 1990: 210). The results of the research should add to illuminating the ways a corporation escapes examination and the consequences of such social harm (Tombs and Whyte, 2003).

This research is located within the framework of critical criminology because it tries to inform what is seen as real (Harvey, 1990). It challenges 'truths' whilst acknowledging the context within which safety crime occurs and the boundaries it operates within (Scraton and Chadwick, 1991). This research sets out to illuminate the:

> structural contradictions that are inherent within the social arrangements and relations of the new dawn of economic expansionism (ibid: 169).

This involves an interrogation of the data, in this case, data recovered from the accounts of secondary victims, whilst also locating what happened to the families in terms of their social and

political contexts (Harvey, 1990). The methods and methodology chosen in order to do this will be discussed in the following subsection.

Methodology and choice of methods

The relationship between methodology and method has been challenged by feminism in its questioning of victimology. It has asked how we can claim to know about the world but also who is permitted to have knowledge and what that knowledge looks like (Walklate, 2007: 320).

This research is concerned with the nature of the victimization – the process – and the individual experience (Walklate, 1989). This requires an approach that is able to find deeper and complex meaning in the accounts of victims. In this research, the victims have been killed and because they were at work and not in a disaster, there are no survivors to interview. Therefore the focus is on those who were affected, the families of the victim, those who had lost their 'loved one'. As secondary victims, they are the main participants and the focus of this research.

In asking people who are bereaved and have experienced additional trauma to share their experiences, my position as a researcher is almost one of inferiority and a reciprocal relationship at least. It would be highly inappropriate to present myself as a detached observer, ignorant of emotions expressed and unconcerned about their experiences. This research requires an emotional connection, remaining distant and objective is unethical. It is argued by feminists that doing so would adversely affect how successful the research is, the interviews must:

> …have all the warmth and personality exchange of a conversation with the clarity and guidelines of scientific searching (Goode and Hatt cited in Oakley, 1981: 33).

In this way, the researcher is not neutral and does not attempt to keep a distance, perhaps ignoring the "paradigm" of interview values "objectivity, detachment, hierarchy and 'science'" (ibid.: 38). As an interviewer, a researcher, I am borrowing and taking the time of family members and requesting they recall painful memories for essentially academic research, the results of which the majority will never see. Since the desire for this research comes directly from the experiences of those interviewed and in response to their suspected poor treatment, which I am gravely concerned about, it is unrealistic and misplaced for me to claim neutrality was highly important or something I attempted to maintain. This was replaced with the need to listen, understand, draw out, and to voice their experiences. Being impartial and detached was never an aim nor a requirement I placed on my behaviour. I did not attempt to be 'professional' nor assume the role of a friend. It was my intention to listen and assume enough confidence so that the family members would not try to censor difficult memories. The fact I was not impartial and therefore genuinely interested was conveyed. Nothing, beyond the sterile nature of the interview, was false.

Qualitative research methods were utilised throughout this research as it is concerned with individual experiences – thoughts, feelings and consequences – which would be difficult to capture and give depth to without an open line of communication. This is appropriate to many critical criminological research methods, and has its advantages as well as its difficulties that require careful consideration.

Qualitative research methods are suitable to this research as it seeks to understand the experiences of people in their everyday lives and being empathetic to the interviewees (Gray, 2013; Blaikie 2004). Information was required about historic events and by a process of elimination, qualitative research methods are the only way to do this. The interview needed to allow for a discovery of meanings (Noaks and Wincup, 2004). The study of such human behaviour, thoughts and feelings in context and looking at how people behave, think and feel is best understood if, as a researcher, I am at least partially aware of the participant's world (Gillham, 2000).

An interpretive approach was unavoidable to show the complexity involved in the interviews (Hollway and Jefferson, 2000). It was important to uncover the nature of the social institutions and social structures that delivered pain to the participants and also the meaning they attached to this (Blaikie, 2004). Whilst comment may be made on the wider meaning, the power to describe harm experienced should be handed to the families. In examining structure and power, such qualitative research may harm dominant interests but this is 'inevitable' (Baez cited in Davies, 2008: 178). There are a set of processes that the research aimed to illuminate and for that reason, observation would be an inadequate method. Social constructions cannot be observed directly where behaviour is normalised (Blaikie, 2004).

The decision to use qualitative research methods was informed by a need to give voice to the emotion and consequences of victimisation. It suited previous personal experience due to my occupation which at that time involved encouraging people to be honest and open about their past painful experiences, and share their anxieties about the future. Interviewing matched my capabilities and skills (Blaikie, 2004). General research questions were as follows:

1. What social, legal and political obstacles does safety crime face that prevent it from becoming defined and treated as a crime?
2. How are the victims and families of victims of safety crime treated by law and key institutions of the criminal justice system including an examination of the police, inquest, Health and Safety Executive, Crown Prosecution Service?
3. What effect does this have on the families of victims?
4. Under what circumstances do families of victims seek to develop more general campaigns, with what aims, and with what degree of success?

Although these were the research questions, it was during the research process that meanings of such concepts were acquired and refined (Blumer cited in Blaikie, 2004).

In order to reach conclusions to the above research questions, the methods chosen included semi-structured interviews and case studies. These will be examined in turn whilst considering questions of validity and reliability.

Interviews

In order to speak to victims of safety and corporate crime, Spalek and King, Matthews *et al* and Spalek interviewed individuals, which were then recorded and transcribed (Spalek and King, 2007; Matthews *et al* 2011; Spalek, 1999). These were useful and suitable models for this research.

Initially, a pilot study was carried out in 2008 on six family members to test the aims of the research, the appropriateness of the interview schedule and to gauge the practicality of the methods, for example, the duration of the interviews. Ethical concerns were also tested, including whether the questions were not too distressing or intrusive. The aim of these interviews was to access the various experiences of victims of safety crimes. The

piloting process led to a number of alterations. Firstly, adjustments were made to the schedule, including a question that asked the families 'what would have constituted justice for them?' This was in response to the detailed knowledge they had gained from their own experiences. Secondly, I purchased a modern dictaphone after the one used in the first ever interview failed after thirty minutes. Thirdly, it was clear the interviews were going to take more time than anticipated, which increased the time required to carry out and transcribe each interview. Finally, the pilot interviews also changed the original aims and led to the addition of considerations about support and campaign groups. This was as a result of many family members who referred to such groups when asked how they responded to their experiences. The aims expanded to uncover information about the formation, aims and relative successes of various groups mobilized following a safety crime.

To build on the pilot, five further interviews with family members were carried out in 2010, four of which were chosen because of their active involvement with social movements. In addition to the eleven bereaved family members who were interviewed face to face, four individuals were interviewed remotely in 2015. These were chosen to boost the information about campaign groups. The first person was a key solicitor who played a prominent part in cases of corporate manslaughter and directly helped one family member featured in this research. The second and third interviewees were both involved in the Centre for Corporate Accountability (CCA) and were able to provide much needed depth. As mentioned previously, the CCA had been operational at the start of this research and I had not foreseen at that time neither the fact this research would involve social movements, nor that it would close. The final person was questioned because of their continued role in a key support group. Again, unknowingly, they were questioned towards the end of the existence of that group.

The first six who were interviewed face to face were initially identified through the CCA, who acted as an intermediary. When informed about the nature of the research, the centre agreed to identify a number of families who they considered would be suitable, i.e. able and willing to discuss their experiences. This was a practical issue but also overcame personal concerns I had about opening people up to the death of their loved one being considered a crime, which they may not have been aware of. The selection therefore was in no way random and does not claim to be representative. The seventh interview was chosen as a result of 'snowball' sampling.

Clearly such a small sample raises significant issues of generalizability and representativeness. Firstly, it should be emphasised that in one obvious sense, in fact, these families were not representative – they had in the first place been clients of the CCA (all cases were closed at the time of contact). They were selected by case workers at the CCA on the basis of their appreciation that they would be the least affected by a request to recount their experience. In this, these families may have been a sample who had come out of the process *least* victimised and most able to reflect upon it. These families had help in the form of an open and operational CCA, which they accessed. It has become very obvious that these victims were further ahead than many created at the time and certainly since. Secondly as the interviews unfolded, it became clear that even across these limited set of cases, common themes emerged between the interviews and perhaps most crucially, the stories and experiences elicited echoed the key themes referred to in the small amount of pre-existing research (Slapper, 1999; Tombs and Whyte, 2007; Matthews *et al*, 2011). This leads to doubt whether what has been accessed was one set of rather anomalous experiences.

As the pilot uncovered, the interviews took longer than expected, which then reduced the number of interviews I, as a self-funded, part-time student could carry out compared to my initial plan. On that note, as this research was self-funded, the time taken to plan, write, meet with supervisors, research and transcribe all came at a cost, both financially and in terms of time. During this research I reduced the hours I worked to provide much needed flexibility in the week, which also reduced the money available to pay the fees and fund travel. From the start to the finish of the thesis, my father and grandparents died, I got married, had two children, was promoted, bought a house to renovate and moved jobs entirely. Each time, this took hours and days and weeks away from the research. After having a family and in order to finish this research, I had to rely heavily on the goodwill of family members, notably my partner who spent many of his weekends off work with our children and without me. Asking for additional help, only felt really possible when the deadline became a matter of urgency and I felt I had no option.

Given such constraints I decided it was better to permit the interviews to be longer and in-depth, rather than increase the number of them. Two more interviewees were considered but it was decided they were unnecessary as a number of themes had emerged that were being repeated by each family member. Due to the period of time the research took, I felt it was important to ensure the deaths occurred at the time of the CCA and prior to the implementation and remit of the Corporate Manslaughter and Corporate Homicide Act (2007). Whilst I did not want the sample to be purely based in my local county (in fact, none of them were), the wide geographical nature of the interviews complicated the practicalities of repeating many more. Travelling long distances using my own finances was not simple. For example, on one occasion, whilst travelling to one interviewee, the gear box on the van gave up quite suddenly and it was only luck that the roundabout was close to an airport so my partner and I were able

to ‘coast’ straight into a car hire business. The van was later collected for scrap! This was neither a cheap nor relaxing experience at seven months pregnant, prior to an interview of bereaved parents.

The interviews lasted between two and four hours and ended naturally, usually when the participants decided they had finished. There were many occasions when vital information was given after the interview had formally ended, i.e. when the dictaphone had been switched off. In those instances, I quickly made notes. All of the interviews were recorded, with notes and transcribed in full afterwards. This was a long process as the shortest interview (with a family member) was 100 minutes and the longest was 213 minutes. The average interview length was 180 minutes.

There are several issues of validity and reliability associated with semi-structured interviews. Semi-structured interviews were used to elicit a wide range of information that focused on specific areas but sought to not limit the data to pre-defined boundaries. (See appendix 4.) Semi structured interviews were chosen as they are most suitable for research that seeks to be led by the interviewees, collecting detailed, rather than vast amounts of information. Hennink *et al* notes that interviews are suitable when covering sensitive issues as they allow an examination of the context, reveal emotions and find the meanings people attach to their experiences (cited in Harding, 2013: 62). As a goal to “see the world through someone else’s eyes” face to face interviews were preferable over non-contact interviews even if this lent itself to bias and personal effects for the interviewer (Hennink *et al* cited in ibid.: 62).

When undertaking research, Spalek (2006) states consideration should be paid to the biases present to avoid what we already have, which is a summary of the process of victimisation and not

how being a victim is actually experienced. Spalek (ibid.) encourages researchers to reflect on their own positions in order to be as subjective as possible to avoid the suppression or reproduction of dominant racial and cultural discourses. Open ended data gathering through the eliciting of biographies with a narrative approach should encourage the revealing of meaning to events and avoid variables that depend upon the skill of the interviewer. These include tiredness, poor concentration, poorly worded questions or unknowingly hitting on sensitivities (Hollway and Jefferson, 2000).

These considerations were taken into account for this research. In a similar way that 'elite' interviewing is conducted with someone in a position of authority, the same could be said of the interviewees in this project (Gillham, 2000). Whilst not in a position of authority, upon reflection it became increasingly evident that the family members were capable of giving answers with insight and had a unique grasp of the subject matter. This became clear as the interviews took place and for that reason, the interviews became less and less structured. This enabled the interviewee to have more control and to best convey their own perspective (Noaks and Wincup, 2004). For example, it was often the case that the interviews could begin with the question, "tell me about your experience, starting with the moment the police first contacted you." Prompts were still necessary for consistency and often the family members asked, "where was I?", but generally, as Gillham noted, the family members knew more about the topic and were able to structure their own knowledge and create the narrative (chronologically) as Spalek (2006) recommended. It was common for participants to divert onto other subjects, particularly to share memories of their loved ones, which I did not interrupt or cut short.

Building a rapport with family members for semi-structured interviews was crucial for the validity of the data. A rapport was developed through the CCA, a telephone conversation and then in person (Leavy and Hesse-Biber, 2011). For example, time was given to settling into the homes of the participants and general 'chit chat' rather than launching as quickly as possible into the interviews. As a female, then in my twenties, I tried to take a minimal role in the interview and simply listened making as few prompts as possible rather than having a two way conversation (Hennink *et al*, 2011). It was difficult not to agree or show (appropriate) exasperation at times, this was not purposively suppressed in the desire to be natural as opposed to being cold and contrived. Some attempt was made to connect naturally with the interviewee to minimise any inequality that might have been felt (Hollway and Jefferson, 2000). The family member being interviewed should not have to feel their account had to be sanitised to protect the researcher or become preoccupied with their welfare, over their own. It was not easy to manage emotions when the people involved were clearly upset (Dickson-Swift *et al*, 2009) but it was important to remain an attached observer rather than a participant. I felt strongly that the interview was their experience and little focus should be anywhere else.

Other considerations were made for the interviews that had not been considered during the initial design. For example, in one interview, I purposefully hid my pregnancy to minimise any considerations the participant may have had to my wellbeing and because I had some knowledge of her own experience. Had she noticed, I would not have lied, but felt it was something that did not need to be drawn attention to and was able to conceal. During two of the interviews, hiding my pregnancy was impossible as I was heavily pregnant. Whilst it was discussed by each family member in a natural manner and appeared not to affect the immediate emotions expressed, it should be noted the participants may have considered I should be protected and altered their own

behaviour. It is true, upon reflection, that these interviews were less 'emotional' than the rest.

Case studies

The second part of the data collection utilised case studies. The case studies in this research are on campaign groups and required:

> a level of visibility that most safety crimes, mundane and routine as these are, simply never achieve (Tombs and Whyte, 2007: 10).

However, the main difference between this research and pre-existing research lies in the way the case studies will be used. Case studies were used to examine the nature of resistance to dominant ideology, in addition to a discussion of context.

As mentioned previously, there was some overlap between the family members who were interviewed for their personal experience and for their membership of a support or campaign group. The fact the interviews were so open led many of the family members to talk about their desire to 'do more'. It became apparent that it was a consequence of the nature of their victimisation that victims were compelled to 'do something' at the end of the process.

> 'Social movements' lie between crowds and organisations or institutions…are reasonably organised collectivities, fairly long lasting and stable, with emerging rules and traditions, and with an indefinite and shifting membership (Blaikie, 2004: 189)

It was considered that case studies were the best way to research and represent them. The support and campaign groups were selected on the basis of the ones that were mentioned by the initial interviewees and those that were well publicised and related to safety crime (of which there are not many to choose from).

The case studies were created using online resources, semi-structured interviews, questionnaires, documents and in one case, a book that two members of one support and campaign group had recently published. A further four individuals were interviewed for their connections to groups, one by Skype, one by phone and two through questionnaires, which they completed because of their own time constraints. Four case studies were created as a result of mixed methods including an examination of relevant documents, internet sources and a recently published book.

Case studies were revived as a method in the 1980s (Blaikie, 2004). They are about making connections and observing events, whilst thinking about them in ways that contribute to the overall theory (King and Wincup, 2007). They offer in-depth information about a small subject matter and in the case of this research, were subject specific. Case studies are criticised for not being useful for generalisation and can take time to create using multiple sources (Gray, 2013).

Much of the additional information on the support and campaign groups came from web pages created by the groups for use to publicise their campaigns. During the progress of this research, the CCA closed and it naturally came under examination. Before the centre closed, information was saved from their webpage as well as documents, such as newsletters, that went on to inform the research. These were treated in the same manner as printed documents as far as the nature of this research, since they

contributed to both understanding of and a method of researching resistance.

Multiple sources were used to approach the case studies from multiple angles to verify the data (Yin cited in Gray, 2013). For example, web resources were used with documents, newspaper reports and supported with the interviews of members of social movements. Information was sought under strict categories that could be replicated by another researcher. They had far stricter guidelines than the semi structured interviews that preceded them, which added to reliability. Although case studies do not lend themselves to generalisation, this is irrelevant for this research, which is more focused upon insight and complexity (Blaikie, 2000).

Whilst face to face interviews are preferable, four individuals were interviewed remotely due to practicalities and because they were adding to pre-existing information and filling in gaps that had been identified. Whilst telephone interviews can be too focused on the aims and were time limited, the Skype interview proved more informal and an appropriate medium between face to face interviews than telephone interviews (Harding, 2013). Telephone interviews can be more formal whilst also minimising non-verbal feedback. This was more suitable in this case, as it did not involve interviewing a bereaved family member, but a solicitor.

Approach to data analysis

When dealing with large amounts of data gathered through interviews and case studies the researcher needs to take a central role in collecting, examining and dealing with large amounts of data from interviews and case studies, carefully selecting which parts to use. The researcher then has to decide how to combine that with relevant theory (Finlay and Gough, 2003). It requires that

they make connections between the information they gather and related theory to uncover the 'truth' (King and Wincup, 2007). Undeniably, what is selected and how it is used is individual to the researcher leading to the potential for a charge of confirmation bias so the aims must be transparent and the findings defensible.

It was pre-determined that no interpretation should take place at the time of the interview to avoid inserting researcher bias into subsequent questions and to avoid a loss of focus in listening (Hollway and Jefferson, 2000). Interpretation was done afterwards and sometime afterwards with a view that critical social research should be reported as "a story with a plot" (Harvey, 1990: 211). The views of the social researchers will inevitably affect the language used in its interpretation and selection, based upon their knowledge, experience and expectations (Blaikie, 2004).

Each interview was transcribed in full to avoid any element of interpretation or the removal of the words of interviewees (Harding, 2013). It was important that nothing was missed and that the entire transcripts should stand without any initial interpretation. This meant the data could be used in a number of ways and re-read to check context, which happened many times. Thematic analysis was used for "identifying, analysing, and reporting patterns within the data" (Braun and Clarke, 2006: 6).

A number of themes were placed under the main topics after many readings of the transcriptions alongside the literature (Gillham, 2000). A theme was identified as something that was significant in the data and also related to the original questions (Braun and Clarke, 2006) although these did co-depend on each other. For example, whilst the original research questions were not changed, different elements were emphasised. It is part of critical

social research that begins describing the abstract before moving towards the specific (Harvey, 1990). It was true that:

> Sometimes issues don't 'jump out' at you until someone says something particularly vehemently or articulately. However, this does not mean that it isn't present in earlier transcripts. Once sensitized, you may be surprised to find how many other instances you can find (Barbour cited in Gray, 2009: 216).

As a cross over with the interviews I carried out as part of my job at the time of the interviews, I highlighted occasions when the family members became upset. This was useful upon reflection as it emphasised what really mattered to them, which could not be second guessed.

Similarities as well as difference were identified, which tended to be in relation to the reactions of official agencies, such as the police (Harding, 2013). As themes were discovered, it was considered that any contradictions should be highlighted in the research and not determined by personal preconceptions (Harvey, 1990). It may have helped that I did not have prior experience of this as an area and what I had expected to see was more sanitised than what I actually saw.

As mentioned previously, similarities were identified as the interviews progressed, which led the analysis. It was important that the need for similarities did not override the truth in the transcripts, the "verbal accounts" (Braun and Clarke, 2006: 18). The proposed themes were re-worked, or re-named to best represent the transcriptions.

Part of the research that was constantly revised was the aim to "…weld theory and data together in an ongoing culmative search for the truth" (Giddens cited in Bottoms, 2007: 83) and in attempting to link the statements made by the interviewees to relevant ideas within existing corporate crime literature (Blaikie, 2004). Whilst it is true that "…it is impossible to produce any data without the researcher having an influence" (ibid: 187) there was an attempt to remain aware of bias and efforts to minimise this selection. However this has not eliminated personal thoughts and feelings that come with being a researcher as Maher observed:

> My own subjectivity has influenced the collection of these data, as well as the analysis and the concepts used to frame them. The account that emerges is necessarily partial and incomplete (1997: 228).

The ethics of conducting such critical research questions will be detailed in the following section.

Ethics

Ethics have become a central and necessary consideration of any research in the past fifty years. Research ethics entail "ontological, epistemological and theoretical assumptions" (Payne cited in Gray, 2013: 68). It has become a standard part of university research that researchers are now required to submit a research proposal for ethical approval (ibid 2013). Miles and Huberman (cited in Harding, 2013) identified ethical issues for qualitative researchers, whether the project is worthy, benefits and costs, informed consent, honesty and truth, privacy, anonymity, how the results and conclusions are used. Gray (2013) outlines four considerations for ethics which will be considered in turn.

Firstly, harm could not be avoided but could be minimised. No greater harm should come to the interviewees (Hollway and Jefferson, 2000). The implications of this were considered early on in the research, prior to the interview. For example, care was paid, where possible, not to schedule the interviews on dates such as the anniversary of the victim's death. The subject matter itself was bound to be emotive in that it asked each family member to return to a time before their loved one had died, to the death and the months that followed. Regardless of whether this was a matter the family members regularly recollected or not, was one associated with unpleasant memories and painful emotions.

It would be dangerous to make assumptions about the nature of the grief, for example to suggest that family members who had lost loved ones many years ago may feel more confident with the subject matter than one who had lost someone relatively recently. How 'emotional' the participants became, could not be predicated or 'designed out'. In situations where participants became visibly emotional, it was only possible to witness this without any attempt to alleviate this pain, but rather, not worsen it (Lee, 1993). It would be inaccurate to anticipate the victims need to be 'protected' as they may have welcomed a chance to give their own accounts and have a voice (Davis, 2008; Cook and Bosley, 1995). Prior to the pilot study I spoke with key support workers who had much experience of working with victims.

Key support workers spoke of families not wishing to be perceived as 'weak' and it was decided the initial letters would not ask explicitly, i.e. each person may want support throughout the interview, yet made it clear they were to do only what they were comfortable with. This was also emphasised in a phone call made prior to the actual interview and each interviewee made very individual decisions about whether they wanted support or not. Many family members already had techniques for dealing with

upset, such as deferring to the other person in the room. For example, during one interview one person intimated for her husband to explain about the formal identification process at the hospital, clearly negating a subject she found difficult to approach. Another interviewee wanted the interview to take place only when her children had left the house and made small talk until that happened.

The aim of every interview was to foster a private, confidential and non-condemnatory attitude to create a 'framework of trust' (Lee, 1993: 98). The research required participants to recall memories that were often painful and encouraged the sharing of unresolved issues (such as the nature of justice). The women's movement highlighted "scholarship" should emphasise "identification, trust, empathy and non-exploitative relationships" (Punch, 1998: 169). Those taking part in research are seen as partners rather than subjects (ibid.). Personal information was shared during the interviews to a relevant contextual degree, rather than remaining strictly depersonalised (Legard *et al* cited in Harding 2013). The majority of interviews took place in the homes of the family members, taking into account that it can be comforting to talk about a harrowing event in a safe place (Hollway and Jefferson, 2000). All of the interviews took place in a private room. Researcher risk was reduced by meeting with people already known to others who were familiar with the field and oftentimes, my partner was nearby (though not in the house). On the occasions when I travelled alone, contact was made with a family member at the start and end of the interview, which was pre-arranged.

Secondly, Gray (2013) details the importance of informed consent as an ethical consideration. The consent was open and transparent based on the presumption that individuals can rationally appreciate and articulate the wider social and class contexts they are placed

within and do not need to be shielded from the purpose of the research (Frisch and Watts, 1980).

Consent was sought by the CCA when they made initial contact with the families to enquire whether they would be willing to participate. It was then repeated in a letter to formalise the interview, by phone when I rang to arrange the interview and just prior to the interview (appendix 1).

Consent is important but the extent to which this can be sought fully is questionable as many of the victims are far removed from academia and can never know how far their words will reach or how they will be used (Murray, 2003). However, research has shown that participants are often able to place their experiences within a wider structure and have a unique understanding of where they sit within social and class contexts (Frisch and Watts, 1980). The critical element of the research was not hidden from the family members and was explained but it is unlikely this will negate the potential implications of undertaking critical social research.

Thirdly, I sought to respect the privacy of the individuals by emphasising the family members could withdraw their consent at any time, including once the interview had ended. Anonymity was ensured and the recording materials were stored appropriately. This was important with regards to the companies studied. Their names were removed from the research with the names of the family members. It may be true that some people could be identified because their particular cases have received more publicity. A description of events, places and people could lead to "deductive disclosure" (Lee, 1993: 186). This fact could not be

altered without changing the detail of their comments and requires existing knowledge of the topic as a whole.

In some of these cases, it can be assumed that the individuals are not concerned with anonymity and would forgo theirs to reveal the identity of the corporation associated with their loved one's death. For example, there was never any self-censorship or questions asked by the family members about whether the names of the corporations would later be removed. Some saw the interviews they gave as part of opposition to the injustice they suffered, a chance to put across their point of view.

However, the assurance that names would be removed and the content made as anonymous had already been assured in the ethics application to the university, perhaps a reflection that ethics has become more about protecting the identity of the researcher and the reputation of the university rather than those that are researched. It is true that it would be foolhardy and potentially litigious to include the names of the corporations involved, which would jeopardise the intentions of this research. By the nature of the research, the corporations in this research are unpunished and therefore, *innocent*.

Finally, for Gray's (2013) considerations for ethics, deception was avoided. The participants were clearly told how their comments would be used, verbally on more than one occasion prior to the interview and in writing, on the consent form, which was in a university ethics panel approved format and which participants were asked to read and sign.

Issues with researching victims of safety crime and sensitive subjects

In this research, the victims of safety crime are examined through the experiences of their families. Every case studied in this research shared a common experience that the victim had died, either at work or as a member of the public in a context which raised questions about the working practices of an organisation (CCA, 2007). In the absence of the victim, it was the people who loved them, principally their family members that sought the truth and had to bear witness to the criminal justice process. Their experiences are the concern of this research.

The difficulties and uniqueness of speaking with people bereaved and the circumstances that followed that bereavement is discussed in the ethics section. What follows is a discussion of personal considerations when dealing with sensitive issues.

The researching of sensitive subjects makes large demands on researchers that requires, "…skill, tenacity and imagination if they are to successfully confront the problems and issues which arise" (Lee, 1993: 210). As mentioned previously, this research began out of a personal interest and concern for those who suffer sudden bereavement as a result of safety crime, so there was a level of attachment prior to the initial contact. This is quite contrary to the positivist concept of keeping a distance and maintaining neutrality. Emotions need not be "the anathema to academic research" (Dickson-Swift *et al*, 2009: 63). Maher (1997) argues there are technical but also personal effects on the researcher of sensitive issues that extend beyond the immediacy of the contact. In relation to this, relevant issues will be discussed.

Firstly, conducting research can impact on the researcher's relationships with family and friends Maher (ibid.). It was noted that one such consequence included an inability to complain or to be patient with those that ferociously bemoaned the lack of 'injustice' of insignificant events. On occasion, this could come across as uncaring or apathetic to the concerns of family and friends who often expressed "everything is going wrong that could go wrong" based on a snapped washing line.

Secondly, in terms of leaving the interviewees behind to return to 'normal' life (ibid.), the recording of the initial interviews were harrowing at times and often left a feeling of 'numbness'. This could largely be dealt with, with a period of quiet that often followed (for example, a car journey home or an overnight stay in a hotel) but in one instance, the interview was followed by a significant event with a close friend. This event should have evoked positive emotions, but instead, was a strange, detached experience. This echoes that noted by Dickson-Swift *et al*, (2000: 13) as a "disconnection from family and friends". Upon reflection, it was preferable for the interviews to be carried out away from 'normal' life. The meeting with families was suited to those occasions when interviewing took place across the country and when nights were spent away from home.

Thirdly, impacts to psychological and physical health were notable in the ongoing analysis (Maher, 1997). Returning to the data surprisingly revealed I had forgotten much of the detail of the cases. Unexpectedly, the re-reading of it evoked real emotion and sadness, which was difficult for anyone to understand as I was the only person at that point that had read the research. This was exacerbated, as during the recent analysis, one of the interviewees died prematurely. Re-reading her insightful interview, I repeatedly thought about the injustice of what had happened to her son, her family and her, personally.

Hall reports that the most upsetting work was analysing the after effects of rape, physical, emotional and material (Lees, 1996: 3). I felt great unease moving between reading and analysing the words of people in pain, recalling the wonderfully fond memories of their loved one and then being with my own children and doing general tasks, after the 'sitters' had gone home. This was more pronounced than doing the actual research, where emotion had been expected. The subsequent personal questioning of the unpredictability and unjust nature of life led to paranoia, anxiety, physical symptoms and hospital appointments. Mirroring the consequences of emotion work reported by researchers "…difficulty sleeping, anxiety, gastro-intestinal upsets" (Dickson-Swift *et al*, 2009: 11). After spending a significant amount of time with the interviewees and then becoming re-acquainted via the transcriptions in order to become immersed in the data, it was impossible to "keep the social world at arm's length" (Blaikie, 2004: 136).

These symptoms may have happened without my experiences as a researcher; in the very least however, the feelings would not have been as strong. The memories that the family members shared with me, about the nature of their loved one's death, but also about their personalities and the emotions of their memories, altered my life in ways I had not anticipated. Greater knowledge means a greater understanding of the world and its workings (Harvey, 1990). This might be enlightening, but not always comforting.

The emotions I felt when I re-read their interviews have added to my understanding of the events they had been thrown into. This does not mean I can speak for their needs or on their behalf. It does mean I am motivated to document their experiences as a testimony and a counter to commonly held assumptions about deaths at work. There is a responsibility to put these views across accurately and testify to their experiences. For some families, I was keenly aware that participating in the research was important. In one case, a bereaved wife expressed:

> I think part of the justice thing was also about talking to you, for me about doing what I think [he] would have thought was right (7).

Ultimately, the connection I felt with the families may have aided the 'safe' nature of the interview where I attempted to openly encourage the families to talk about their loved one without shame or embarrassment. As noted:

> the naturalistic researcher is not a detached 'scientist' but a participant observer who acknowledges (and looks out for) their role in what they discover (Gillham, 2000: 7).

As in feminist research, reciprocity is important, as the researcher and the researched should both gain from each other (McNamara cited in Gray, 2013). The generosity that I was shown throughout the interviews was poignant. Generosity in allowing me to bear witness to their grief as well as inviting me into their homes, offering tea and Yorkshire parkin, a Sunday roast and a bed for the night. Self-disclosure was considered and navigated by respecting the parameters of the interview whilst also being human (Dickson-Swift *et al*, 2009). Being invited into another person's home, and discussing personal issues, is not the basis of a friendship but neither is it a formal meeting. The most difficult part of disclosure was not sharing with the families the similarities between the cases as they arose, as a form of validation for the families who had thought they were isolated. Through the families' willingness to revisit the time their loved one died and in recalling what for many, was the worst time in their lives, I have been able to understand the consequences of safety crime victimisation in detail. This research and its insights wholly depend upon them. To quote:

> [The] intellectual's error consists in believing that one can know without understanding and even more without feeling and being impassioned (Gramsci cited in Sim, 2003: 254).

After listening to the families and seeing part of the devastation their experiences had caused, it only supported and encouraged the motivation I held beforehand.

Additional issues

Research into safety crime can be said to be subjugated too due to issues of lack of funding, which requires working for free as well as problems of accessing the families of victims who are often rendered invisible. For example, accessing victims of safety crime in the future could be far more complicated and potentially risky since the closure of the CCA. Austerity measures increasingly limit the freedom university researchers have to examine that which is deemed to have low market value (Tombs and Whyte, 2003). It is perhaps rare that this research was not preoccupied with such issues or with the concern of gaining future research because it was self-funded and as a by-product of that, completed on a part-time basis. It was started purely out of a personal interest.

In response to the low probability of securing a funding grant, the decision was made to reduce my full-time job to part-time and start studying part-time. The decision as to where to study was made purely on the basis of where the expert in safety crime was, which necessitated long distance study.

The decision to self-fund, whilst freeing, was also exacerbated by the nature of the participants, who lived between Glasgow and Weymouth. Most of the interviews required a stay overnight before or after the interview. The families that contributed to the

research were chosen not for their locality to me, but because of their suitability to the research and via the CCA, which operated across the UK. It did however make the research more costly on a personal level, which may have put off or will put off other researchers in the future. A one off grant from the university eased two interviews when expenses were paid. Travelling across the UK and speaking to the families was one of the most interesting aspects of the research and part of the whole experience.

The intention of this research was to evidence the effects that impact on individuals and families of people who have been killed as a result of a safety crime. They should not be invisible because this increases their suffering unnecessarily. In terms of how it could be used is difficult to judge, but as far as the need for publication, it is my intention to present the results to the people it affects. For example, to organisations such as Hazards or other related organisations, this is an "interventionist consideration" (Sim, 2003: 245), perhaps unique to traditional criminology and concerns of those on funded studentships, seeking full-time work in an academic institution.

Conclusion

The use of semi-structured interviews and case histories were selected as suitable methods for this research. Semi-structured interviews were the best way to give emotion and to enable the detailing of the experiences of the families. This process became less structured as the research progressed, which gave the experts chance to open up and share their thoughts. This was also the most valid way to gather data and create themes following full transcription of the interviews. Case studies were chosen for the second, modified part of the research. In order to examine the corporate accountability movement, case studies were considered

the best way to observe and document the history and nature of a number of influential groups. Ethical and practical issues were discussed, linked to the sample size and representativeness. Further details were examined that are unique to research of families of safety crime victims as well as potential problems of publishing, censorship and funding. The challenges included dealing with sensitive data and carrying out the interviews to accurately reflect the experiences of the families and to 'give them a voice'.

The following two chapters will present the data. Chapter Three will highlight the experiences of the families using their own testimonies as witnesses to the state response to safety crime and subsequent social and legal obstacles. Chapter Four will continue with testimonies from families and people relevant to the various campaign groups and data from the case studies to examine the political response to safety crime. It will examine how the families who created or joined support and campaign groups impacted upon the obstacles outlined in Chapter Three.

Chapter Three

Obstacles faced following a safety crime: Social and Legal

Introduction

Chapter One reviewed the literature to show the recognition of safety crime as a distinct sub-category of criminology. Chapter One established that victims of safety crime are far from ideal victims for the criminal justice system, they are instead, problematic.

Through the responses of the various agencies, the victims of safety crimes are constructed to be culpable victims and the corporations[5] avoid being defined as criminal. The process of construction will be detailed in the following sub-sections starting with the way potential cases of safety crime are suppressed as they approach and progress through the criminal justice system.

As soon as the victim died, an official process began for all of the families in which they were processed by various state agencies. For all of them, this began when the police knocked on their door. From here, they went on to be processed by the coronial system, the criminal justice system and the HSE. The families had little choice in who they came into contact with, when and how they were treated. For many of the families, each of the officials involved began to construct their loved one as culpable, blameworthy for their own death. The individuals and even the

[5] It is difficult to know the structure of each alleged perpetrator in the cases and therefore, whether it holds the status of being a corporation or not. There is at least one large corporation examined in this research, but for the sake of consistency, the term 'company' will be used in the following chapters to refer to the employers, businesses and charities concerned, unless directly quoted from the original data.

personalities involved influenced each case, the nature of which will be exemplified in the following sub-sections.

Suppression: the police

The police were the first agency all of the families came into contact with. This was because it is standard procedure for the police to inform the next of kin when a person has died. Following a suspected safety crime, the police have the authority and rights to secure the scene of the death, a duty to collect the evidence and to take statements from witnesses. These statements are part of building a case to present to the Crown Prosecution Service (CPS) or to pass to the HSE. For some families, the police were present throughout legal proceedings and a number of families were assigned a Family Liaison Officer (FLO). The extent to which the police carried out these roles, varied. Out of the 11 cases, six were not investigated by the police. One was not investigated until a complaint had been made (appendix 7). The role of the police will be detailed in the following sub-section.

Police response

The truth was the first and the last thing most of the families referred to, they waited patiently to know the truth about the events that killed their loved one. The scene of the death was crucial to establishing this. However, many of the experiences of the families illustrated how the scenes of deaths were not treated as potential crime scenes but instead, approached as accidents.

In the majority of the cases, families were told by the police that they were passing the case over to the HSE, after they had established there had been no 'foul play', that there had been nothing to suggest criminality was involved:

> I said ‘who’s collecting the evidence?’ And he said, ‘what do you mean?’ And I said, ‘well are CID [Criminal Investigation Department] involved?’ He said, ‘they’ve had a look’, [I said] ‘had a look?!’ [The police officer said] ‘Well they’ve been down to the scene,’ I said ‘what did they do at the scene?’ And then he just changed the subject. He said, ‘we don’t believe there’s been foul play’ (2).

In one of the cases, the father of the victim recognised the police were concluding their investigation too soon and without good reason. He expressed the view that he was being ignored and although he tried to ask questions to find out more and to change the situation, his pleas were disregarded:

> The police said they didn’t believe there was any foul play, they hadn’t given me any evidence to say otherwise and that police officer just ignored me on the phone. It was as though, ‘what do you want me for?’ (3).

The opportunity for the cases to be defined as criminal lay principally with the police who often gave the impression that the deaths were random and not a matter for the police. In the following case, the FLO assured the partner of the victim that the questions she had were unnecessary:

> She [the FLO] was at great pains to tell me that she didn’t think anything criminal had happened, she told me on one of the phone calls, because I kept asking questions…she said to me “listen I absolutely know that nothing criminal happened, this is just an unfortunate accident” (4).

In the following case, the police broke the news of the ‘accident’ to the family and had no further contact:

> The police came to see us and told us he'd had a bad accident, they took us to the hospital where he was, but from that day on we never saw the police again, we'd no comeback they never got back in touch with us, [and] we'd no help (1).

The police quickly passed the cases over to the HSE in 73% of the cases. One of the families recognised the police should not have done this and that in doing so, they had ignored protocol:

> He [the police officer]…said, "Oh it's a Health & Safety thing, nothing to do with us". Now that was wrong, the protocol for the consultation between the HSE, the police and CPS had actually come into operation the day before. So they should have known about it and they should have called in the CID immediately, but they didn't (5).

The mother in the following case detailed how even though the police officers had realised her son's death was a crime, they failed to act as such:

> They called for a Scenes of Crime Officer [SOCO], so they did know it was a crime…but then they didn't read it like a crime because they had no idea who was there. They didn't seal off the area. They didn't even stop people getting on & off the boat (5).

The families asked questions of the police, such as why evidence had not been gathered and why statements had not been taken from witnesses. Some were met with "a total wall of silence" (5). The police made it clear to the father of a victim that witnesses were unnecessary "because it was an industrial accident", the father replied to the police officer that it was "irrelevant" but was powerless to control or conduct the investigation himself (3).

In the few cases where evidence was gathered, this happened months after the death, which placed limitations on what could be ascertained, which the mother of the victim recognised:

> we had one health and safety inspector plus two CID people, trying to unravel this….[the] first CID interview [six weeks after my son's death], [and the] first CID interview when anyone [was] present the day [my son] was killed was…12 weeks after the event. [The director] wasn't interviewed until 16 ½ weeks after [my son] was killed. Once CID was involved they conducted the job well, but lapse of time allowed inaccuracies and hindsight. [The director] and other witnesses had the opportunity to discuss what had happened (5).

For the following family, the police investigation was launched immediately. Doing so at this stage of the process made a huge difference to the future success of the case:

> The contact with the police was brilliant. We were given a FLO the day the accident happened who is still a family friend. He helped us with everything, any questions we needed to know, any part of the investigation with the HSE because it was the HSE's field, it's not really the police's field. The police backed up the forensic evidence and stuff like that. They did an investigation. They sealed off the area as well as a crime scene (6).

The police had the ability to define how the person had died. The death of one husband was initially counted as a road traffic accident (RTA). Had it not been for the actions of the victim's wife, it would have remained that way:

> I had a letter from [the] city council, the HSE, and in the letter he told me the police had filed the paper and they treated it as a Road Traffic Accident (RTA) (4).

The wife of the victim pushed the case forward, altering the trajectory of the case and the way it was subsequently viewed and crucially, the response of the police:

> My father is an ex police inspector and he said, "right we're going to write to the deputy chief constable"…we composed a letter and said, "there's no way this was an RTA you should now instigate an investigation, a corporate manslaughter investigation bearing in mind all this evidence, [previous] incidents" and so we sent the letter off and within a day or two…a team of police officers were put on the case to look into charges of corporate manslaughter (4).

This led to a visible police presence and resources:

> They had an inspector and a team of about three or four officers investigating…over the months they had to take witness statements, they had to interview various members of staff, staff in head office...they request[ed] documents, stacks of documents, well it went on for nearly two years…it was immense really (4).

This was a stark contrast to the immediate investigation, which according to the wife, "was basically 2 minutes…" (4).

As seen above, in approaching the deaths at work as 'accidents', the police failed to treat the victims as legitimate. The tendency to frame the deaths as random misfortune and the subsequent lack of investigation, stifled the opportunity for the cases to proceed. The manner in which the rights of the families were suppressed will be illustrated in the following sub sections.

Hidden rights

In a situation alien to the families, they relied upon knowledge from the police and official agencies, they were their only guide. Many families were unaware of the rights they had and by the time they were made aware, it was too late to act. This was at a time when they were very vulnerable as explained by the mother of one victim in the following case who was denied access to her son's body:

> I couldn't eat anything until he was found…I couldn't lay him out, none of us could say our farewells and it's had a devastating effect to this day…you've got people in authority all taking advantage of your vulnerability and your emotional state so I didn't appreciate it when I found out what I could have done… [I was] never told I could (7).

This reoccurred throughout the families experiences, many members chastised themselves in hindsight:

> After the post mortem he [the police officer] said we could see him again…again we could only view [my son] through glass…I don't know why didn't I stand there and say, "I need to see him properly" (8).

Even when they did have rights, this was not explained to families by the agencies, which ultimately led many of the families to feel responsible.

In the months that followed the death of their loved one, information continued to be provided reluctantly to the families, which provoked suspicion and further pain:

> it was a 'them and us situation'…questions weren't being answered, and the more…you're not getting open and honest communication, your little molehill grows into a very big mountain, very quickly (7).

The families needed the official agencies to carry out their jobs fully at an extremely difficult time in their lives, but many discovered to their cost, that this did not happen. The rights they had were blocked, for example, the families were not aware they could have their own medical representative at the inquest and were not informed or found out too late to use this right. The needs of the families were disregarded, the right existed, but only on paper, useless to the people who needed it in what were to become life changing moments. The ways the families were disregarded was often combined with a lack of empathy, which had an adverse effect, as will be demonstrated in the next sub-section.

The families were in an inferior position to the agencies they came into contact with, they did not know the procedure and were at their most vulnerable. There were many occasions when those bereaved were treated disrespectfully by the agencies, which caused them unnecessary pain. In the following cases, families expressed their anger and frustration at the way the police dealt with them. Firstly, a number of the families were upset about the way they were informed their loved one had died:

> The police who came to us were brutal…it was late at night; they had taken twelve hours to get the news to us. They were just so callous (5).

One mother had regularly contacted the police station for news of her son whom she feared was dead. On one of those occasions, still unaware her son had died, she was invited into the police station to speak to a police officer who:

> started asking me questions. What [my son's] name was, where he was born, what his date of birth was, what colour his hair was, his eyes, his height, had he got any distinguishing marks or scars? All these things he didn't explain to me at all. I'm of the generation that you just answer, if [the police officer had] said 'jump', I would have said, 'how high?' I respect them and the last question he asked me was, 'what funeral directors are you going to use?' That's how I found out my son was dead… if I hadn't had my daughters I would have jumped into the Thames (7).

In the following quote, a wife of the victim was visited by two police officers in the early hours of the morning. They informed her that her husband had died but said they could not leave until they had told her how he had died. She was fearful about what she was going to be told at over eight months pregnant and with two young children sleeping upstairs, she requested the police tell her friend. As they waited for her friend to arrive she recalled the police officer was:

> in the house going, looking round saying "so who likes Graham Greene then?" I was like, "they are [my husband's] books" and he was "well, so he likes Graham Greene then?" I don't want to talk about Graham Greene at the moment, thank you. He was [saying], "I've got to tell you what happened". I was saying, "I don't want you to tell me, all I know is that he is dead"... Every time he [kept] going "I've got to tell you," I was screaming. "Don't tell me, don't tell me" and he was going "Ok, I won't tell you, I won't tell you", and then he [would repeat] "but you really need to know" (9).

The police had a huge impact upon the families in the long-term when they did not show empathy, especially in the immediate aftermath of the loved one's death. In the previous case, the woman was "petrified…the police were going to come to my house", she moved house soon after:

> that was one of the reasons I had to move out of the house because that night is just imprinted in my brain, how awful it was. I'm not saying that a nicer police officer could have made it a nice night because it was an awful night regardless...[but] I had all sorts in my head that needn't have been (9).

The families respected the police and did not expect to be treated poorly as relatives of victims nor as members of the public, but for some, this continued after the initial meeting:

> [the] Liaison Officer rang, my sister was with me, and I asked when I could have [the body of my son] back…and she said, (I don't think she realised that the phone was on the loud speaker)…she said, "doesn't she realise there's nothing left to bring home?" That's the last time we heard from her, she never, ever contacted us again (10).

In one case, the FLO chose to act as a liaison for the company who employed her partner, in ways that would be unimaginable for a traditional suspect:

> She kept phoning and asking things of the firm for me…she asked if the boss in the driving agency could come and visit me…there was a couple of phone calls asking me if representatives of the firm could come to the funeral…I said no (11).

Not viewing the family member as a victim or the employer as a potential offender, the FLO continued to contact the partner of the man who had died for example, requesting that she returned material that belonged to the company, "…and it became a wee tussle, [the company] were obviously phoning her" (11). The reluctance to place the company under suspicion was set against the willingness of the police to doubt the innocence of the victim. This will be detailed in the following sub-section.

Implicating the victim

The police often returned to the families and posed questions that that the victim might have caused his own death. This led to the families feeling they were under suspicion and to defend their loved one:

> The police came a week later and started to ask questions about [my son]…"Did he drink? What was his family life like? And it sounded as though they wanted to lay the blame at [his and his colleague's] door. I said there were problems with [my son's] relationship but he wouldn't have done anything as he had a child and he worshipped his daughter and yes, he liked a pint but he wasn't a big drinker (10).

A procedure continued to be followed that implicated the victims, supposing they had either committed suicide or had acted in dangerous ways that might have led to their own deaths. In the following case the victim had been killed entering a car park in a queue of traffic. It had been established that the car in front of his car had not been able to reach 10 miles per hour at the time of the incident. The police still pursued a line of enquiry that blamed the victim:

> our car was taken away for examination to make sure there were no mechanical faults on our car and I can always remembering the police man asking me if my husband was a boy racer, trying to apportion the blame to him. I said "no and I'll tell you this you'll find nothing wrong with our car either" because my husband always kept his car in tip top shape he always had the MOT… police look at things from all angles really, they think of the easy way out (4).

The wife in the following case was questioned about her husband's mental health as she was waiting for her friend to arrive to be told about how her husband had died. This line of

questioning led her to think he had committed suicide, which was contrary to the evidence the police had at that point. The police officer asked:

> "Did he have mental health problems?' [I asked], "What, did he kill himself?" He was going, "No, no, he didn't kill himself but I have to ask you these questions". I just think that was so inappropriate now that we know how he died; there was no need for me to have been asked these questions (9).

As seen in the previous sub-section, the families of the victims were largely treated as though they were not victims of a crime but of bad luck. For the majority of the families, this was decided by the police at the scene of the death. The fact the victim was killed at work, informed decisions about the necessity of an investigation and was repeated when they first met and questioned the families. This placed the victim under suspicion and began a process to establish a narrative of 'accident' which only made it more likely the death of the victim would be viewed similarly at the next stage: the inquest.

Suppression: the inquest

As a standard process to determine the cause of death following a sudden or unexpected death, the families placed much hope on this process. They were desperate for the truth and expected to hear the truth at the inquest and to have it heard publicly and in front of a jury.

Two of the families did not have an inquest because their cases proceeded straight to court to hear charges for corporate manslaughter. However, for the majority of families, this was the only process that attempted to establish the facts about how and

why their loved one died. Out of the 11 cases, three did not have an inquest (appendix 6). One family member was warned they were told not to expect to hear the truth, “A number of times, at the meeting here, the inquest, [the HSE Inspector warned us] you’ll never get [to hear] what you want to hear” (3).

As this next sub-section will show, for the majority of the families, they did not get the truth. 63% of the cases that had an inquest, returned a verdict of ‘accidental death’, one was ‘narrative’ and two were judged as ‘unlawful killing’. The families left the process feeling distraught as the truth was suppressed and manipulated. There are various ways this was achieved at the inquest. The first way was through continued delay, as the next sub section will show.

Delay

Delay was a common experience of the families, for example, some waited a long time to find out their loved one had died. Another family had to wait for a month before they could have a funeral or find out where their son died:

> We had him cremated and it wasn’t until a week after the funeral when we went to collect his ashes from the Crematorium that we found out which firm had killed him (5).

The families had to wait a long time before the actual inquest. The shortest time was seven months (1) and the longest was four years (4), the average waiting time was approximately two years and three months (Appendix 6).

In the majority of cases, nothing was classed as urgent, there was no race for justice. As discussed previously, there were delays

with the investigation, if one took place at all. As a consequence, interested parties who were present when the person had died refused to make statements, which permitted a partial account of the truth. The following account from an ex-partner showed understanding to those people who refused to give statements after time had passed:

> You can understand to a certain extent, we're three years down the line if you'd have got statements off these men should I say that week or the week after, I think for [my ex-partner's] sake…they would have actually signed certain statements, but three months, eighteen months down the line even, you're not going to get [them], [the employer] pays a decent wage…all those blokes have got families…[my ex-partner is] not coming back, they're three years down the line they don't want to jeopardize their jobs (2).

Even when faced with a police investigation, members of the company refused to answer questions and official documents went missing. In the following quote, a wife of a victim expressed her confusion at how the companies were "able to get away with this":

> it was frustrating it took so long and also that these companies…they have stalling tactics, the police ask them for certain documents and it will take them two months to get them…they can't find them or certain things have been shredded, 'oh we can't find those' and…they interviewed people under PACE [the Police and Criminal Evidence Act] and they declined to answer questions…so as not to incriminate themselves (4).

In one case, friends of the wife and victim refused to appear at the inquest as witnesses because they said they were scared the company involved would enact revenge on their families. Understandably, this hurt the wife:

> My solicitor contacted all the people that were there [when my husband died] and they all refused to speak to her and they are all my friends and [my husband's] friends. I found that one of the most difficult things [crying]. So I couldn't go to the inquest because I knew that they were trying to shaft me, I felt…trying to stop the truth from coming out (9).

Such protracted delays did not prioritise the families who were often forgotten. For example, many had the inquest thrust upon them at late notice, in the following case, after four years of being on 'standby' the wife of the victim:

> suddenly had a phone call…from the coroner's clerk and he rang me on a Monday morning…he said "I'm very sorry…Can you get to the coroner's court in four hours' time for the preliminary hearing? I forgot to tell you it's being held this afternoon" and I said, "how could you forget? I'm the most important person in this case"…he had the cheek, bloody cheek [to ask], "have you got legal representation?" I said, "I've been waiting for your phone call and that was going to be my first question, do I need legal representation?"…there's no way you can get a solicitor in four hours (4).

This happened in another case when the families were given a fortnight's notice after ringing for more information. Her lawyer had not been told and she had not been told anything about the process.

Due to the lack of notice in the previous case, the wife of the victim had no option but to represent herself against a wealthy company who had been given prior notice of the inquest and arrived at the coroners court fully prepared. Whilst she was aware of the power imbalance, this did not deter her:

> I had to sit in the front there, next to this top London barrister, me having no legal experience at all, none at

> all, I don't think they'd even experienced this before …It made me laugh in a way…I think I came as a shock to them…I think they were expecting some nervous widow who couldn't compose herself but then it was four years on and anger will fuel you on, even after all that time you think you're not going to let them get away with it (4).

The delays were the first part of the process, once at the inquest, with or without representation, the families expected the facts to be uncovered and were shocked by the quality of the evidence that was heard and the way their loved one was treated after death. The way the truth was selected was part of the suppression of the truth. This will be detailed in the next sub-section.

The selection of evidence

Once at the inquest, the families expected to hear evidence and facts, which would give them the answers they needed. This did not happen for the majority of the families. The purpose of the inquest was to establish facts and not to apportion blame. The families were frustrated they were told not to seek responsibility, "[we were told] this was not the court to do it, but where is it?" (3).

Who was considered "expert" was vitally important in the construction and suppression of the truth at the inquest. Those classed as professional witnesses was questioned by the families. In the following case, the professional witness called by the company had been a colleague of the victim. In the two years between the victim's death and the inquest, he had been promoted. The father of the victim considered, "…it's obvious to me he wasn't an expert [but] the inquest officers class him as an expert" (3). As an 'expert', he made claims about the victim's actions prior to his death, which frustrated the father:

> I was surprised that he was allowed to be a professional witness, he said "there's nothing you can tell me about driving, I've been driving 20 years". He said "I've tried the scenario and I can't understand it…I've even tried to do it the way [the victim] did it, he was never trained that way" (3).

The father could not understand how the coroner held the experience of the lorry driver in defence as equal to the evidence the HSE presented as prosecution. He was clear he believed there was no parity between the two.

Other families expressed surprise and confusion that people who made unsubstantiated claims were unchallenged at the inquest:

> This is the thing you get the feeling that people are allowed to lie all the way through…there were no consequences [when they lied] (2).

In one case, the HSE had a phone call from an anonymous individual. They informed them the company who employed the victim had ignored advice that would have made the job safer because it would take up more time and therefore, increase the costs. This was contrary to what the boss of the company said on the stand at the inquest:

> I'd been speaking to [the victim] a few weeks before, and I'd told him, "…take your time on this job, it doesn't matter about money" (2).

The ex-partner was incredulous the employer went unchallenged in the court as she knew he had a reputation on the site:

> have you ever known a boss to stand there and say that?...you can hear everyone…smirking as he's saying it… Jesus that was why the 'Bull' [the employer's nickname on site] was there, he'd be there shouting and moaning and groaning (2).

The representation of the employer was not heard at the inquest, instead, he was able to claim the victim had worked in an unsafe way in the past:

> his boss turned round and said…he'd seen [my ex-partner] do something a week before that wasn't safe…[that he'd] had to call him up on it but he didn't say what it was (2).

There was no official evidence of this reprimand, yet it was heard in the court.

Limited time was a factor that came up as a potential cause of death of another victim, but was similarly refuted by the employer. This line of enquiry was not pursued:

> There was a mechanic who…said he had…been told not to fix certain parts of the tail lift [the part of the lorry that killed the victim] because it meant the lorries would be off the road for weeks but all the managers came on [the witness stand] and said they knew nothing about that (11).

The most common type of evidence that was presented to the court was paper based, for example risk assessments. These were often collected months after the incident, which the families considered were open to manipulation. When such information appeared to have been changed, the families were shocked this was permitted and when it was presented, went unchallenged:

> there's a massive, massive question whether there was any training [as] some of the documents went missing, there has been ongoing argument about when defects are repaired. The mechanic will sign the particular defect the day before, there was ticks against them and both the mechanics have said they don't use ticks…they're both in different colour and you don't need to be an expert [to see] they're both in different handwriting so it looks as though, after the event somebody has panicked and went to the paper and ticked them but that can't even be mentioned [in court] (11).

In the delay between the death of the victims and the inquests, individuals representing the companies changed their version of events. The families were stunned that they heard 'new' evidence at the inquest and could not understand how this was permitted:

> she signed a full statement [immediately after the victim's death] saying exactly what had happened…The police had signed it, she signed it but then she stood up in court and said "no that was wrong, I didn't say that."…the Coroner let her off because she was old, which to me made it a lot worse for us (1).

This was repeated in another case when the family were surprised the coroner used statements taken by the police rather than those taken by the HSE (8). In another case, similar sentiments were expressed:

> we even had people lying in court under oath, they knew damn well they were lying, so did the police and so did the HSE. They'd been questioned under PACE, they'd been interviewed and when this person started giving evidence they all looked at each other and said, "well she didn't say that [before]" (4).

The families had waited years for the inquest and expected to find out the truth about how and why their loved one had died. Most found the process frustrating and upsetting as they had to bear witness (in silence) as the truth was intentionally complicated in a public court. The court was not a source of comfort but a site of more pain and confusion for the families. Consolation for two families came from members of the jury. One mother took comfort in a letter (quoted below) that was sent to her from one of the jurors after the inquest had ended:

> I feel you are right this to me was an accident waiting to happen and why the coroner did not pick up on this is beyond me…Myself and the rest of the jury felt the old lady was too scared and felt she would be blamed…At the inquest nobody can apportion blame on anybody else but in my eyes the poor condition of the balcony rail has been the major factor in the death of [your son]…I hope by telling my view to you it will help you a little with the pain of your loss (1).

This had a huge effect on the mother who kept the letter and had tried in vain to find the jury member to write a 'thank you' note. Here she received small validation that was denied to her in the inquest. Similarly, the family in the next case noticed members of the jury were upset when they returned the verdict of accidental death:

> two of them cried actually because all they could do was give a verdict of accidental death, nothing else because they didn't have enough evidence to prove the other way, they were directed by him [the coroner], by the inquest officer, [it had to be either] accidental death through operator error or poor maintenance (3).

This was significant to the family and authenticated their own thoughts in ways that had been suppressed by the court. The direction of the coroner had a large impact at the inquests, from

the ability to withhold verdicts or in the treatment of the family. One family concluded the inquest court was, "…a show, 12 just men" (7). The coroner had ultimate power in the court and the families recognised the implications of this. This will be discussed in the next sub-section.

The role of the coroner

The coroner became an important part in the quest for the truth, but for many families, left a lasting harmful impression. The majority of families did not see the coroner as protecting their interests or as neutral. Instead the coroners were guided by their preconceptions that what had happened to their loved one was an accident. The fact that the coroner led the jury prior to the verdict, left the families puzzled as to the function of the jury:

> I just wished [the coroner] made a decision, [had] given us the option [of an unlawful killing verdict] rather than saying we can't have the option…the jury didn't really get the choice…I don't understand why there's a jury there because the guy virtually tells them what they've got to bring back (3).

The summing up was crucial as the coroner had the last word in the case and directed the jury. The importance of this was mentioned in the following case where the family had hoped the jury would be able to make their own minds up. The family felt the final judgement was not made by the jury but by the coroner, as in his summing up he said the loved one's death "was more or less an accident" (5).

In the only case to secure an unlawful killing verdict, the coroner did not sum up, which surprised the wife of the victim who reflected that perhaps this was because the coroner was "newly appointed" (4). The wife of the victim in this case held a positive view of the coroner and felt validated by her. For example, she considered that for one witness, "the coroner knew [a witness] was

lying", requesting a new witness the following day that discredited the testimony of the previous witness. This was a unique experience in terms of the cases researched.

The family in another case felt alienated by the coroner and saw the 'accidental death' verdict as a 'win' for the coroner and the company, against them:

> The fact that [the employer] lied, which the coroner more of less said 'well, she's an old lady, we'll skip that'…And also to say that they were saying it was an accident caused by [my son] …at end of the day, the coroner won, didn't he? (1).

The family felt the coroner protected the employer, for example, they were told not to speak to her and throughout the inquest, the attitude of the coroner:

> was 'why are you being nasty to this poor lady who's witnessed this accident?'…he was all for that woman…'Well she's infirm' she was in a wheelchair [for the inquest] all his sympathies were with the woman (1).

This was common and another mother felt she had to pit herself against the coroner (9). This was after many encounters with the same coroner who had affected the families of victims in many ways, yet was still permitted to lead inquests. One of the ways the families had been hurt by the coroner was because unnecessary post mortems had been authorised:

> nine out of ten times invasive post mortems take place on the deceased, when, quite frankly, an external examination or just an MRI scan will show exactly what's gone wrong…And that hurt a lot of people because we found that out, sort of 18 months later that they cut [the victims'] hands off (9).

She challenged the coroner who responded without thought to the families as victims who were bereaved, vulnerable or with rights:

> I said [to the Coroner], "You had musicians in there, artists, people who were creative, to cut their hands off you just don't understand", he said, "I don't understand your obsession to see a dead body" (9).

Many of the families did not realise that they needed representation at the inquest. The majority of the families relied upon legal aid for representation. In one case, the family were fortunate to be represented for free through contact with a charity. However, the barrister did not successfully counter the coroner and the family reflected he controlled her unduly:

> I don't know whether the barrister was learning the trade or whether she'd just passed her exams but the coroner was horrible to her, wasn't he? Like you say, it wasn't criminal and every question she asked it was like, "you can't do that, you can't ask that, can you re-phrase that"…he was like a judge (1).

Expecting that their needs, and the needs of the victim, would be represented or at least protected in the court, many families left the process bereft. One partner concluded, "Who represents the person who died? Nobody does, absolutely nobody" (6).

The coroner had a huge impact on each of the cases and through the process of the court, the families left without answers and feeling worse than when they entered. Their hope for the truth and public acknowledgement of their loved ones had ended and the truth had not been uncovered or heard publicly, but suppressed through delay, the selection of the truth and the direction of the coroner. For some families, this was the only court they entered.

For a minority, the cases of their loved ones went to the crown court. Their experiences echoed those detailed above. This will be explored in the next sub-section.

Suppression: the crown court

A minority of families reached court where the employers either faced corporate manslaughter charges or were prosecuted for health and safety offences. 36% of the 11 families brought charges of manslaughter against the companies to court. Of those, all but one case ended in acquittal. That director was convicted of corporate manslaughter before the charge was overturned upon appeal (Appendix 7).

By the time the families reached any formal court, they were highly informed about what had happened before and after their loved one had died. In the crown court, the families hoped for justice, punishment of the offender and that this judgement would mean another family would never go through what they were going through. This research will demonstrate the gulf between these expectations and the reality and how, as in the inquest, the truth was complicated and suppressed.

Achieving justice does not depend upon one state agency and the families were not in a position to propel the case forward as interested individuals. Instead they relied upon state employed individuals to build their cases. For the families who had lost loved ones as a result of a safety crime, the cases which had been built were disabled and the truth was suppressed. There were a number of factors that meant justice was almost an impossibility to achieve. This will be explored in the following sections.

The problem of evidence

Cases were developed some time before they reached court; the suppression detailed in the previous chapter affected the possibility of justice at the stage that followed. Families assumed the various agencies were doing everything they could. It was too late when many found out this was not happening. The mother of the victim in the following case reflected that if she:

> could turn back the clock…I wouldn't have put so much faith into the Justice System…I wouldn't have sat back, my sons used to say, "Mam you need a solicitor"…and I would say, "no the CPS, the police are fighting for [my son]." I put all my faith in our Justice System and that was so ignorant of me (10).

The mother put her trust, unknowingly into the CPS, she imagined the state had stepped in and was passionately representing her son. Similarly, one family reflected they were fortunate to even get the case to court because:

> statements weren't taken, evidence wasn't kept, measurements weren't taken and still we managed to get it through into court (8).

Crucially, this was not because the evidence did not exist that was to be pivotal at court, but because it had not been collected. One family had benefitted from a full police investigation, but recognised the importance of evidence in court, "It is a big hurdle as well if you haven't got the evidence". However they walked straight into another hurdle:

> [The Judge asked] "Why is this case before me? It was an accident at work." It was only the HSE who

> said it wasn't an accident at work. It took two weeks to switch that judge's mind set from "this man shouldn't be before me" to "he's guilty of manslaughter". (11).

In the previous sub-section, a unique case was detailed, unique in this research because it ended with an unlawful killing verdict at the inquest. Such a verdict should have given the case a greater chance at court, however it did not:

> when you have an unlawful killing verdict the coroner redirects the police and the CPS to look at the evidence again and even then they [the CPS] still came back and said 'lack of evidence'…that took another two months…this is nearly five years after my husband's death (4).

The CPS explained they were unwilling to prosecute because of lack of evidence. The wife of the victim in this case asked for it to be put into a court room to let the jury decide even accepting:

> you probably wouldn't have got [the corporation] on corporate manslaughter because it's too difficult to prove, you've got to prove the controlling mind…you'd never get that because [the head of the corporation] is not even based [in England] (4).

The wife in this case recognised the limitation of the law but still wanted her husband's case to be given a chance in the court. Unable to do any more, the wife sent the CPS a letter telling them "they were useless" and should be disbanded (4).

For those who made it to crown court, there were similarities expressed between the judge in the crown court and the judge at

the inquest. One family expressed that they were surprised by the way the evidence was evaluated:

> the court case was a bit of a rollercoaster ride because the judge didn't seem to take any interest in all these expert witnesses coming up from the HSE…after listening to all the testimonies of these expert witnesses…he [the judge] went to his [local] garage which he called a "roughty, toughty garage". [What they said at his garage] meant more to him than the stuff he'd learnt from the HSE. That, I found strange (11).

For another family, witnesses had been assured they would not be prosecuted even if the information they provided made it clear they had failed the victim:

> [My son's] own employer, who was brought as a witness, (and we didn't know this until after the court case), was given immunity from prosecution, so was another company who was involved…In the trial it came out…under the Health and Safety at Work Act, they hadn't done their job (10).

Information about why the employers were immune from prosecution was withheld from the family, "We don't know why…and we can't find out" (10).

In the case above, the family expressed similar sentiments to another family. They knew the case was going to collapse early on, "we knew the whole truth wasn't going to come out" (10). This was in spite of indications that her son's death was not as random and unpredictable as an accident:

> They [my son and his colleague]…stopped the job and asked the managers if they needed breathing apparatus, were the vapours toxic? Two of the managers said they would email…the suppliers of the chemicals.

> The Crown Prosecutor…in his opening speech said that an email had been found in a drawer and that two of the managers had received this email that told them to stop what [my son and colleague] were doing…because there was a great possibility of a fire and explosion. They ignored the email and put it in a drawer and sent [my son and colleague] back into the chimney (10).

After her son and his colleague returned to the chimney and resumed work, it exploded and they were both killed. The employer was found 'not guilty' of corporate manslaughter, which led the mother of the victim to conclude, "The trial was a farce". Further detail of how this case ended in a verdict of 'not guilty' will be detailed later in this chapter.

As evidenced in the previous sub-section, at the coroners court, the accused were able to change their statements. This occurred in the crown court too as illustrated in the following case. The manager had told the family personally what had happened in the days following the incident, including at the hospital and at their son's funeral but had later changed his mind:

> the Manager…changed his plea. [He said] that he wasn't involved at all, [that my son] had done it on his own. When [my son was alive and] we were at the hospital, he told us he was helping…him…but he decided to change his plea [at court] (6).

All of this information was new to the father, who was surprised, "he…change[d] his statement after he had taken legal advice. It just seemed ludicrous" (11).

In the time between the death of the victim and court cases, the suspects who had given statements changed their pleas. For many, the impact of the delays detailed in the previous sub-section meant many had not been asked to give statements for some time after the death had taken place. This had a real effect in the court, for example, in the following the case, the police took two months to take statements:

> In the meantime he [the owner of the corporation] had been able to talk to the people who were there…and that the captain's testimony altered [between] when he gave it to the police to when he gave it in court. I'm not being slanderous or anything but I am saying that there is the awful possibility that people were persuaded to alter what they were saying because they hadn't been interviewed on time (8).

The way the police officers approached the scenes reflected their assumption a crime had not taken place. When called to one scene, the police sent a probationary police officer. Because they were under the impression they were investigating an accident, it was deemed unnecessary to caution the witnesses prior to taking any statements. At the initial court case, the judge agreed this was acceptable as:

> at the time there was no need to caution because he [the manager] hadn't committed any crimes as far as they were concerned (6).

This case was unique in those researched, as the jury returned a guilty verdict and the manager was given a nine-month sentence for manslaughter. The case had overcome all of the obstacles many families of safety crime experience. But the lack of caution given prior to the taking of key statements was to impact on the case in the coming months.

After the manager had served less than three months in prison, the family received a letter from the police informing them the case was back in court, at the Court of Appeal. They were told they had nothing to worry about because, "…it was only one item that was under scrutiny". However, when they sat in the appeal court the judges reviewed the entire case:

> They said that the fireman who had…interviewed [the manager] and [got the] same story [as] the police…should have given a caution [too]…Even the Chief Inspector from Sussex Police…said…"that's nonsense" [because] the fireman does not have the Power of Arrest so they wouldn't need to caution anybody. They only needed to find out what caused the accident (11).

This was treated as irrelevant by the judge at the Court of Appeal:

> This judge was adamant that the fireman should have realised that and he threw the case out on the grounds [that] the police hadn't cautioned them at the hospital and the fireman hadn't cautioned him [either]. Our barrister asked for a re-trial they just said, "No"…There was no jury, just these three judges. They turned to [the manager] and said, "You can leave with your reputation intact" (11).

The family left the court in shock, unable to change the outcome. They were forced to accept the judgement and to see the manager

released and further, officially cleared of all charges. This had a lasting impact on the family who had seen justice delivered only to witness it being dismissed.

Most of the cases attempted to show they had taken a duty of care for the victim through conducting risk assessments. In one case, the risk assessment:

> suddenly went amiss, nobody had found it.…when Health and Safety spoke to people on the job [they] said, "yes not to worry", they had all the things but when they went up to pick up the others…there was no risk assessment…Apparently, the solicitor that came here that day…he said, "It's the first thing that goes missing on every job and there's nothing you can do about it, it's missing" (2).

Employers were regularly questioned about risk assessments in the court. In the absence of the victim, the court sought proof from signatures and 'ticks' on forms, which families found problems with, just as they had in the coroners' courts. In the following case, the 18-year old victim had been on a college placement:

> He [the safety officer at the college that approved the garage as a placement] produced Risk Assessment and Method Statements that [my son] had apparently read and signed. However, when we looked at the signature, it was not [my son's] signature. My wife…had [his] Provisional Driving Licence…she put it next to it and it was totally different (11).

The family took this to the police but they were told the court was not the right time and place to raise their suspicions:

> we showed it to the police but apparently he was acting as a witness for the prosecution so there was nothing they could do until after the court case. Then we were supposed to go and see him and quiz him about the forgery but that never happened (11).

The process provided many opportunities for failure and the families often walked away without the chance of justice. They found themselves relatively powerless to counter the suppression of the facts. Some families mentioned that had they had access to money, they could have pushed their cases further, detailed in the following sub section.

The problem of money

One family referred to the 'money factor', which was echoed in many other interviews. As they navigated a very difficult situation, the families found money was required to ease the process. This was at a time when many of the families had lost the main breadwinner and they had had to pay out for unexpected funeral costs:

> Well, it is because [my ex-partner] never left anything, he didn't have any insurance, he didn't have his own flat and between us we had to pay for the funeral, it's a stupid thing, the kids are his dependents and unless you're on a government grant, you can't claim anything to pay for it (2).

A small number of families received compensation from the government. One of the few people who received compensation in a civil claim reflected other individuals thought the money should be used to fund the court case:

> but why should you? That money is for our future, we've lost the main breadwinner in the house, there's no money coming in the door. That money [is] supposed to supplement the money you would have had coming in and there's no way I could have got that money back…no way, it's gone (4).

Money was important to the cases as it served two purposes. Firstly, it helped the process in court, from representation to accessing court documents, (both of which the employer could afford.) More than one family expressed they had no experience of dealing with solicitors, other than selling and buying houses. Faced with the loss of a loved one and upcoming court date, they had to find legal representation. There were a minority of families who had assistance from unions:

> Because of Unison, they wanted to get a manslaughter verdict…I guess a lot of people wouldn't be able to afford to…I'm lucky that I've got somebody funding me (4).

Other families did not have that opportunity and even if they were granted access to legal aid (which many were not), they put their financial future at risk:

> Even if you get legal aid, if you lost…the legal aid have to take back whatever assets you've got, so you could lose your home…even today on a legal aid form…you need a magnifying glass, it's not highlighted (9).

Some families were told they needed a barrister to represent their interests at the court, both the crown and the coroners court. The costs were high:

> so if I had hired a barrister to represent me at the inquest…that would've cost me £30,000, now why should I, as an innocent party here as a widow, have to pay £30,000 to get an unlawful killing verdict on my husband's death?...my husband didn't ask to be killed that day (4).

Families believed that even those paid to officially represent the victim and their interests were not thought about either, one mother summed up:

> [solicitors and barristers] used our tears and our broken hearts and it's made them money. They will utilise your tears and heartache because it makes some money (9).

A father of a victim recognised the legal teams would profit and compared that to the compensation he received from the government after his young son was killed:

> Whatever [compensation] you get, the lawyers are going to get five times more. That is what really pissed me off…people say, 'human life is cheap', but it is not until you find out that your son is worth £3,500…you can't even get a good second-hand car for that. £3,500 was the cost to bury him….if I had had my time over, I wouldn't have bothered with the compensation. We were told it would affect the company getting insurance…[this is irrelevant because] it is under new management (11).

As can be seen from the above, money was needed for the families to secure justice. Even if they were eligible for legal aid, had assistance from the unions or found the money themselves, this was not the end of the need for money.

The court process required money for certificates and transcripts, which was an additional cost the families had to bear, from £3.50 for death certificates (3), to thousands of pounds for transcripts (7).

After the death of her son, one mother reflected that she had spent thousands of pounds trying to build her own case:

> Over 20 years I've spent over £300,000, through research…the cost of going to courts and obviously the courts start at 9.30am…travelling at peak [times] up and down through the years, and paying for solicitors, I mean a consultation with a barrister is £10,000 (9).

Secondly, money was also needed when the families were refused justice from the state agencies, as funds were necessary if they wanted to take the case forward via a judicial review or private prosecution. At the end of the formal process, families were struck by the injustice of the process and looked into whether they could do more, but money also led that decision:

> at the end you feel as though you've dotted and crossed all the t's and the i's but…you just felt there was nothing else you could do [unless] the money is there, it's a money factor again (2).

One family felt disappointed by the HSE and paid a private solicitor £250 an hour to enquire as to how to appeal their decision not to prosecute. The solicitor informed the family that to take it further they would have to go to a judicial review and take the HSE to court. No one could tell them how much that would cost and they were told that to challenge the decision would be financially "foolhardy" (1). This was in stark contrast to one case

when, upon hearing the unlawful killing verdict, the company made it clear they were going for a judicial review and distributed leaflets they had prepared:

> [the corporation] had prepared a statement to give to the press as they were leaving the courtroom saying that they were going to go for a judicial review…they handed one of the leaflets [to me] (4).

Whereas families knew they would have to find the money for a judicial review from somewhere, for example, re-mortgaging their house, the wife of the victim in this case reflected that it would be easier for large companies. In her case the company was large and she reflected that they could "just put an extra penny on the beans" (4) in order to challenge the coroner's verdict.

Those affected by relatively small, less profitable companies still felt they were financially disadvantaged. Even those companies had more assets than the families and were in a better position financially to affect justice:

> You get the feeling that people think these subcontractors are these little firms, [the head of the company had] spent £2 million on a property in Barbados, he's got a big farm…and he races grey hounds…he's got a farm in Ireland plus he owned several houses round [the local area] (2).

The law allows for a private prosecution on paper but again, this relies upon the wealth of the families, and required far more than they could risk financially:

> A Private Prosecution was enormously expensive. I know from [another case] that when they wanted to bring a Private Prosecution…some years before [my son] was killed, that they were quoted £250,000 to get as far as the first Magistrates' Hearing (8).

The ability to achieve justice and combat the suppression of evidence relied upon money, which frustrated the families and consequently left them paralysed to challenge any judgements. They were bewildered and angry and more than one family expressed how they left the process with no faith in the criminal justice system and viewed it as a 'game'. This will be explored in the following sub section.

The problem of knowing the process

The families were unused to dealing with solicitors and barristers and had expectations about what the crown court would do and what would be uncovered. They were disappointed by the process and shocked how matters other than the truth were considered as important.

In the following case a wife of the victim was stunned that her appearance was important to the legal team (7). The barrister asked her to stay for the duration of the court case:

> [the barrister] said, "if you want to win it, I think you need to stay because… you are our greatest asset because you don't look like you deserve this to happen to you….you are an articulate woman, you will give good evidence for us…and…the judge will feel sorry for you (7).

The barrister asked to see her so he could see what she looked like and after meeting her, he agreed to take on the case because of her appearance and demeanour. The wife in this case asked:

> so if I had gone in with a nose ring and umpteen tattoos over my body, would I not have deserved it? He [the barrister] said, "probably not although you probably would have deserved it more. That's the game, isn't it?" I found that really quite...you've had all this to deal with and you go to a barrister to see if you deserved it or not…I didn't know what this grieving widow was supposed to look like really (7).

The same phrase, "a game" was repeated by the mother in the next case. Here her expectations of the legal process were drastically different from her actual experience. She described the court case as a:

> real roller-coaster ride. Never having been in a court before, you don't understand the whole legal process and it is very much a game. It's so obvious now to me that it is a game. My faith in British Justice went out of the window (6).

The notion of the court being a game was repeated in the quote below, where a wife of a victim outlined her reasons for privately suing the company, related to what she thought her husband would have done:

> They reckon that I have got between 75% to 80% chance of winning, but 20% chance of losing and if I lose, I lose everything. So do I accept the offer which is half the value? It's like the game, Deal or No Deal. That is the issue for me…it is not about the money, it will be earmarked for the children anyway…I have to think, what would [my husband] do…I think that [he] would have taken it right to the end. He wouldn't settle out of court, I think he'd go and he would want to go if it was me, and it could have been me [who had been killed] (7).

The truth was relegated in one case where, in spite of indications that her son had been a victim of a safety crime, the case had "gone so terribly wrong" (10). The lack of evidence and the poor case that was brought to court was no match for the high burden of proof required in corporate manslaughter cases. Consequently, the family were encouraged to accept a plea bargain:

> They said [the company] would plead guilty under the Health & Safety at Work Act…They had to have our agreement; we had to agree to it. We said that "no, the CPS had messed this case up and we were not agreeing" (10).

The actions of the CPS had been an obstacle in securing justice and because the family did not agree to a plea bargain they were threatened:

> We were told that if we go on with this and we lose, [and they said] 'which we think you will, your granddaughter will get no compensation' (10).

Threatened with receiving no compensation for her young granddaughter, and unable to make the decision alone (her ex-husband and son's partner were interested parties), they agreed to drop the charges of corporate manslaughter. How the case then proceeded was a shock to everyone. The case was not simply halted, but the owners were declared innocent:

> We went back into court, the jury was brought in and it was explained that there had been a change in the case… [the lead juror] had to stand up and repeat after the judge…that they found these three men not guilty on the manslaughter charge…which I thought was unbelievable (10).

Echoing sentiments made by two of the families at the end of the inquest, the mother described how the actions of a juror will remain with her. After the 'not guilty' verdict was read out, the mother of the victim noted:

> I will always remember looking at that jury and there was one young lad who I would say was about 26, the age of my lads and he just looked at us and shook his head in disbelief (10).

After this decision, the mother and her son found a number for the CCA. They rang them and were put in touch with a solicitor but were told that ultimately:

> because the judge had closed the case and had got the jury to find them not guilty, there was nothing else we could do (10).

In terms of corporate accountability, the case had finished and the company faced only health and safety charges. The details of this are covered in the next section. The mother asked questions about why the case had gone wrong but did not receive any answers. Hoping that an inquest would give her more information, she pursued this retrospectively but was refused on the grounds that the case had already faced charges mounted by the police, had been heard and then failed at court. Though covered by the Human Rights act, she was told that her son's death "didn't come under that" (10).

After the stress of losing a close loved one, going through the bereavement and the upheaval that one family member described as like "glass on the kitchen floor, it shatters and you just can't put it back together again" (9), the families had to fight for justice. It

was a fight they were ill equipped to win and one they did not realise they were fighting until it was too late. Restricted financially and provided with limited knowledge, justice for their loved one was disabled. The families were witness to the delivery of apathetic justice, justice that did not care for the loved ones they had lost. In their absence, they had to bear witness to the 'game', their pain was not alleviated and justice was evaded.

For all but one of the families, both courts failed to deliver justice. The final stage for the families and the company was prosecution for health and safety charges. Chapter One established the weaknesses of regulation and how it fails. The experiences of the victims' families with the HSE will be explored in the following section where it will be argued that regulation is another area where the truth is suppressed.

Suppression: The Health and Safety Executive

The main body the government created to respond to safety crimes is the HSE. As seen in the previous sub-section, a small proportion of cases reached crown court, but all cases failed (in the long-term) to secure justice there. The alternative and most common route for justice for those harmed and killed at work is to see their employer face prosecution for health and safety offences.

In spite of this being the most well-worn route, families did not have any better experiences here, which will be detailed in this chapter. The sanctions fell short of any expectations, which were echoed by more than one judge when they expressed their "hands were tied" (6).

A restricted regulatory agency

The current limits put onto companies do not reflect a world where health and safety had "gone mad". As detailed earlier, families were subject to long delays during investigations because the HSE were concerned with 'maintaining continuity' (1). This meant that when staff members resigned or were absent due to illness, the investigation was put on hold. The families assumed the HSE were spending time building a powerful case against the compnanies, mirroring their expectations of the CPS and police detailed in the previous chapters. One mother of a victim was given the impression the HSE were "onto something" and under their instruction did not share details of the case with her own mother for fear that "something would be said on the bus" that would jeopardise the case (1). This did not come to fruition and the case was dropped by the HSE.

Families were told conflicting information. In the following case, the family were told the HSE were going to prosecute, then were informed it was "not in the public interest" (3). Instead the company would be "kept an eye on", which the family interpreted was "all to do with finance" (3). The father was informed his son's employer had been put on probation by the HSE for breaking a previous order. This was the last contact he had and he did not know whether they complied. As a consequence, he found himself sitting outside the workplace of the company, without being sure why:

> I don't know, it's frustrating because I could see that the company were not all cowboys but I can see they were run by cowboys, they were cost cutters…they sacked a driver a few weeks before [my son died] because he had two accidents, and they blamed him for both accidents…people were saying it wasn't their fault (3).

One family had to call the HSE because following the death of their son, they were not contacted. The inspector who called at the house expressed to the mother that he thought her son had caused his own death because, "he shouldn't have been doing what he was doing" (5).

This was in contrast to another two cases where the HSE inspector was described as, "excellent, really good" (11) and in another where the inspector was described as:

> the most thorough and intelligent man I came across in the six years, he was like a rat up a drain pipe, he left no stone unturned. He was very professional, astute and very thorough and he did everything to the letter…in a way he became like a friend, he was coming in here for so many years…he could see who the guilty party was and he wanted to prosecute (4).

Both of these cases had the most success in terms of public disapproval, as seen in a previous sub-section, one reached an unlawful killing verdict at the coroners' court and the other realised a corporate manslaughter verdict in the court (although, as noted previously, the charge was later quashed on appeal).

There were cases of inspectors having to carry out a difficult job on their own. In one case the inspector was unable to access the victim's body or the scene so she had to persuade an excavator driver to operate the machine to facilitate access. The driver was "white and shaking all over" because just hours earlier, he had witnessed the death of the victim (8). The mother of the victim reflected the inspector "had so much to do…she was on her own and she didn't have time to take statements" (8). Consequently:

> it took me months to find out all the people who should have been interviewed and, in fact, we [had been pursuing charges of] Corporate Manslaughter

> Case three years later before I found out everybody who was there who should have been interviewed (8).

The findings of HSE reports are not publicly available and family members had to fight to have access. One mother managed to read the report because she:

> fought like hell and eventually they let me read it at the Police Station as long as I didn't make any copies. They wouldn't let me take photographs or make copies of it…It is the law that you are not allowed access [to it], I think it is all to do with, you know when the Freedom Of Information Act came in, HSE Reports were exempt. It is all to protect business in case anything that is released in the HSE Report could be an advantage to people who are enjoying Industrial Espionage (8).

Under resourced, underfunded and mocked publicly (Pearce, 2008), the HSE was the final stage for many families and the last hope they had of justice. The following sub-section will detail the sanctions imposed upon a proportion of the companies featured in this research.

Restricted punishment

The case of the family who were told to drop the manslaughter charges if they wanted to ensure their granddaughter would receive compensation, returned to court to hear the company plead guilty to health and safety charges:

> their barrister spoke for them, they never opened their mouths. The email was mentioned, they said 'they didn't have the training' but what training did they need to read an email and if they didn't understand it why didn't they give it to [my son and his colleague]? I'm sure they would have understood it. The manager

> who signed the work permits said he didn't have the training to sign them (10).

As at the inquest and the crown court, the truth continued to be selected and utilised in favour of the company. In the case mentioned previously, the company received a fine:

> £14,000 between three of them for two lives, so it was £7,000 each per life between three people, with time to pay. Then they asked for their costs to be paid. It was a joke. I think their costs were paid (10).

The family who secured an unlawful killing verdict at the inquest returned to court to hear charges for health and safety. As detailed earlier, the CPS had refused to take the case forward to the crown court for manslaughter charges. The hearing for health and safety charges took an hour with no jury. The HSE had high expectations the fine would be high, "…even [the] health and safety [executive] thought three quarters of a million [pounds]" (4). When the judge returned, the company was fined £225,000. That year, the company in question returned pre-tax profits of £520.4 million (Thompson, 2009).

On sentencing, the judge said:

> his hands were tied…but he did want it publicly noted that their health and safety was far below what the public should expect (4).

Similarly in another case in Scotland, the sheriff apologised that he could not give a higher fine because the company had entered a guilty plea:

> [He said]…"this should have been in the high court"…Fines were £19,000 and £14,000… one of the lawyers for [the defence], stood up and said "I think you'll find the discount is higher than that" and haggled with the sheriff [who said]…"my hands are tied, I have to give them this discount"…there was a couple of pals [of the victim] who were really, really upset (6).

Another family were expecting the company to receive a high fine as the judge had said:

> I want to know what the value of your property is because this is a serious offence and you will pay dearly (11).

At the end of the proceedings, the owner was fined £10,000 and ordered to pay costs. The father of the vicitm in this case concluded,

> I think too many people get away with a fine because it was deemed an accident at work and it's not, it's someone murdered at work. That's the difference…outside of work, you might go to jail for murder. If you do it at work there is a big possibility that you will walk away from it (11).

The HSE are an agency designed to hear the cases of deaths at work and have the power to hold companies accountable. The reality is that the HSE as a body offers regulation that is restricted and constrained by outside factors such as funding and the sanctions it offers are inadequate.

The victims are not viewed as victims of crime and as covered briefly in previous sub-sections, in their absence, the victims were placed immediately under suspicion for causing their own deaths, either by committing suicide or at the hands of their own mistakes. This narrative was pursued in various ways by state agencies, to the distress of the families. The following sub-section will document this process, how the victims and the families were silenced and what effect this had on them.

Suppressed: the process and its effects on secondary victims

As Chapter One attested, the victims of safety crimes are 'problematic' victims, far from the ideal that has been utilised by various governments in the pursuit of harsher criminal justice measures. Instead safety victims are portrayed as victims of misfortune or victims of their own carelessness. In their absence and after their death, the families had to bear witness to this deliberate construction as the criminal justice process progressed. Their protestations at the questionable portrayal of their loved ones were silenced, which was to have a lasting effect on the families. Whilst responding to sudden bereavement and the loss of a central family member, the families found themselves excluded by the criminal justice process (if they entered it at all) and distanced as not 'real' victims. They were doubly victimised by the death and by the legal process and its agents.

As shown in the sub-section above, justice, whilst a priority for the families, elsewhere the truth was negotiated, money increased or decreased the possibility of making the truth official. The seriousness that was attached to the cases was seen in the way the families and the victims were treated in court. This will be illustrated in the following sub sections.

De-humanisation of the victim

Families related how the court process was an insult to them and the family of the loved one that had died.

> The [defence] barristers just ran rings around them and the witnesses; they said that the witnesses lied on the stand so why weren't they held in contempt? …nothing was done. No consideration at all was given, not so much to me but two of [my son's] brothers [who] were in that court…they were given no consideration, the way they watched me being treated (10).

The process permitted the victims to be forgotten in the same way the people who represented the company were able to hide as they attempted to prove their own innocence. This was extended to the explanations the companies offered in the court as to how the victims died, which seemed incredulous to the families.

For example, in the following case, the family listened at crown court when the barristers for the company tried to plead their innocence. They argued it was not an explosion that killed the victim but a fall:

> In the heat, the fire was so intense in that chimney that it melted the metal ropes that held up that cradle. How on earth could he [my son] survive that heat and be killed from a bang on his head? Do they think we were stupid? They said it was a fall because, if it was a fire it would [have been caused by the unsafe] contents of the chimney (10).

The mother of the victim felt the barristers assumed she was 'stupid' and found it hard to believe such an explanation could be offered in court. The court was unable to prove otherwise in this case as:

> those who did the autopsy…were questioned by the managers' barristers…They had done tests on [my son's] lungs [and] liver for drink, if he smoked, no, sorry, did drugs but then they lost the organs and no other tests could be done as it was pointed out in the court case that, if they had done tests, it could have shown just what had killed him…They lost them and that was it…There was no explanation, we weren't told beforehand, we just heard it in the court like we heard a lot of information in the court (10).

The family were not told beforehand that her son's organs had been lost and were unable to find out any other information, no explanation or apology was offered to the family. There were other occasions when the families felt the process was trying to "demoralise" them:

> We stayed in because we weren't part of the jury so we could hear the legal argument. Then [we] had to be taken out...The Family Liaison Officer said, "We've got to tell you this, the defence is going to bring up the fact that [your son] asked the ambulance driver if he was going to die". We didn't know that at the time. We were upset but were told to be prepared for it when it [came] up. We went back into court and nobody even mentioned it. It was just another ploy. Something to get you out of the room, try and demoralise you then bring you back in again (11).

In another case the relatives unknowingly buried their loved ones without their hands and organs, which they later discovered had been used for teaching (9). They discovered the truth years after the event and the mother in this case expressed how she would not rest until her son's body was exhumed. She has doubts about who she buried.

When one company was cleared of manslaughter charges because the family agreed after being threatened with losing compensation (as detailed previously) the company was indifferent to the

feelings of the family as exhibited by their actions immediately after:

> one of [the members of the company] stood in front of us, shook his barrister's hand and said, "thank you for getting us off." That was before they went in on the second day to be charged with Health & Safety [offences], so basically they weren't bothered about the Health & Safety, it's nothing. They thanked them for getting them off which I find absolutely horrendous (10).

When the families attempted to influence the process in some way, for example, by challenging officials to ask relevant questions, the professionals involved responded defensively and without concern for their welfare:

> the Crown Prosecutor took us to this room and got really nasty…I asked questions…I … said somebody was killed on their site three months after [my son], "why wasn't this mentioned?" They looked shocked; the Crown Prosecutor…he asked, "Where did you get it from?" So [my son] piped up and said, "Off the internet last night." [The Crown Prosecutor] then turned to me and said, "We don't really have to speak to you because you are nothing, you are only his mother and you are nothing, we don't have to tell you anything" (10).

The family were dismissed by the Crown Prosecutor in the case above, when, at the start of the process, the mother had assumed they would fight for her son.

Families were discounted in the court process when seats were not saved for the families in the courtroom. One mother was only able to sit in the courtroom because a police officer gave up his seat for her while the victim's brother and father had to stand outside.

Similarly, the position of another family member was controlled by the defence:

> We were put in the Gallery and his family was in the Gallery as well. They were [making] snipes at us and our Family Liaison Officer…said to the judge, "look, it is not right for this family to be sitting next to them". [We were moved to] the Press Box at the front...Then his solicitor complained because we were directly opposite the jury and we might intimidate the verdict so we had to move. That's when we realised that it was all a game (11).

To see their loved one forgotten in the legal process wounded the families. One partner summed up, the families were treated as though they were unimportant:

> It matters that there was a man in the middle of this…[At] every stage of the proceedings the person and the families are forgotten, absolutely forgotten, the prosecution has got nothing to do with the fact that somebody had died [it] became apparent every day (6).

The partner of the victim made her feelings clear when she concluded her partner "had absolutely no chance in that workplace and he [had] no chance in that court" (6).

Aside from the failure of the process to deliver justice, a number of families pointed to the mistreatment they suffered when the victim, their loved one, was treated inhumanely after their death. For example, in the following case the:

> QC got up and said, "sir, can we check our records because the lady here has lost her only daughter and

> you're referring to Mr so perhaps we've got a muddle up?" He looked down [at the photographs and said], "it just looks like a man". And [the mother had] lost…her only daughter…that's what we were dealing with, that's how he treated us, mistreated us. Did he remain in that role? He's still in that role today (9).

In the same court, the mother illustrated her own frustrations believing the official she dealt with had, "no conception of what it's doing to us inside in our heads, in our hearts". Attempts to redress that balance were not warmly received:

> [I said]…"my son's got a name and you're reading out numbers [assigned to him in the morgue], it's hard enough that we're here…you're calling them numbers,…he's got a name, he's not [a number]…Well anyway he [the coroner] went back in…and he kept looking and kept saying [my son's name] then…he said [addressing me], "well I've now said your son's name 12 times, I hope that suffices" (9).

The judge had huge power to influence the feelings of the families and in the following case, they had a positive impact that outweighed any fine:

> he twice spoke to us as a family and…kind of acknowledged us, actually that's been more assistance than any fine…this one person acknowledged [us] (6).

Another family expressed that they wished they had been treated better by the head of the court, as they left feeling like they were criminals:

> Just that would've helped, I think if the coroner hadn't treated us like we were criminals…and not treated us so harshly, which they did, it was harsh (5).

One mother of a victim became increasingly upset by the proceedings and how her son had been forgotten in the process. She retaliated by printing out photographs of her son with his daughter and taking them into the court because:

> that was my way of saying, this is a person…they have got a face because in the court the person who has been killed is not treated as a person…he is a person, can you remember him? I will never let you forget what you have done (10).

The victim was not at the heart of the process, as demonstrated in a previous sub-section. Aspersions were routinely cast upon the circumstances of their death, no matter how obvious the truth had seemed. The families were often treated as an inconvenience and when they fought against their 'natural place', they suffered more. They were chastised when they were not silent. The next section will detail how the families are shown that their loved ones are culpable victims and that any efforts they made to counter this were silenced. This was at a great personal cost to the families, long after the formal proceedings had drawn to a close.

Implicating the victim in court

It was common in the cases surveyed, for the victims to be implicated in their own deaths and constructed as blameworthy and culpable victims. This was played out at the inquest and witnessed by the families as they waited for the truth after years of delay.

People involved in the criminal justice system recognised that this could impact on the families, for example, it was recognised most keenly by a defence barrister in the following case:

> We were stood outside waiting to go into the Court Room and one of these manager's barristers came out to us…he said…."This has got no reflection on your son but it is the way the trial has got to go…we are not blaming your son". We were taken aback for his barrister to say this…we'll never forget it (10).

As implied by the barrister, for the company to be blame free, the blame had to be located as the fault of the victim. For one family, the father of a victim reflected that at the inquest:

> They made it sound at the inquest that he worked in an unsafe way, but in actual fact…he wasn't a risky person, he worked hard, very hard (3).

The victim was forgotten in the process, forgotten or discredited. One family obeyed advice by their legal team, which they regretted:

> I was upset because I asked to be able to read out a statement from the family at the inquest but was advised not to by our solicitor so I don't know quite why, that is to my eternal regret…solicitor or barrister didn't want us to read it out (1).

The families ended the process trying to defend the loved one they had lost. In many cases they were left trying to suggest explanations for the actions of their loved ones just before they died. In the following case the victim was held responsible for not

maintaining the temporary vehicle he had been given. His father asserted this was wrong because:

> There were even some comments that his original lorry was spotless, his cab was like a normal car and he'd spend hours [cleaning and maintaining] them. He had respect for his vehicle and the one he was driving [when he was killed] was a younger vehicle but in worse condition (3).

For the court, its officers and the company and its interested parties, it was suitable for the victim to be portrayed as risky and careless. The families were forgotten and sidelined in the process, and whilst this was positive for the company in the short-term, the impact of blaming the victim had long-term consequences for the families. In the following case, the ex-partner was clearly distressed about the way her children's father had been misrepresented in the court and what that meant for her and her children:

> I didn't want it to seem like it was all [my ex-partner's] fault and that was all we came away with. It's not as bad as somebody committing suicide but you would like them to care enough about their own life because it's caring about theirs [the children] because what's been done has hurt them, it's hurt me, it's hurt them, but it could have come away that it wasn't his fault…it was like they were all trying to blame him…because no one wanted to pay out a big lump of cash, we didn't want to blame him for another reason, that's the thing [crying]. But it's the other side, there's nothing worse than somebody trying to say it's your fault that's what it felt like and it wasn't like that because you had a bloke that was really good, that worked fucking hard and if he could've done something for you, he would've done it (2).

The families did not want, nor expect to be in the position in which they found themselves. They expressed that their grief had been compounded by legal processes. One mother turned to her son, the brother of the victim and commented, "I have to do something here as they are just making my son a nothing" (10). The loved one they knew was not the person that they had seen created in the court; "That wasn't a bloke that was seen there that day, they were virtually saying he was irresponsible" (2). Instead of finding and revealing the truth the court had, as one father commented, killed his son over, "Life will never be the same. It's an assassination of that person" (3). The father summed up he wanted the court to know what was not being represented, what was stripped away, "That was a person that had a life and has left people [who] loved him" (3).

Families who fought for information or to alter the trajectory of justice were seen as an obstacle to the process of the court. Those who refused to be silent were punished. This process and its effect will be detailed in the next sub-section.

The treatment of secondary victims

The majority of families were the only ones who were fighting for their loved ones at the court. Given the process appeared to be favourable to defending the company, relatives that resisted this were not treated well. For example, when families challenged the process, when they asked questions, they were unnecessarily interfering in areas they had no business in:

> I started being…the woman who was 'awkward', because I was asking questions…I was a nuisance, I was interfering, why didn't I let them go and do their job? I mean we had no rights and it was so wrong of me to be emotionally upset. There is still that brick wall there…obviously there's more questions because I keep saying why and [the police] say, I shouldn't ask why (5).

For one mother, her grief, and dogged pursuit of the truth whilst challenging the coroner, was interpreted as pathological:

> he [the coroner] told them that I was unhinged and in need of hospitalisation…they should completely disregard what I was saying, that I was not sane (9).

The families fought for information and to find the answers in the processes they found themselves wrapped up in, where their loved one, the victim, was the focus but misrepresented. When they did not receive the truth or when they were treated unkindly, some blamed themselves. One partner linked the lack of truth and the way she was treated by the police to her own politeness and agreeability:

> I went through a stage where I thought that if I had been different to the liaison worker, if I'd been *nicer*, I thought if I'd been nicer, would it have made a difference? [Crying] Sorry…I felt terrible, terrible guilt as though I hadn't done [my partner] any justice, but I didn't know what I was supposed to have done but I felt as though I should have done [something differently] (6).

As the individuals who represented the court were not fighting for their loved one, the family members took on the burden and reflected this was their last chance to show their loved one was loved:

> you always think, this is the last thing I can do for him...[crying] sorry… It's hard to say, I think if I could go back I think I'd [have been] more, what's the word? More pushy and more aggressive, which I couldn't have done at the time, looking back you think you can do things, I think we should have (5).

These effects were long lasting, the families took on an unreasonable amount of guilt as a result of the legal process they had been thrown into. The guilt and pain endured long after the formal process had ended and was apparent when I spoke to the families, some three years or more after the official process. It is impossible to say whether this will dissipate or worsen in the decades to come.

The families were vulnerable and had their own lives to continue with, lives that had been irrevocably changed. The future was challenging anyway due to their bereavement without the additional de-humanising process they found themselves a part of. One wife was angry about the work she had had to do to pursue her case:

> nobody knows what pressures are on you and the frustration and anger of it all that are on you, nobody knows, as far as I'm concerned, me as a widow shouldn't have to do with that, it should be automatic, the system is in place that when somebody dies, a company has killed them it should be automatic that it's thoroughly investigated, you as a widow shouldn't have to research corporate manslaughter, you shouldn't have to seek the people out and say, "hang about now, I don't agree with this, it should be this, this and this" (9).

Family members could not be passive witnesses if they wanted to see justice done. Instead, they felt:

> like you've got to do everything because that's the only way you get closure on it all…[to put] it all to bed and know you did your best (2).

The families were doubly disadvantaged. Not only did they not have the finances that the companies had, they were emotionally

connected to the victim. The absence of that person, that loved one in their lives altered their lives and the lives of their families, which in every case but one, involved young children. Partners were open about the problems they had experienced and how they coped with the case:

> I had to teach myself how to face every day…I could see my teenage daughter was self-harming…because she had fallen out with [my partner] the night before, I also went back to work after six weeks because we needed a wage so I was kind of…off my face (4).

Children who had otherwise been well behaved changed their character, which in this case, the mother had to respond to as well as having another child and a newborn baby:

> Then I had [my son] playing up at school, terrible, questioning your authority all the time. He's the oldest and the one affected by it, very affected by it. So, I have got him getting into fights at school, not doing what the teachers are telling him to do which is all out of character. So you are trying to deal with that and the new baby. It is just very, very difficult (5).

The companies had a process that was favourable to their status, a system that sought to blame the dead victim, money to fight as well as the will to do so. In contrast, the families were not seen as victims, did not have surplus cash (exacerbated by the loss of the breadwinner) and were emotionally wounded. They had to respond to their own bereavement as well as the reactions of other family members and friends. This made any fight even more difficult. The companies did not help with any of these consequences, as one mother noted when her daughter who had been in the car when her father had been killed, "…they didn't care my daughter was screaming every night, having nightmares" (4).

The families were silenced by the process and the victim forgotten. This made it easier for the companies to evade responsibility, responsibility that the family of the victim absorbed. Many reflected they should have done more, fought harder. This was a burden many of them took on at an impossible time in their lives. Whilst companies may have had a 'close shave', they left the process validated, *innocent,* and able to continue operating. Employees could move and work for another organisation, they could still claim to be prioritising safety. The families could not. Their lives had been irrevocably altered. Fathers were absent, sons were gone and the families had to cope with bereavement, the effects of secondary victimisation and an injustice many felt they had partly caused.

Conclusion

The families began the process innocently believing they would quite quickly discover the truth about what happened to their loved one before they died, many wanted to believe it was an accident. They thought their priorities would match those of the state agencies they were forced into contact with. For some, the faith they had in the agencies stopped them from asking questions as they waited for the process to reach a logical conclusion. For many of them, by the time they realised their faith was misguided, it was too late and the (limited) opportunity they had. To challenge or to influence the process, had gone. The victims and the families of victims were not represented, but suppressed through the official processes, starting with the police.

The perception that deaths at work were accidents influenced the reaction of the police who, as the first guardians of the scene of death, failed to approach it as a scene of crime. The dead victim and the families of that worker were not legitimate victims, they were disregarded. Without a victim, there was no crime and no role for the police to fulfil. The fact that in many cases the police

did not subsequently collect evidence doomed any further action to failure for the next stage, where the companies faced charges in court.

Families were suppressed by the police in a number of ways. The rights that the families did have were not always exercised because they were not aware, or made aware of them. This later led some families to blame themselves. The failure of the police to treat the families with care in the initial encounters had a lasting effect on some individuals. On occasions, the police worked with the companies and made it explicit to the families that what had led to the death of their loved ones was accidental. The police were also the first official agency to place the victim under suspicion. They let the families know the evidence they had, did not necessarily discount the guilt of their loved one as the process began.

For the families that had an inquest, the truth continued to be suppressed in a number of ways. The families had to cope with years of delay as they had no choice but to wait to finally discover the truth. They accepted that no one would be blamed, but wanted to know how their loved one had died. They were further disappointed by the way the 'truth' was constructed, selected and negotiated. For many of the families, a perpetrator was found, but companies were not considered to be criminal, and not held to account as the families had expected or had been led to believe they would be. The evidence they had was easily defended and dismissed in the majority of the cases. Whilst families had been optimistic about the presence of a jury, they were disappointed and unaware that the coroner held such sway. This was noted when witnesses were chosen by the coroner but most keenly felt in the summing up and when the jury members were directed to a verdict. In the absence of financial resources, the families lacked power to challenge any decision and were forced to walk away, confused and hurt.

Those families that reached court to hear charges of corporate manslaughter were in a minority. To get to this stage meant the evidence had to be strong enough to pass the CPS and have a chance of meeting the high burden of proof that was required. Then due to the nature of the judicial system the victim had to be implicated in the process in order to make the companies innocent. The process permitted the 'assassination' of the victim, who in their absence was unable to defend themselves. This left the families horrified and confused. On reflection, certain family members blamed themselves for not doing enough. They considered that if they had changed their behaviour, they would have been treated better, the truth could then have been uncovered and their loved one fairly represented. However, they were never going to be legitimate victims, not because of their own actions but because of what they could not control, the nature of where and how their loved one died. One influence over the case was access to money, which none of the families had readily available, which was in direct contrast to all of the companies. The families reflected they had been in a game where the odds were stacked against them.

The companies who faced health and safety charges benefited from delays in the HSE investigation and lack of evidence. The fines that were given to the companies were small, which the judges noted in more than one case. Regulation was restricted, in its investigation, power and ability to convict appropriately.

The process the families witnessed, that allowed the companies to avoid being viewed publicly as a criminal, relied on the victim and the families being de-humanised. They were not considered in the process but seen as unimportant and a hindrance if they attempted to become involved and influence the process. Whereas the company was enabled in rejecting the label of criminal, the victim was a culpable victim, worthy of blame, risky and implicit in their own death. Instead of being represented, families found

themselves attempting to defend their loved ones in court. Once the process was over and had failed to achieve justice, family members were affected in the long-term, they felt partly responsible and the hurt multiplied because of how their loved one had been misrepresented and forgotten.

The obstacles created and developed by the criminal justice system meant that justice was unachievable for every family detailed in this research. Some of the families felt compelled to respond to their sense of injustice. This will be discussed in the following chapter.

Chapter Four

Obstacles faced following a safety crime: Political

Introduction

Chapter One demonstrated that victims of safety crime are largely excluded from criminological study and that their victimisation is rendered invisible. Chapter Three showed how this affects the reality the families live through. The social and legal processes mean that the families of the victims are not seen as legitimate victims and are forced to watch as the system fails. At the inquest, in the majority of the cases the death of their loved ones is officially recorded as 'accidental' and they either do not reach crown court or if they do, they do not see justice prevail.

This chapter is focused on how pressure and resistance seeks to secure political change. This will be examined through the response of the families of victims when they create or join groups to support and/or alter the representation and treatment of other victims of safety crimes. It demonstrates why and how families, and those concerned by this, have mobilised collectively to form groups in response to the obstacles they encountered. This includes those of suppression and de-humanisation identified and explored in the previous chapter. This chapter will examine whether this alters their previous near exclusion from the concerns of the criminal justice system. The success of each group will also be evaluated.

"How do you get your voice heard?"

The social and legal processes that render safety crime invisible were detailed in Chapter Three. The effects on the families were touched upon. These effects lasted after the official processes were brought to a close, and for many this was the impetus that led to individual family members either creating or joining a group to support and/or alter the representation and treatment of other victims of safety crimes. The long-term effects that the families bore will be highlighted below.

Long-term effects on secondary victims

As discussed in the previous chapter, many of the families felt silenced by the legal processes and unable to have a voice. They were suppressed and given no place to have their say. Connected to their status as losing a person whom they love/loved, who they saw unrepresented or blamed in the court as a victim of safety crime, they also felt they needed to speak on behalf of their loved one. The long-term effects will be examined in terms of suppression and de-humanisation in this section.

Suppression occurred in the first instance when the families were prevented from putting across views they thought were crucial and which were not being represented. In the following case, the mother of the deceased found herself speaking out at the inquest after her legal representative did not press a point she thought was common sense. This was a point that she believed was obvious and hoped would exonerate her son who was the victim in the case:

> You try to say something in court and you're slapped down….[I was told by the coroner that] I'd be put out

> of court…I didn't want to miss anything else. It's hard to get your voice heard, how do you get your voice heard? (5).

In the case above, the mother tried to express her grief and frustration in other ways and to right the wrong of the court. Pitted against the potential power of the corporation, she was blocked:

> I did write one letter to the [local paper] that they wouldn't print, he [the journalist] said, 'I'm awfully sorry but we'd be libel'…the media are frightened to death of upsetting people (5).

The local newspaper was afraid of the financial repercussions of publishing the mother's letter, further silencing her. The court was at the end of a long process for many of the families who recognised they had no control:

> You're at the mercy of everybody else, you're told when the inquest is going to be, you're told when [he, the victim and their son] can be buried…when you can bury that member of your family, you [wait to be told] how they died, you have no control, do you? (3).

The families had been unable to find answers to their questions but hoped such a formal process would reveal how their loved one had died and what had caused it. No family member imagined they would be able to return to 'normal' life, but they had not considered they would come out of the process without the truth and feeling worse:

> I think this has been the hardest part, I know [now] we won't get the absolute truth, I think I'd held on to

> that, [that] I'd not get closure but [would get] the truth (6).

Secondly, families were not only changed by the deaths of loved ones, but affected by the way they were de-humanised, which influenced future family life. In the following example, a mother had lost her son and was told by another son that he would not visit her in England again:

> With the court case, the injustice of not getting justice, [the victim's] brother said in the middle of the court case, "I am going back to Ireland and I am not coming back…my brother was killed, they are responsible" (10).

He was disgusted that his brother meant 'nothing' to the court:

> we've waited two years for this court case and now they have rubbed [my brother's] face in the ground. [He] doesn't mean anything in this court, they took his life and now they've just made him meaningless, nothing (10).

There were serious long-term effects the families suffered after their cases had finished that were as a direct consequence of their experiences in the criminal justice process. People referred to other family members and survivors who had been deeply affected by the ordeal of the criminal justice process:

> I've had 9 mothers die of cancer[6] after the disaster, we've had 10 suicides, other premature deaths of survivors who have just dropped dead. And I know

[6] One of the mothers, who took part in this research and is featured throughout, died in 2015.

> it's from the stress and the deep trauma that they've gone through and still live through (7).

In this case, the flatmate of the victim died suddenly in his twenties in the years that followed. There was an acknowledgement that whilst their lives had changed, it was the process that had added harm and hurt to the families in ways that were not easing with time:

> His younger brother…was 11 when [he] died. I've brought the lads up on my own from them being little. [The victim] was always like a father figure to [his younger brother] and it hit him really hard…he got kicked out of school, his personality changed, he became very angry, disruptive. He still won't talk about [him]. [His] older brother, he can't accept the way we were treated as a family and in their own way they find it very difficult to cope and it is coming up to eight years now. That hasn't lessened. They still feel that (10).

Another mother of a victim thought about the way she had been treated by the coroner and stated "I'll remember [his] name for the rest of my life" (5). Many families thought about their own experiences but also what it meant for other family members:

> [I know] the moment we're born we're certain to die. I totally accept that at any point any of us could die but I can't get over that [my partner's] parents who brought him into this world, he was a late baby, she had him when she was forty odd that they don't have the right to know what took him, or what could have been done to avoid taking him (6).

The effects were long-lasting, not only as a result of being bereaved but as a consequence of their secondary victimisation. Victimisation was exacerbated as families of victims of safety

crime because the truth was suppressed and their loved one was de-humanised as part of this process.

The families wanted the system changed to show regard for the families as suffering and as legitimate victims. They recognised that they were treated differently, and with less respect, because their loved ones had died in a workplace death:

> Basic respect is not there because you are not looked on as victims. Would they speak to a family member who had lost somebody in an RTA [Road Traffic Accident]? No they wouldn't. That's when the word accident comes in; you are a trouble causer as it was an accident. The more you ask questions; maybe they are embarrassed as well because I don't think they know how to deal with work place deaths (10).

Families protested that the word 'accident' was inadequate, had wider connotations and needed to change:

> I hate that word, 'accident', because an accident is something that can't be prevented. My son's death and a lot of other deaths in the work place could have been prevented so therefore it is not an accident. I do get angry when I hear people say…"your son had an accident at work and he was killed". No, he didn't have an accident at work. He was killed at work. Somebody put money before life and that is why my son died and it wasn't an accident. I do take offence when people say that (10).

By the end of the process the families had become experts in their own cases. Whilst this was not validated by the court process, or in an official capacity, they each had a detailed understanding of the difficulties of securing justice following a safety crime.

The families made links to the way justice would have to be delivered differently to companies, for example, linked to profit and power. The wife of a victim in the following quote recognised that a fine would hurt companies but that this should be extended to cause pain to others who benefit from profit:

> [It would have been justice if] somebody [had] gone to prison, the directors…and a sensible fine….also the assets and the turnover should be looked at and the fine has to be based on the turnover, how much they make, that's the only way they are going to learn…money, that's all they're interested in…You should look at the company assets, you can't tell me £225,000 is going to hurt [the billion dollar corporation involved in this case], it's not. It's billions…I also think the share price should be affected as well because the shareholders don't like that either, the share price should be dropped and on all their literature it should be stated there they've been prosecuted for something (4).

All of the families argued that money was a crucial factor that led up to the death of their loved one and controlled the process that followed. This was set against the needs of the families, the victim and future victims:

> At the end of the day they're running a business and its money and that's what they see, no one is in business to not make money but they forget about the people that are making the money for them. It will continue to happen it doesn't matter what law comes out (3).

The majority of the families saw justice as the passing of a prison sentence to highlight guilt, "The length would have been irrelevant to me…I didn't want them accusing [my son] of doing it on his

own" (3). One family member drew comparisons to the maintenance of vehicles:

> You have to have an MOT on your vehicle, so have an MOT on the company, it's going to happen to families every single day of the week and it will continue to happen until the owners of the companies are made to realise the buck stops with them and they're the ones who are going to go to prison, not piddly fines, that's not going to do anything to millionaires. It doesn't because at the end of the day your employees are paying the price, "cut jobs, get rid of them" (3).

For another mother of a victim, a prison sentence was the only way justice could have been achieved because the company knew the risk they had subjected her son to, a risk which was taken to maximise profit. For her:

> It was blatantly obvious they knew what they were doing, they read the email. A 12 year old could understand the word 'danger, explosion', they put [the email] in a drawer and hid it. They knew that once they signed that hot cutting gear permit and sent [my son and his colleague] back in that chimney, they knew the possibility of an explosion.

The company involved were sub-contracted and won the tender to dismantle the chimney because they had the cheapest quote, cheaper by at least £22,000:

> They took a gamble – do we pay £30,000/£40,000 or do we carry on with the £8,000? Let's say there is a 50% chance there could be, 60% chance there could be, 70% chance there couldn't be, they would take that chance…Therefore they should have got a prison sentence (10).

The subject of money upset family members. Many had an extended family who assumed they had received a massive amount of compensation. The popularly held perception of a "compensation culture" referred to by Chris Grayling, the Justice Secretary in 2013 and refuted by Professor Lofstedt (Tombs, 2016) influenced extended family and friends who were suspicious the families had received a huge pay out and that money had been hidden somewhere (2). The majority of families received no compensation and more than one had to get into debt in order to pay for the funeral of their loved one.

When asked what they thought the biggest obstacles to justice, one mother of a victim was clear who had blocked justice in her son's and future cases:

> The Government. Are they going to bring in stronger laws? Accidents do happen at work, we know that, we are not saying every single person who has an injury or accident at work is through bogus employers, we are not saying that…we are saying are those, are not accidents that could have been prevented. We are up against the Government and big corporations (10).

It became apparent that in a number of cases families expressed the injustice fuelled them on to personally fight for the changes they wanted to see and that this had been helpful to them:

> I would have lost it completely, the only way I could have survived my bereavement was to hang onto the anger of the injustice of it all and start fighting to change attitudes, procedures and laws. It became an obsession (9).

Decisions were made to fight back and to do so to enact justice for the loved one who had been de-humanised by the court process. At the end of formal proceedings in the following case, the mother of one victim:

> I decided, they are not going to do that to my son, my son is something and I will do something in [his] name. We can't do anything for [my son], we can't bring him back. I exhausted all the avenues but, by telling what happened to [him]…then just maybe it will prevent other families going through what we've gone through (10).

Families recognised that their experiences were not isolated and that many others had gone through similar emotions and painfully, that many others would in the future. They acknowledged "the thousands of families who have gone through this, we are not the only ones (6).

The formal process had caused additional pain to the families. There were similarities in what changes they wanted to see. This can be summed up by the one family member who worked with other bereaved families as part of a group who campaigned for changes to be made. They called for the following:

> Full and fearless inquiries,
>
> Getting an apology,
>
> Learning the full truth of what happened,
>
> Being supported through the civil and criminal justice systems that ends with an appropriate resolution,

> Having it understood that commemoration and remembering are essential parts of the – lifelong – aftermath… Receiving adequate compensation (14).

Faced with the large gap between what justice was to the families and the reality of their experiences, some families joined with people who had been in similar positions. Up to that point, many had fought individually and had had no idea what they were facing until they were far into the process. By the time they gained knowledge that *might* have helped them fight, it was too late. By joining with others, they hoped this could be avoided for future victims and families. Their experiences will be examined in the next section starting with an overview of what motivated family members to create or join with others as part of a group.

A collective response

None of the interviewees had any intentions, prior to the experience of losing a loved one, of spending time, money and energy in joining a group, but some joined with other families and individuals who had found themselves in similar positions. They were spurred on by what had happened to them:

> [I was] so angry and hurt later…you had the people that were supposed to uphold the law, later break it….[fighting] was the only way I'd [have] survived because if I'd been at home I would have lost it completely. The only way I could have survived my bereavement was to hang onto the anger of the injustice of it all and start fighting to change attitudes, procedures and laws (9).

Many family members wanted to use what had happened to them for something positive, which was made easier when joined with

like-minded people. Two members of one of the groups, studied in this research, published a book on its history. In it Eyre and Dix (2015) argue that many relatives were:

> consumed by a mixture of grief and anger. These emotions are inescapable but quickly become destructive. The only remedy is to channel them into a constructive activity such as a support group (Eyre and Dix, 2015: 21).

Many of the families created or joined groups to right the injustice they had suffered as a result of corporate killing. This will be explored in more detail in the next sub section through an examination of four such groups; Families Against Corporate Killing (FACK), the Simon Jones Memorial Campaign (SJMC), the Centre for Corporate Accountability (CCA) and Disaster Action (DA). All of these groups supported and worked to alter the representation and treatment for the victims of safety crime. In the 1990s and early 2000s, they made up a significant part of the corporate accountability movement.

The motivation of the groups

The various groups family members and individuals went on to create or join reflected their desire for justice and what they identified as lacking in the social, legal and political landscape. All but one of the groups covered in this research began in the 1990s. This was at a time when politically, Labour had taken a lead on the issue of law and order and had been campaigning from a populist stance, claiming to be "bringing power back to the people" (Ryan, 1999:19) in "a heyday for victim policy" (Elias, 1993: viii). Within criminology in the 1980s and 1990s, critical victimology began focusing on social change and relieving human suffering (Elias, 1986) and the victims of safety crime were incorporated

into the study of victims generally (Mawby and Walklate, 1989). As discussed previously, the number of disasters in the 1980s and 1990s were all high profile and such shocking events caught the attention of the public (Blumer cited in Haines, 1999). This all contributed, bringing the victim and the plight of the victim to the fore.

22 years ago, Ann Elvin called for a national helpline for the victims of families of those killed at work and set up a national support group, although in her book she reflects, "We are so badly funded that we can barely run any more" (ibid: 97). Prior to the existence of the groups detailed below, there were many individuals and interest groups which crossed over and contributed to each other. For example, in the early 1990s, David Bergman helped Ann Elvin prepare a legal submission after her son was killed at work and was contacted by the Construction Safety Campaign (CSC). Her campaign was subsequently used and noted by the Simon Jones Memorial Campaign. There are many similarities between the groups, each will be examined in turn below.

Families Against Corporate Killing (FACK) were created through another campaigning group. A coordinator at the Greater Manchester Hazards Centre brought a number of families together who expressed similar sentiments. A founding member of FACK contacted Hazards due to a feeling of injustice:

> I felt this can't be right, there's no justice there at that trial…I thought I can't leave it here, I felt I had to do something (11).

Founding members were frustrated and shared a belief that they themselves and other families were bereaved because of unsafe and unhealthy workplaces and that nothing was changing to prevent this happening to families in the future.

The Simon Jones Memorial Campaign (SJMC) was slightly different from the other groups featured in this research as they focused on the single issue of Simon Jones' case as well as working generally on the inadequacy of the law. The Simon Jones Memorial Campaign comprised of a small group of around 60 people, situated across England. Created after campaigns such as the Construction Safety Campaign, Hazards and Disaster Action, it was focused on revealing the truth and challenging that "profits are more important than the safety of…workers" (Burrell, 2004).

Simon was born on September 1st in 1974. He lived in Brighton and was a regular visitor to the New Kensington pub, where Brighton's activist community gathered. His parents, Anne and Chris worked as teachers and lived in Banbury with his brother, Tim. Simon had written for SchNEWS, a Brighton based, free weekly newsletter that supports protests and causes which include the fight of the Dockers in Liverpool and opposition to the Newbury Bypass. Simon was an undergraduate of social anthropology at Sussex University and was taking a year out and time away from studying. Living without a regular source of income, he had been talking about writing a novel and had begun sketching out ideas before he signed up to an agency offering temporary, casual contracts (Brooks, 2012).

Personnel Selection is a 40 year old recruitment company. Advertising "It's what we do best" (quoted on Personnel Selection website, 2015). Personnel Selection create contracts, both

permanent and temporary in commercial, industrial and engineering and catering sectors. Simon signed up for work at the Brighton office and was subsequently sent to Shoreham docks to work on a temporary contract for £5 per hour at Euromin Limited.

On the 24th April 1998, Simon found himself working as a stevedore unloading a docked ship, moving up and down with the tide, under pressure to beat the tide alongside other casually employed staff. Low on staff and short on time, they picked two banksmen, neither of whom spoke English. Reliant upon non-universal hand signals to operate the crane to position the grab, it was Simon's job to load the cobbles into bags, which were then hooked onto the crane as quickly as possible to empty the ship and beat the tide. The crane operating in the hold had been modified by the director of Euromin, James Martell. In place of the safe lifting hook, which the excavator had been supplied with, hooks had instead been welded directly onto the grab forcing workers to operate within its jaws. The crane itself displayed a warning sign in the cab that prohibited anyone being in the area of the grab when it was in use (even prior to the dangerous alteration) but the director insisted workers operate with his modification. The crane operator was unable to see the operation when the grab closed on Simon, quickly causing his death, barely two hours after he had arrived at the docks.

The subsequent campaign was created in response to the lack of information provided to the family. At the funeral, friends of Simon's began to talk of 'doing something' in response. A friend who had worked with Simon at SchNEWS (a weekly direct action newsletter) had written to the family to ask if they would support a campaign, the details of which they were yet to work out because as Anne (Simon's mother) said "they were all in shock as well". The SJMC also responded to the lack of justice and committed the campaign to "direct action to ensure that politicians don't get away

with brushing his death…under the carpet[7]". (From here until page 240, extensive use is made of web-based materials. The URLs will be presented via footnotes rather than in the body of the text itself.)

The desire to highlight the lack of justice also featured in the creation of Disaster Action (DA). The Herald of Free Enterprise Association (HFA) was a group created by survivors and family members of those who had drown so when the liner sunk off the coast of Zeebrugge in 1987. Through that group, an invitation was sent to other similar disaster groups that had been created in the late 1980s and early 1990s. Those who received the invitation were invited to meet with a view to find out whether one group could better encompass and combine all of their aims (Eyre and Dix, 2015). At the first meeting, all of the groups who responded found they had a shared experience which echoed that seen in the individual cases detailed in the previous chapters. All the groups shared:

> a total lack of information from official sources, complicated problems in claiming compensation and a lack of legal guidelines for the establishment and management of disaster funds…all added pressure to an already intolerable situation. (Disaster Action Newsletter cited in Eyre and Dix, 2015: 11).

Pam Dix, founder member and executive director of DA, said in their early meetings members experienced, "outrage and distress…who despite the difference in the causes shared a common experience of a lack of redress" (14). As conveyed earlier, the groups brought together as part of DA had shared experiences where the families were given little information and

[7] http://simonjones.org.uk/campaign/index.htm

had been hurt further by the process. This was summed up following the decision to launch DA, in their first pamphlet:

> As an umbrella group for these grass roots organisations, we're well aware of the dreadful common thread running through these disasters.
>
> They weren't Acts of God.
>
> They needn't have happened.
>
> We don't want anyone else to go through what we've been through.
>
> (Disaster Action cited in Eyre and Dix, 2015: 32).

The CCA was different from DA, the SJMC and FACK as it was not started by bereaved families but on behalf of them. The founder, David Bergman was a prominent campaigner who had called for a change in the law from the 1980s. He researched and published work with the HFA and DA before creating the CCA in 1999 (Eyre and Dix, 2015). The CCA aimed to scrutinise official bodies and the existing weak laws.

The families became surer of the context and causes that led up to the death of their loved one once they joined with others. Injustice, anger, frustration and a desire to change were commonly mentioned throughout the interviews. The next sub section will detail the aims of each group.

The aims of the groups

In order to reduce the injustice of those involved in a safety crime, each group set out clear aims. These will be detailed, in turn, below.

FACK aimed to "halt complacency about deaths at work[8]" and compelled the government to create laws that held managers to account and ultimately deliver justice to those who committed crime. Their website stressed they were not about retribution or revenge, but law and order, justice, equity, accountability and deterrence focusing on those employers who had been negligent.

In addition, FACK aimed to stop workers and members of the public from being killed in preventable incidents, acting to direct bereaved families to legal help and emotional support. The families in FACK voiced their grievance that they were "robbed twice", firstly they had lost people they loved because of the failure of employers to obey health and safety law and secondly of the justice that should (but does not) come to help them[9].

FACK saw supporting families as crucial in preventing further injustices:

> [for those] families who have lost loved ones; they can come or ring if they need someone to talk to… There is nothing, absolutely nothing. There is nothing out there for families where people have been killed in the workplace (10).

> We want families to be treated with respect and dignity, they are victims, recognise families as victims (11).

[8] http://www.hazardscampaign.org.uk/fack/about/

[9] http://www.hazardscampaign.org.uk/fack/about/

As mentioned previously, the SJMC was unique in that it was created and focused on the case of one individual, Simon Jones. It aimed to:

> fight for the truth about Simon's death to be revealed and to challenge the profits-before-people set up that killed him[10].

It did not become involved in other cases, although it did focus on changing the law that affected other victims of safety crime.

DA described itself as a self-help organisation with a, "needs driven, user-led approach that is seen as an addition to self-support"[11]. The commonality between the founding members of DA was reflected in the principles that were outlined at the launch in 1991. Its aims were to:

> Encourage all organisations that have a duty of care for the safety of people (their customers and their employees) to accept that this responsibility resides with people at the top…to raise the level of debate on the subject of corporate responsibility…for [a] change in the law as it relates to corporate manslaughter (Maurice De Rohan quoted in Eyre and Dix, 2015: 13).

In 1991, DA set out its aims in their launch pamphlet. These aims were threefold:

[10] http://simonjones.org.uk/campaign/index.htm
[11] http://www.disasteraction.org.uk/guidance_for_responders

> Accountability…Attempts by the relatives to bring companies and individuals to court have been thwarted, we believe, because of defects in the criminal justice system. Disaster Action will be calling for a new legislative structure of corporate criminal offences and sanctions.
>
> Support…Providing support and guidance to individuals and groups touched by tragedy is another of our aims.
>
> Prevention…Disaster Action aims to break the cycle of tragedy and misery…We believe that these changes will encourage a new corporate culture (Disaster Action cited in Eyre and Dix, 2015: 39).

DA had a general desire to:

> raise awareness and understanding of what it feels like to be directly affected by disaster and the practical implications in terms of addressing people's needs (Eyre and Dix, 2015: 55).

David Bergman wanted to be more political than the aims of DA would allow, which was one of the reasons the CCA was created. The CCA aimed to support workers and the public by highlighting the inadequacy of law and legislation, changing law to prevent future victims, working with victims that were being created and ensuring the bodies tasked with responding to deaths and injuries fulfilled their roles appropriately. According to the website, the CCA was:

> concerned with the promotion of worker and public safety, focusing on the role of state bodies in enforcing health and safety law, investigating work-

> related deaths and injuries, and subjecting them to proper and appropriate prosecution scrutiny[12].

The aims of the groups detailed above shared many similarities. Tackling the injustice meant helping future victims in some way and affecting the officials tasked with responding to them. How the various groups achieved this is documented in the next sub section.

Methods of achieving justice

There were similarities and stark differences between the ways the campaign groups achieved their aims. Made up of people who had been through unique and distressing experiences, all of the groups wanted to support families who were new to the process, offering everything from legal advice to moral support. The methods used by each will be detailed below, starting with FACK.

As a national campaigning network FACK achieved their aims by remaining visible and through protesting. They were funded via donations including money provided from two legal firms and links with trade unions. Using its website, FACK tried to draw attention to their cause by regularly publishing press releases on deaths at work to highlight injustice and the inadequacy of the law. For example, a FACK member attended a British Safety Council meeting to speak about the organisation's campaign:

> I am determined that it shouldn't happen to anybody else. It is based on legislation…there was a man there who was in charge of all the HSE inspectors. I asked him, 'how many actual inspectors have you got?' You

[12] http://www.corporateaccountability.org.uk/about/main.htm

> can expect a visit from the HSE once in a lifetime. They still won't put the numbers up (6).

Making a link between workers and the loved ones they had lost, in 2013, FACK protested in Manchester to support workers who had been blacklisted, urging the HSE to defend the rights of workers who complained about employers. For example, many victims of safety crime had spoken to their families about how unsafe their workplaces were prior to their deaths. FACK stated on their website:

> We depend on those brave enough to stand up for our health and safety, what a disgrace we don't have a government or HSE that will do the same[13].

One FACK member actively worked to act for the interests of young people to encourage employers to obey the law, training and empowering young people to speak up if they were in danger. He appeared on TV, radio and in the press to raise awareness of the 'Speak Up' campaign to raise awareness of deaths at work using the NVQ Safety in the Workplace scheme[14]. Another FACK member wanted health and safety to be included in education at school so:

> that before these young kids go out to work, there should be some sort of teaching on health and safety and their rights (10).

To this end, the FACK member quoted above delivered speeches to training providers. She urged them to tell students about their

[13] http://www.hazards.org/blacklistblog/2009/11/20/bereaved-families-support-blacklist-protest/

[14] http://www.hazardscampaign.org.uk/fack/about/fackupdate08.pdf

rights and to emphasise it was their responsibility to keep themselves and their colleagues safe and to not be afraid to speak out:

> So by us at FACK, going around and making our speeches, we are trying to get that message across, work with us, let's make a difference together (10).

They continued to raise awareness in workshops they have run at the Hazard conferences and appeared on a BBC documentary and the radio, especially on Workers Memorial Day.

Similar to FACK, SJMC positioned itself as a direct campaigning group, which protested in visible ways between 1998 and 2002. Commenting on the first protest on September 1st 1998, five months after Simon's death and on his birthday, his mother Anne (AJ) observed:

> furious with the lack of apparent progress, [a number of Simon's friends] and all the rest of the crowd…they all went down and occupied Euromin [where Simon had been killed] (AJ).

Aided by access that a worker provided from inside Euromin, 30 protestors occupied Shoreham docks, raising banners that read "Simon Jones RIP" and "Casualisation Kills". Since they were aware that work had not been stopped on the day that Simon had been killed in April, they aimed to stop the work on his birthday and placed a wreath on the gates. Anne described Simon's friends in the campaigning group as "seasoned campaigners" and as a result, they contacted the media beforehand. Two days after shutting down Euromin in 1998, campaigners occupied the

Brighton office of Personnel Selection hanging banners from the windows that read "Murderers". Political leaflets were handed out that asked "why should agencies like this take half your wages when you're doing all the work?" Anne reflected:

> Things really took off after everybody occupied Euromin [and] Personnel Selection and gave them the treatment as well. After it had been on every news programme, by six o'clock it was leading the news, their protest. So people had seen it all over the south of England (AJ).

In 1999, protesters mobilised outside the House of Commons whilst other members simultaneously occupied the Department of Transport and Industry (DTI) in protest at its failure to regulate employment agencies. Leaflets were handed out until the workers were evacuated and the police arrived.

The SJMC was very clear that protesting was the best way to achieve their aims, given the limited options they had:

> As long as this government and its agencies refuse to take action against companies that profit from casualization at the expense of their workers' lives we will continue, where necessary, to break the law so that justice will prevail[15].

Unlike the SJMC, DA would not become involved in the campaigns of other groups, even those it arose from. As Pam Dix explained, "DA has been careful to preserve its original mission by becoming associated with specific campaigns…rarely" (14).

[15] http://www.schnews.org.uk/archive/news6282.htm

Previously, DA did not accept funding from the government. However in 2011 it accepted an invitation to apply for a grant provided by the Ministry of Justice's peer support fund. This allowed DA to refer victims in need of counselling to a trauma care unit (Eyre and Dix, 2015). They received funding in 2008 from the Department for Culture Media and Sport to research disaster funds (ibid.). Despite using government grants, they stated "Any future sources of funding for Disaster Action must enable the charity to maintain its independence from government or vested interest" (ibid.: 2015: 168). Pam Dix explains:

> The integrity of our position was crucial and could not be compromised. Power also came from our determination to stick by the original principles and not to seek or accept funding from any source that could potentially present a conflict of interest (14).

At the earliest points, DA worked on altering the criminal justice system. In 1991, they wrote a submission to the Royal Commission on Criminal Justice as well as to The Joseph Rowntree Charitable Trust (Eyre and Dix, 2015). In a submission to the Law Commission in 1994, they called for safety crimes to be treated differently by the criminal justice system. After the Law Commission issued a consultation paper on Involuntary Manslaughter in 1995, DA prepared a response, working with David Bergman. For this, they worked with other agencies, including the HSE and the Trades Union Congress (TUC) and subsequently one of the members was invited to speak at a Royal Society for the Prevention of Accidents (RoSPA) presentation (ibid.). DA continued to push for a draft bill on Involuntary Homicide to go before parliament in the following years.

In 1997 and 1998 DA conducted a survey of the top FTSE 100 companies to investigate how many mentioned health and safety

in their annual reports[16]. After a change in government in 1997, DA decided to publish a book on the need for corporate accountability in order to renew interest in the Corporate Manslaughter bill (ibid.). DA published *The Case for Corporate Responsibility: Corporate Violence and the Criminal Justice System* in 2000. Written by David Bergman, it argued that the laws on involuntary manslaughter should be reformed to encourage corporate responsibility. It formed part of a submission to Lord Justice Clarke's Public Inquiry into the identification of Victims following Major Transport Accidents (Eyre and Dix, 2015).

DA has focused its efforts on other official agencies that its members have come into contact with such as the coronial system. Desperate for information, loved ones found "key questions were being blocked" and instead they became "caught up in the personal, political and legal aftermath of disaster" (ibid.: 81).

DA continued to try to influence the coronial system when its members participated in a campaign to retain the role of the Chief Coroner culminating in a charter published in 2012. This involved meetings and work with other charities including the Royal British Legion and members of the House of Commons and House of Lords. On the need for inquiries, DA took part in a consultation that resulted in the House of Lords Select Committee reviewing the Inquiries Act 2005, sharing the experiences of the members of DA (ibid.).

To continue to contribute positively to the future experiences of those affected by disaster, DA made submissions to inquiries such as the Identification of Victims following Major Transport Accidents (2001).

[16] http://www.disasteraction.org.uk/publications/

Unlike DA, the CCA did work with other groups such as the SJMC, for example in 2002 the centre joined the SJMC in a campaign that attracted a 100 strong rally through Brighton (called 'Life Before Profit – Stopping the Corporate Killers'). The rally united a range of campaigners, Simon's family, the London Hazards Centre, and the CCA and representatives of the networks that had been created[17]. By that time, Anne Jones was a board member of the CCA.

In a similar vein to DA, the CCA advocated and campaigned for policy changes on behalf of those killed, injured and suffering from an illness as a result of work. According to a case worker this involved:

> writing to agencies asking for them to change or clarify their practice in dealing with bereaved families or writing responses to government consultation papers about potential changes in the law, or meeting with policymakers to press for change (15).

On a day to day basis, the centre utilised the media, "…through writing articles, carrying out interviews and updating the website" (15). David Bergman regularly wrote articles for the national press. The articles used the ongoing research the centre was carrying out to highlight the inadequacy of the current law, to call for a new corporate manslaughter law and to hold the HSE to account.

As the main agency designated with responding to work-related deaths, the CCA was in contact with the HSE and regularly wrote about the regulatory agency in press releases. The CCA closely

[17] http://simonjones.org.uk/campaign/index.htm

monitored the HSE – its day to day activities, press releases and the decisions the government made that affected the body; decisions such as funding and the number of inspectors in the field. The CCA sought explanations when the HSE dropped cases the centre was involved with, and publicised any documents relevant to the reform of the corporate killing law. They encouraged members of the public to use the HSE and informed them of what to expect and how to complain effectively.

The following are examples of how the CCA monitored the HSE's daily activities; in 2000 the centre highlighted the low numbers of inspectors across England, Wales and Scotland, region by region, and contrasted this with how it was impossible for the agency to fulfil their responsibilities[18]. In 2002, a press release highlighted a fall in workplace inspections and what the consequence of this was as a percentage of deaths, major injuries and industrial diseases that were not being investigated[19]. In 2003, the CCA published ten years' worth of complaints made about the HSE and concluded with advice on how members of the public could complain about the HSE as well as other government agencies[20]. Any new information relevant to workers and members of the public that was given to HSE inspectors was publicised and scrutinised by legal experts[21].

The centre continually used the HSE's own written policy to contrast this with their actions. The CCA made it known whenever the HSE attempted to reduce the investigations into workplace major injuries and contacted them for clarification on why and how this related to their aims[22]. In 2008, the centre criticised the

[18] http://www.corporateaccountability.org.uk/press_releases/2001/27Feb.htm
[19] http://www.corporateaccountability.org.uk/press_releases/14Oct02.htm
[20] http://www.corporateaccountability.org.uk/press_releases/2003/13jan.htm
[21] http://www.corporateaccountability.org.uk/press_releases/2003/Aug18.htm accessed 29/7/15
[22] http://www.corporateaccountability.org.uk/press_releases/2003/11Aug.htm

HSE for failing to fulfil its obligations[23]. In one case in 2004 the CCA made public a report the HSE wrote about the inadequate health and safety practices of the Scottish Ambulance Service (SAS). When the HSE refused to recommend the Ambulance Service be prosecuted, the centre took it directly to the Crown Office in Scotland. Two years later, when they refused to prosecute, the CCA made a statement:

> The decision by SAS to make improvements in health and safety following the report are very welcome, but decisions by public bodies to comply with the law that they should have been complying with in the first place should not displace the need for criminal accountability when serious failures have been identified[24].

They made regular freedom of information requests to interrogate the reasoning behind the decisions the HSE made, which enabled the centre to access internal audits and statements issued to staff by the Chief Executive[25]. In May 2004, they drew attention to the fact the HSE had stopped investigating all accidents involving the public that were possibly caused by unsafe working practices of local authorities, hospitals, prisons and the police, which meant they were failing in their statutory obligation (Maguire, 2004).

Debates were as public as possible. In February 2000, David Bergman replied to Jenny Bacon, the then director general of the HSE to argue against points she had made about their evidence based prosecution policy. Bergman used statistics about the number of companies that had escaped prosecution because the HSE could not afford to investigate:

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[23] http://www.corporateaccountability.org.uk/press_releases/2008/apr17hsepress.htm
[24] http://www.corporateaccountability.org.uk/press_releases/2007/jan22scotambulance.htm
[25] http://www.corporateaccountability.org.uk/press_releases/2005/feb7public.htm; http://www.corporateaccountability.org.uk/press_releases/2007/apr25hseaudit.htm; http://www.theguardian.com/politics/2003/mar/04/freedomofinformation.immigrationpolicy

> The HSE's "published prosecution policy" is simply a joke…corporations that kill or injure are immune from criminal justice simply because the government is not willing to fund criminal investigations and prosecutions (Bergman quoted in the Guardian, 2000).

The CCA's relationship with the HSE was not always a critical one; when a HSE report concluded a new corporate killing offence would "improve safety and increase accountability", the CCA publicised the report[26]. Reports written by the CCA were timed to coincide with national debates and conferences. They questioned the moves the government and the Health and Safety Commission (HSC) made in relation to policy that would have affected the safety and health of members of the public and workers. A report *Making Companies Safe: What Works?* authored by Dr Courtney Davis, (then deputy director of CCA) drew upon international research to call for an increase in inspection and enforcement rather than the move to voluntary guidance and compliance[27].

The CCA was at the forefront of this assistance, offering emotional support as well as being instrumental in pushing cases through the criminal justice system. It provided free, independent and confidential legal advice and assistance to families bereaved as a result of a work-related death. The assistance offered was "detailed and comprehensive" and could take "several years" such was the nature of the criminal justice response to a death at work[28]. Cases which had closed could come into the CCA's remit for a short period of time but those families who contacted the CCA soon after the death of a loved one could be pursuing the case for years. A former caseworker reflected that as part of the CCA:

[26] http://www.corporateaccountability.org.uk/press_releases/2003/19Feb.htm
[27] http://www.corporateaccountability.org.uk/press_releases/2004/sep12report.htm
[28] http://www.corporateaccountability.org.uk/about/main.htm

> We were part of a community of justice organisations and individuals working together to assist bereaved people. We tried to live the idea of remembering the dead and fighting for the living (15).

In order to fight for the living, the centre scrutinised the actions of the public bodies. At the time of the launch of the advice service for families, David Bergman stated:

> Families want to know that the Police, the Health and Safety Executive, the Crown Prosecution Service and Coroners are fulfilling their investigative and prosecution responsibilities. The Centre will advise families on what these are and how they can ensure that these organisations act in an appropriate manner[29].

Accordingly, the centre offered advice on the roles of the relevant agencies that investigated work-related deaths and determined whether or not criminal offences had been committed. Working with the law as it stood, the case workers at the CCA worked through individual cases, interrogating the health and safety laws and the offence of manslaughter to see if it could be applied. Crucially, this included ensuring any investigation was adequate. The caseworkers at the CCA diligently followed the cases to the end, for example, they regularly questioned the HSE for explanations when cases failed to reach court. For the years that they were open, the CCA became an invaluable source of knowledge and support to many families via this casework.

Each of the groups chose different methods to achieve their aims. FACK protested, sought to raise public awareness, worked with unions and supported family members. SJMC was unique in that they actively campaigned for justice as Simon's case was ongoing.

[29] http://www.corporateaccountability.org.uk/press_releases/2001/5Sep.htm

DA chose similar methods to FACK, for example, supporting family members and raising awareness but clearly stopping at protesting and sought to maintain political neutrality. The CCA were, as David Bergman intended, more combative than DA, working with other campaign groups and directly holding state bodies to account.

The groups had varying aims, which all worked in the same direction, to change the law, to affect the current law and support family members. The following sub section will examine how the groups reduce the de-humanisation they themselves had experienced and for other families affected by later safety crime.

The effects of creating or joining groups

In addition to raising funds and identifying crucial contacts, families identified the comfort they drew from being around people who had very similar experiences to themselves. As detailed in Chapter Three and earlier in this chapter, families had to deal with sudden bereavement, (often of their children), whilst also negotiating a de-humanising legal process. In addition to this isolation, many friends from traditional social networks found their grief and experience hard to understand. Subsequently, many families found they were simply avoided, for example, one family felt that after losing their son their world had become smaller and it was "just the three of us" (1). No explanations were needed when in the company of other families.

Members of FACK highlighted the fact that the:

> people in FACK are the only ones who know what it feels like to lose somebody under these sort of

> circumstances so we have a common bond, if you like (6).

> the members help each other. If you can talk, they understand because it has happened to them whereas with other people, it is 'get over it'…you can't just get over it whereas, within the group, we all understand that as we have all lost loved ones (10).

In the case of the SJMC, whose aim was to fight specifically for Simon, the highly visible nature of the campaign put Simon's mother in contact with a wider network of people:

> without the profile of the campaign, I wouldn't have got people to listen to me, because they kept it in the public eye, Channel 4 took it up…in 1999 or 2000 (AJ).

Anne began to receive emails informing her as to how she should proceed to find out the answers that had initially mobilised the campaign:

> [Members of the campaign] were forwarding letters and emails to me that they had printed off. All of them were saying the same thing, 'tell her to contact Louise Christian' (AJ).

Louise Christian had worked on a number of high profile cases, starting with the Marchioness case and including the Paddington Rail Crash and Southall Rail Crash, which made her well placed to be taking a safety crime case to court. As a solicitor, money should still have been a barrier but this was circumvented as she offered to work for free. Louise Christian advised they start raising money

in case they lost the judicial review but she advised Anne to find money to pay the expenses of the barristers. Anne turned to the campaign group and their work to raise funds. In response, the campaign group organised a night at Brighton Town Hall:

> [One campaign member] has a habit of knowing people and he bumped into someone at a party. I had 'phoned him and said we desperately need to do some fundraising. He said, "oh, we could do a comedy evening". He got in touch with Mark Thomas and Mark said Jo Brand will come as well so we had the three of them. That evening raised £10,000…the money was in case it [the ruling] went against us (AJ).

Anne reflected on how the members of the group affected her, "I was getting emotional support, emotional as well as physical support from them" (AJ).

The group achieved the seemingly impossible when, (as detailed in the previous chapter), the CPS was forced to reconsider the decision not to prosecute. The case reached the Crown Court but once the defendant, Martell, was cleared of criminal charges, it could take the case no further. The group continued to protest against the decision until ten years after Simon's death.

As a member of DA, Pam Dix noted that the experiences the families went through were unique and led to unique relationships:

> The mutually respectful, trusting relationships with members of DA will last my lifetime; some of them are people with whom I can discuss the most difficult and darkest things without fear of being judged, diminished or dismissed…I have gained hugely from

> knowing that we have been able to make a difference. As an organisation that is usually under the radar, DA (and I) have to take satisfaction in knowing that we were there, that without us the experiences of others would have been worse, in catastrophic situations that are beyond the imagination of most people…reaching towards being humble enough to learn from and listen to the experience of others and incorporating that learning into our work (14).

This unique experience made the friendships many made stronger and members were motivated to fight for change together.

As detailed previously, the CCA was not created by families who had been affected by a safety crime, although many did become involved, for example, they joined the board. Nevertheless, the experience affected the staff members:

> I still feel it was a privilege for me to work with bereaved families at a very difficult time in their lives. I remain inspired by the strength and dignity I observed. I hope that I, alongside my colleagues, helped make things less lonely and intimidating for families, but I don't know for sure that that is so (15).

As illustrated above, being a member of a group had unintended positive effects for some of those involved. In the legal process, the families were silenced and treated poorly, they were isolated voices in the court that called for their loved ones to be treated justly. Through contact with other families, they found the support and understanding that was absent when they were individuals, facing the companies.

A common aim of the various groups was that all of them wanted to and felt they were well placed to aid the future victims they knew would be created. As identified and discussed in Chapter Three, by the end of the legal process, the families were experienced in the nature of safety crimes. Many reflected that they wished they would have known more and done things differently. Some felt guilt that they had not done enough to represent their loved one and had allowed the system to silence them. This caused long-term pain. The following sub section will explore the ways the groups countered the suppression they had experienced.

The successes of the groups

Whilst the process had ended for the majority of the families, they recognised they were in a position to be another family's expert in the future and by offering advice, they could alter the outcome for another family. Or, at the very least, they could reduce the subsequent guilt they themselves had experienced by raising awareness of what the families should expect from the criminal justice system and the HSE. The ways each group supported and advised families will each be discussed in turn.

Firstly, FACK defended the rights of families, for example, after an explosion killed nine in 2004, they fought for the families to see Public Inquiry report before any conclusions were drawn. They also stated via their website that to treat the incident as a 'tragic accident' would be:

> a gross misspending of public funds, and a tragic wasted opportunity to contribute to a major improvement in workplace health and safety[30].

Families were helped directly, for example, after the death of Christopher Knoop, in 2008, FACK held a vigil and supported Christopher's sister outside the court. In this case, North West Aerosols Ltd were fined £2 each for two safety offences and £1 towards costs because the company was not making a profit and had been put into liquidation after Christopher's death[31]. The directors were not charged and following the verdict FACK used their website to comment:

> We feel that if Directors had positive legal duties for the H&S, then the individual Directors of this company could have been held to account in court[32].

Secondly, as a single issue group, the SJMC did not help victims of safety crime directly in ways similar to DA or the CCA but left a legacy that other groups, such as FACK have found useful. The website remains active and spells out to the families and friends of victims what they should do:

> 1 DON'T CALL IT AN ACCIDENT
>
> 2 GET A GOOD LAWYER
>
> 3 KICK ASS
>
> 4 FIND ANY WITNESSES
>
> 5 CONTACT THE MEDIA

[30] http://www.hazardscampaign.org.uk/fack/news/iclreport.htm
[31] http://www.hazardscampaign.org.uk/fack/news/nwaerosols.htm
[32] http://www.hazardscampaign.org.uk/fack/news/nwaerosols.htm

6 SEE YOUR MP

7 THEN KICK ASS (PART 2)

8 CONTACT THE CENTRE FOR CORPORATE ACCOUNTABILITY[33].

Thirdly, DA worked in different ways to help the families that contacted them. It offered emotional support and was a contact many found valuable in terms of being aware of their rights and procedures.

DA provided an independent advocacy and advisory service that aimed to represent the interests of those affected by disasters. Pam Dix explained their focus was based on general principles and that they saw it as important to, "…give guidance, rather than advice, both to survivors and the bereaved as well as to the responding agencies (14)" This included offering views and sharing the experiences of members on police family liaison, identification, recovery, the viewing and release of bodies, the inquest process, death certification, compensation and obtaining disaster funding. It provided emotional support for survivors and the bereaved and guidance on creating support networks and survivor groups. The activities of DA since 1991 worked towards providing, "…non-judgemental, practical advice based on our personal experience remains at the core of what we do." (Disaster Action cited in Eyre and Dix, 2015:114).

DA won various awards after 1991. It won the Society Guardian Charity Award in 2004 and the Nationwide Awards for Voluntary Endeavour in the adult category in 2005. Maurice de Rohan was named the Most Influential Executive in the Business Travel Industry in 2008. This was in recognition for his work that led to

[33] http://simonjones.org.uk/articles/killedatwork.htm

the Corporate Manslaughter and Corporate Homicide Act. It was given posthumously (Dix, 2006).

Fourthly, the CCA helped numerous families with their casework, which showed itself to be a popular and effective service to bereaved families. It was much larger than had been anticipated, at any one time there were 50 cases being processed by the CCA. In 2007, there were 270 cases on the books, 150 of which were on-going.

The caseworkers and support from the CCA appeared vital to some of the bereaved families, one person widowed when her husband died at work said, "What would we have done without the CCA?" (2). In feedback to the Centre, a family member involved with the caseworkers reflected:

> You made me feel so much stronger and able to go on fighting for justice.

> he [the caseworker] was always ringing us or writing us or 'do you need any more help?' And afterwards he was really nice, he hoped we were ok[34].

In addition to the emotional support offered to the families, the CCA was crucial in pushing the cases forward, increasing the effectiveness of the bodies tasked with dealing with their cases. One caseworker said:

[34] Available: http://www.corporateaccountability.org.uk/advice.htm

> We helped a lot of individuals have a more satisfactory involvement in the legal processes following their relative's death. We helped make agencies think about the needs of bereaved people when doing their work (13).

Family members whose cases were helped along by caseworkers said:

> they must be more powerful than they think because it started off a wee ripple, I then got a letter from health and safety with a name (6).

Part of the skills they offered families were how to obtain knowledge about where to go, who to ask and the right questions to ask:

> I would advise them [bereaved families] to talk [to CCA] because that's the only place there is to go, to talk to them first…because you don't know the questions you're meant to ask at the beginning (2).

This was instructive in increasing the effectiveness of the cases, the earlier the caseworkers were involved, the more impact they could have. Some family members were more equipped than others but even those who accessed the relevant information were supported by the CCA:

> That's why we were so grateful to the CCA because all of a sudden there was a light at the end of the tunnel, someone was going to help us, somebody was going to guide us through it to help us with the inquest…If it hadn't been for him or the CCA we

> wouldn't have known what to do because there was nobody else would tell us what to do (1).

The emotional support the presence of the CCA provided was noted as important at the stages where the family members found they were being met with dead ends:

> I think that first phone call with Maninder I just cried…I didn't know anything; Maninder just probably saved my mental health…just listening…just letting me [talk]…I was being 'Mrs. Keep everybody together', so to have an opportunity where I wasn't 'Mrs Keep it altogether', Maninder wrote letters and there was a list of questions (6).

At the very least, the CCA offered moral support and showed relatives the path they could take:

> I think I did it for myself in the beginning; it's just their moral support when you're faced with the police and come up with some more questions from a different angle you hadn't thought out. It carries a bit of weight, in a way, that you've got other people backing you up (4).

The CCA had the knowledge to inform families of procedures such as when the cases were going to 'expire', which would have made any further progress impossible:

> Maninder turned around and said because of the time limit thing you…should see a solicitor because that was stuff they couldn't do from their side so we found a couple of solicitors…(2).

As a testament to the difficult work they were carrying out, the caseworkers stayed for a long time with the centre, even at the end of its operations when hours were cut in an attempt to prolong its activities, a board member reflected, "it was incredible that so many people stayed so long, as far as they could" (13). When the centre closed, the casework ended and in its place, the website offered archived information on the obligations of each public body from the police to the Maritime and Coastguard Agency with a copy of an advice leaflet[35].

Families were helped by agencies such as the CCA and many were concerned about the consequences of its closure:

> you can't let that go, you've got to keep going. It's so frustrating, governments should be funding these organisations to help, because it's the likes of us that need the help, the companies will just get the best of the best to work for them but we can't afford a barrister, that's what pees me off. If we were millionaires… (3).

Each of the groups documented in this chapter helped families who were bereaved and going through experiences they had already been through or had knowledge of. In this way, they all minimised the isolation and subsequent guilt of the victims that came after them. Some groups did more than that, impacting on the cases and increasing the likelihood of justice. The following subsection will explore the political successes the groups had in terms of altering official processes that otherwise suppressed the victims and the families.

[35] http://www.corporateaccountability.org.uk/press_releases/2005/feb24director.htm

Changing the law

Chapter Three identified and explored how the victims and the families of victims were suppressed. This suppression attempted to construct the victims not as victims of crime, but as victims of misfortune. As victims of an accident they were portrayed as risky individuals who were doing something they should not have been doing. The ways in which the cases were suppressed was enabled by decisions made by the government and enacted by the law. Consequently, all of the groups were concerned with changing the way future victims were treated via the law. They sought to change it by firstly being aware of the way it was operating and secondly by engaging with the government and pushing for political change. From one group to another, this was achieved in different ways.

The state was recognised as one of the main obstacles to FACK's success and they consistently sought to apply pressure to enact change. They wanted to keep fighting for tougher laws and stricter enforcement of those laws as well as higher fines and more appropriate penalties for guilty employers. In addition, they fought for more funding for the HSE so it could deter and inspect employers *before* the deaths of workers: "Join us and help us make work safer and save lives, better safe than a broken heart"[36]. FACK sought a review of the way work-related deaths were investigated and the way families were treated. They urged people to have more rights at work (for example, safety representation) so they could protect themselves against unacceptable risks to their lives and health[37].

[36] http://www.hazardscampaign.org.uk/fack/news/lindawhelanstatement.htm
[37] https://www.tuc.org.uk/workplace-issues/health-and-safety/risks-newsletter/risks-2006/risks-265-15-july-2006#tuc-12121-9

FACK lobbied for changes to be made to the Corporate Manslaughter and the Corporate Homicide Bill 2010 and have expressed disappointment that it fell short of what is needed[38]. They wrote to ministers and called for public inquiries and encouraged anyone to lobby MPs and councillors to support health and safety at work. FACK responded to consultations, for example, "The Draft Charter for Bereaved People from the Ministry of Justice and Directors' Duties at the Department for Work and Pensions (DWP).

FACK wanted positive legal responsibilities to be introduced in the place of voluntary guidance, which they viewed as unenforceable. When legal duties were breached such as gross negligence, FACK sought custodial sentences for directors. They stated in a campaigning leaflet:

> We don't want to see lots of employers in jail because that would mean lots of dead workers. We want the sanction of imprisonment because this is the highest punishment society metes out to wrongdoers, and it is clear that current law and enforcement, and voluntary duties on directors are not a credible deterrent to stop workplace deaths[39].

A member of FACK stated the necessity of prison sentences for the guilty:

> We are campaigning for more prison sentences, definitely, it is the only way, if you know you may go to prison for something, you will say, hang on, I don't want to be in prison (11).

[38] http://www.hazardscampaign.org.uk/fack/about/fackleaflet10.pdf
[39] http://www.hazardscampaign.org.uk/fack/about/fackleaflet10.pdf

Ultimately, FACK wanted the government to listen and as one member hoped:

> that regulations will be changed and we will become stronger. If you take a life or put somebody's life at risk and that person dies, you should be treated within the law, like anybody else who takes a life (10).

In 2008, FACK met with Lord McKenzie at the DWP in a call for juries to be involved in all work-related inquests in England and Wales. In the same year, they responded to consultations, such as the Draft Charter for bereaved people from the Ministry of Justice[40]. As an example of success, one member stated, "We wanted Workers' Memorial Day to be a National Day and to be recognised and we have got that" (10).

As part of the SJMC, Anne Jones worked on the law as it developed. Whilst representing SJMC, Anne met with government members and was called to a Select Committee on what was to become the Corporate Manslaughter law after initially responding to the original proposal by the Law Commission. The SJMC responded critically to the draft bill for reform in 2005 and also consulted the following year with the Macrory Penalties Review Team. Anne continually wrote to MPs and the Prime Minister with the help of the campaign:

> Their energy kept things going. If it hadn't been for their energy, I wouldn't have started writing letters even to my local MP let alone Tony Blair and Gordon Brown (AJ).

[40] http://www.hazardscampaign.org.uk/fack/about/fackupdate08.pdf

During its operation, the SJMC contacted Michael Meacher, which led to him expressing support publicly in 1998, when as a result of the campaign, he admitted on BBC radio that the government's plans for protecting people at work were 'not enough' (Brooks, 2002). Other visible and influential public figures also took the campaign further into the public domain such as George Galloway who referred to the group in the House of Commons to highlight the human cost of casualization, comparing the campaign to the Stephen Lawrence Campaign:

> The Simon Jones Campaign hopes to be equally successful in ensuring that the truth about casualization – that it is killing people for profits – is widely understood[41].

At the formal end of the campaign, the group reflected upon its success:

> We would like to restate what this campaign has been all about – ensuring that the circumstances surrounding Simon's death were put in front of a jury and that the truth about casualization was exposed. We have achieved this…The Crown Prosecution Service have put obstacles and obstructions in the path of this prosecution at every turn. The Health and Safety Executive have consistently shown themselves to be either unwilling or unable to take the necessary action against employers to ensure the safety of workers[42].

The group was highly successful at exercising the law as it stood. Without their involvement, the case would have disappeared. With their involvement, the company involved in Simon's death went to

[41] http://www.publications.parliament.uk/pa/cm199899/cmhansrd/vo990303/debtext/90303-14.htm#90303-14_spnew2
[42] http://simonjones.org.uk/trial/sjmcstatement.htm

court and received a Health and Safety fine and a ‘not guilty’ verdict that was difficult to understand. They revealed the truth about the circumstances of Simon’s death and fought for the case to go as far as they could possibly push it. Aware they were unable to prevent anything similar happening to another family in the future, they purposefully left advice online to help families who found themselves in a similar position.

DA focused on changing the opinions of the official agencies who responded to corporate crime. For example, members of DA began giving speeches to senior police officers soon after its launch. This included advice on how to be more caring and compassionate following a disaster. This drew on the experiences of members who spoke to police officers about how their contact with official agencies had led to further suffering (Eyre and Dix, 2015). In 1992, Iain Philpott was invited by a Chief Inspector in the Metropolitan Police, Moya Heath-Wood whilst she was developing the Management of Disasters and Civil Emergencies course (MODACE). Moya Heath-Wood later left the Metropolitan Police and moved to work with the Red Cross. This led to DA contributing to the British Red Cross European Union project in supporting individuals in disasters in 2006 (ibid.). Work continued with the British Red Cross in 2009 as DA contributed to the Informed Prepared Together project where they set out guidelines for “the human aspects of disasters” (ibid.:145). The Informed Prepared Together project was based in Europe and was the start of DA working outside of the UK. Pam Dix participated at a workshop in Geneva, which was followed by further seminars at The Hague and in Milan (ibid.).

DA specifically dealt more with the emotional after effects, notably experiences with Post Traumatic Stress Disorder (PTSD). With direct experience themselves, members of DA aimed to highlight that their response (campaigning and speaking out) were

not atypical of those dealing with trauma and sudden bereavement. DA counter stereotypes held that the bereaved are vulnerable and unhinged because in the past, members had been targets of unwanted psychiatric intervention. The prevention of future mental disorders became an important part of the work of DA. In acknowledging the "ripple effects of secondary traumatisation [caused by] the very systems set up to respond to disaster", DA aimed to reassure individuals their reactions were acceptable, in some cases, usual and to inform them that the impact could be felt for many years after the initial disaster (ibid.: 73). This was achieved via the sharing of experiences of its members, for example, a leaflet was produced to:

> inform and help those who might go through similar reactions…to help friends and family members to understand the feelings of those close to them with personal experience of disaster (ibid.: 71).

Members of DA worked with the National Institute for Health and Care Excellence (NICE), provided personal testimonies regarding the experiences of those experiencing PTSD and were invited to speak to those training as mental health practitioners, counsellors and psychotherapists (ibid.). Following the London bombings in 2005, Pam Dix sat on an advisory group that led to the first programme ever to screen those affected by disaster and treat those in need (ibid.).

Other organisations began to invite DA to share their knowledge in "humanising policies and procedures" (ibid.: 46). The activity of presenting the experiences of the members to people who were likely to be involved in emergency responses was part of DA's aim not to be frontline professionals but to positively influence those who were. DA remained in contact with the police and following the 2004 tsunami, a Chief Inspector from the

Metropolitan Police contacted Pam Dix to ask if the organisation would provide advice on matters such as the repatriation of survivors and bodies and communication with families and survivors (ibid.). They continued to offer bespoke courses on the human aspects of disaster.

DA applied pressure to the government to waive the seven-year rule to allow interim death certificates to be issued for those missing and presumed dead following the 2004 tsunami (ibid.). Following the London bombings in 2005, DA persuaded the then Secretary of State to create a centre (Family Assistance Centre) for those affected. Two members gave oral evidence to the House of Commons Work and Pensions Select Committee on DA's thoughts on the 2005 draft of the bill and some of their amendments were included in the final bill.

Between 2006 and 2013, DA attempted to address the shortcomings of the coronial system and participated in consultations on the Draft Charter for the Bereaved in Contact with the Coroners' Service, and Coroners and Justice Act 2009 (ibid.). As part of a Ministry of Justice consultation with stakeholders, DA worked with other groups and made submissions which included the recommendation that, "All coroners must be trained to see the bereaved not as a nuisance but as the people who have most at stake in the legal process" (ibid.: 89).

There were many changes to DA during the time it was operational. Pam Dix sums up that the changes were related to "societal expectations" and "figures of authority (14)" She explains the DA found that in the 1980s there was a:

> largely paternalistic approach that basically said ‘we know what is good for you’” and over the last decade and generation, this has started to change…There is a shift towards accepting that the ‘victim’ (a word we dislike and feel should really be used for those killed in a disaster) has legal and moral rights (14).

DA continued to follow whether guidelines they had a role in producing were working effectively. For example, in the case of the design of mortuaries, DA fought for the families to be central but reflected this has been seen as less important in recent years and compromised for cost reasons (Eyre and Dix, 2015). As Pam Dix and Anne Eyre stress:

> Complacent statements such as ‘Society has changed, it could not happen again’ are not good enough: work must be done to *ensure* that this is the case – and remains so for the future. (ibid.: 173, emphasis in original).

Dix counts its successes as:

> the passing of the Corporate Manslaughter and Corporate Homicide Act
>
> Getting the authorities to recognise that identifying and addressing the needs of individuals affected by disaster should be at the heart of emergency planning and response
>
> The special relationships and mutual support developed through our experience of great adversity
>
> Creating a real, and lasting, corporate memory of 29 disasters that would otherwise be missing
>
> More broadly, recognition of the fact that it is beneficial for people to band together if they wish to, and to make their own, informed, choices about how

> they are involved in the aftermath of a disaster that has affected them (14).

The CCA also called for the reform of the law, it is significant that the life of the centre spanned the proposals and implementation of the Corporate Manslaughter and Corporate Homicide Act (2007). In 1997, the government announced their intention to reform the law on corporate manslaughter following years of campaigning by various interest groups. At the time of the creation of the CCA in 1999, the government continued to promise a consultation on the law but progress had stalled. Subsequently the centre spent time continuing to lobby for reform of the law and was committed to the creation of an adequate law.

For ten years the CCA kept up to date with all developments, using their website, conferences, press and maintaining contact with public bodies and the government. In 2000 the centre commented on 'leaks' for example when the government recommended the HSE would be given authority to prosecute companies rather than the Crown Prosecution Service (CPS)[43]. This leaked proposal materialised and the centre wrote to John Prescott days later to underline the reasons why this was concerning[44]. The centre also opposed the provision that the offence was not intended to protect workers and members of the public abroad from companies based in Britain. The CCA reviewed the election manifesto in relation to corporate accountability prior to the election in 2001[45].

In December 2001, David Bergman wrote in the Guardian about the case of Simon Jones and contrasted the number of deaths that

[43] http://www.corporateaccountability.org.uk/press_releases/2000/14Apr.htm
[44] http://www.corporateaccountability.org.uk/press_releases/2000/14Apr.htm
[45] http://www.corporateaccountability.org.uk/press_releases/2001/17May.htm

had occurred since the government had delayed on promises of a corporate manslaughter law:

> The government agreed four years ago to reform this archaic law and allow a company to be convicted via senior managers…During those four years, over 1,500 people have died in work-related deaths: the executive has estimated that if the new offence had been in existence at the time of Simon's death, perhaps 40% of these deaths could have resulted in prosecutions of companies (Bergman quoted in the Guardian, 2001).

In 2002, the CCA publicised that the Home Office had written to private companies to seek their opinions on the potential effects of reform of the law. They examined the letter for any sign of implementation of the law and expressed further concerns:

> It is being suggested that in the new offence the company's failures will be measured against "industry standards" even if the industry standards are inadequate[46].

The CCA also expressed concern that crown bodies would continue to be immune from prosecution, an issue that would persist and cause disagreement amongst the campaigning network that had been created. The proposal to provide immunity to crown bodies would not affect many of the bereaved people the CCA dealt with. However, the centre was clear they did not support crown immunity and aligned with other groups for whom the move would affect, such as INQUEST. The CCA pooled its resources and sought legal advice, which they sent to the Home Office. It concluded:

[46] http://www.corporateaccountability.org.uk/press_releases/01Oct02.htm

> Any reform to the law of manslaughter must apply to all employing organisations – including Crown Bodies, and not just companies – in order for the Government to avoid being in violation of its human rights obligations according to human rights lawyers at Matrix.

> the CCA has produced a briefing indicating that there should not be any practical difficulties in prosecuting unincorporated bodies, and indeed the law contains provisions for such prosecutions at present[47].

The CCA and David Bergman consistently featured in the press in response to the action and inaction of the HSE and the corporate manslaughter law. They watched the Queen's Speeches for signs of reform of the law and examined speeches made by the Prime Minister and ministers around criminal justice. In October 2003, David Bergman wrote to the Guardian with DA's Pam Dix to highlight the lack of a corporate manslaughter offence. He contrasted the lack of laws with a statement of David Blunkett where he stated it was a miscarriage of justice when a guilty person escapes justice. Together, Bergman and Dix called for the then Home Secretary to announce a forthcoming bill in the upcoming Queen's Speech (Guardian, 2002). Since proposals for a new law did not materialise in the Queen's speech, Bergman and the CCA were back in the press in July 2003, commenting:

> current manslaughter law does not allow the prosecution of companies where there is a gross and systematic management failure, but where there is insufficient evidence to prosecute any senior company official individually for manslaughter[48].

[47] http://www.corporateaccountability.org.uk/press_releases/2003/01dec.htm
[48] http://www.theguardian.com/business/2003/jul/13/transportintheuk.hatfieldtraincrash

After Tony Blair announced at a TUC conference in 2004 the bill would go forward, in what could have be seen as a victory, Bergman reflected that:

> These delays now mean that legal reform appears dependent on the Labour government winning the next election[49].

When the draft bill was announced in 2004, the CCA publicly posed a number of questions to the government such as whether crown bodies would be included and who would investigate and prosecute the offence[50]. The centre welcomed the publication of the draft bill the following year, repeating concerns as part of the consultation process[51]. The concerns were namely about crown immunity and were voiced alongside the co-director of INQUEST. When the draft of the bill was published in 2006, Maggie Robbins (who had taken over as director from David Bergman) commented: "We welcome that a bill has finally been introduced but feel the bill may be fatally flawed"[52]. Once again the centre sought legal opinion, which they published as the bill was discussed in the House of Lords. When the House of Lords supported an amendment to ensure the Bill would drop elements of crown immunity, the CCA wrote to them and urged the government to pass the Bill:

> The Bill is far from being perfect in the CCA's eyes – but the new offence represents some improvement on the current law[53].

[49] http://www.theguardian.com/business/2004/nov/23/ethicalbusiness.queensspeech2004
[50] http://www.corporateaccountability.org.uk/press_releases/2004/nov23queen.htm
[51] http://www.corporateaccountability.org.uk/press_releases/2005/jun27mansresp.htm
[52] http://www.corporateaccountability.org.uk/press_releases/2006/july21billresp.htm
[53] http://www.corporateaccountability.org.uk/press_releases/2007/may09corpmanstat.htm

Once the Corporate Manslaughter and Corporate Homicide bill had passed through the House of Lords, the centre welcomed the move, "we do think it will increase the chances of greater justice and accountability for work-related deaths"[54]. Soon after, they continued to be critical of retrospective clauses which meant the law could not be applied for some years, "People have failed to recognise the significance of these clauses – and how they will delay this offence"[55]. The CCA closed soon after the publication of this press release and consequently the centre has not been able to judge the effectiveness of the reformed law.

Whilst the CCA were not consulted directly by the government, they persisted in their calls for the law to come to fruition. When at times it seemed as though it would disappear altogether, the CCA pushed for the government to deliver on promises they had made in the shadow cabinet. They also did their best to shape the law and to raise its visibility long after the press and the public had moved on to other issues. This was a long and protracted process, for example, the then deputy Prime Minister, John Prescott commented in 2000 that he would "bring in a new piece of legislation which will take into account…corporate manslaughter arguments" consulting with "all parties that are concerned" (BBC, 2000). Whilst the CCA did not have a seat at the table, they were most definitely a 'concerned party' who made their voice heard in the newsletters they produced, the conferences they organised and the press releases they published.

The CCA published a quarterly newsletter that provided detailed and up to date information on safety and law enforcement called the *Corporate Crime Update* (CCA, 2007). This was sent to subscribers and handed out at conferences. In the newsletters, up to date information about work-related deaths was covered,

[54] http://www.corporateaccountability.org.uk/press_releases/2007/july23lordsagreement.htm
[55] http://www.corporateaccountability.org.uk/press_releases/2008/apr02newman.htm

including criticisms of the HSE, articles written by board members and members of the advisory council, statistics on how the fines given to companies compared to their turnover and international comparisons on enforcement, accountability and sentencing (Newsletters No. 23 Spring 2008 and No. 24 Summer 2008). The front of each newsletter detailed clearly the number of deaths in the three month period the newsletter covered and contained further details of each death on the back page.

As noted above, the CCA organised conferences around Britain, which brought together ministers, employer organisations, trade unions, academics, bereaved families, lawyers and various speakers[56]. Bereaved family members regularly attended and were able to meet people who could help them, from groups such as FACK to meeting suitable solicitors (6). The conferences had themes such as 'Law Enforcement and Corporate Accountability', 'Manslaughter Investigations into Work-related Deaths' and some were held jointly with the Trade Union Centre (TUC) and INQUEST[57]. The conferences raised issues, applied pressure, hosted debates and provided a platform for the families. Organisations such as the Confederation of British Industry (CBI) and union representatives were invited and able to argue their point of view in a public forum along with board members and the advisory council of the CCA. The CCA were pivotal at bringing groups together at crucial times, for example when the National Audit Office (NAO) began an inquiry into the role of the HSE in improving health and safety in the Construction Industry, the CCA held a seminar and invited trade unions, stakeholders and bereaved families to discuss the issues[58].

[56] http://www.corporateaccountability.org.uk/about.htm
[57] (http://www.corporateaccountability.org.uk/Meetings.htm
[58] http://www.corporateaccountability.org.uk/press_releases/2003/14Apr.htm

One of the successes of the CCA lay in their research ability. This research was useful to academics who gained access to information via the Centre. "It was the key resource for investigations by the trade union movement that contributed to parliamentary select committees for about 4 or 5 years" (14). The accuracy of the statistics that were gathered highlighted the inadequacy of the system, for example, the lack of directors who were being prosecuted for manslaughter following a work-related death[59].

The daily information recorded by two part time workers into deaths at work, happened at a time when the HSE did not publish such information. In 2008, the Information Commissioner (IC) forced the HSE to provide the CCA with the details of those who had died in work-related deaths following the start of an inquest[60]. It was a major success that the HSE then began to publish their own monthly statistics detailing work-related fatalities. This information is now available on the HSE website. As their experience with case work grew, the knowledge of the centre became "more valuable and expert" (15) and they were able to compel the HSE to action:

> I think what it was, we had the HSE come down and that was due to the pressure from the CCA and we had them here and they finally gave us information that we wanted to know (3).

As part of advocacy for the families, "the Centre had an impact politically", this became more important in the absence of any other provision (15). The CCA responded to government consultations, which were published on their website. They included the original government document, their own response,

[59] http://www.corporateaccountability.org.uk/press_releases/2005/feb24director.htm
[60] http://www.corporateaccountability.org.uk/press_releases/2008/jul24infocom.htm

what other relevant organisations had to say and the action that the government subsequently took. This covered a wide range of issues related to workplace safety, from changing the language around 'accidents' (to 'incidents') and to altering the code of directors.

The Centre influenced the revision of the Protocol of Liaison in England and Wales (1998) in 2002. Prior to its publication, deaths at work did not necessarily involve the police as it was seen as the HSE's role to solely investigate. The Protocol of Liaison was crucial to bereaved families whose cases would have struggled to reach the prosecution stage without a police investigation and the evidence needed to convict. Although as this research evidenced, the Protocol was not rigorously upheld.

After the CCA began working with the Public Law Project (PLP) in 2004, the two organisations offered training for solicitors, members of trade unions and advice workers raising awareness of the unique issues related to workplace and public safety[61]. This was crucial in an area where few solicitors had sufficient awareness of safety crime.

The CCA influenced the changes made to the Regulators Compliance Code. Unhappy with its tone, the Centre criticised it and by keeping the issues public, the government improved the code by inputting a new section that stated the HSE can prosecute criminal behaviour that threatens genuine business corporations[62].

[61] http://www.corporateaccountability.org.uk/training/main.htm
[62] http://www.corporateaccountability.org.uk/press_releases/2007/nov20compliancecodefin.htm

The CCA responded to proposals by the Health and Safety Commission (HSC), bringing together the statistics they had compiled and concluded with their own recommendations[63]. In 2005 the CCA investigated proposals made by the Health and Safety Commission (HSC) that would have led to deaths of members of the public rarely being investigated[64]. This information was only uncovered when a caseworker asked the HSE why they were not investigating the death of a victim as part of their casework[65]. The centre called for advice from two public law specialists who deemed the proposals as 'unlawful'[66].

When the role of the Coroner was reviewed in 2002, the CCA worked with other groups to ensure the families of victims of work-related deaths had the right to an inquest with a jury at a time when the Home Office proposed the removal of both[67].

The Centre was part of the corporate accountability movement that led to the Corporate Manslaughter and Corporate Homicide Act, (2007) "we contributed to the Corporate Manslaughter Act making it onto the statute book" (13) keeping it in the public eye and on the political agenda when it may have been sacrificed or compromised upon (15). The Centre interrogated the law as it stood and called for change by focusing on key details. When the Centre first opened, it gave evidence to the Environment Select Committee in November 1999 on the lack of HSE investigation, how this was different between regions and provided a set of questions the MPs could pose[68]. They utilised the facts they had to ask key questions such as:

[63] http://www.corporateaccountability.org.uk/press_releases/2000/25Oct.htm
[64] http://www.corporateaccountability.org.uk/press_releases/2005/mar16pubsafetynew.htm
[65] http://www.corporateaccountability.org.uk/press_releases/2004/may27.htm
[66] http://www.corporateaccountability.org.uk/press_releases/2004/jun24.htm
[67] http://www.corporateaccountability.org.uk/press_releases/07Oct02.htm
[68] http://www.corporateaccountability.org.uk/press_releases/1999/2Nov.htm

> Only 10% of major injuries investigated result in a prosecution. Do you think, in light of all your studies that indicate that 70% of workplace deaths are the result of "management failure" that in only 10% of major injuries investigated, there is sufficient evidence to prosecute?[69].

The Centre was created after the Labour Party had continually made a "number of legislative promises in the area of safety and accountability", notably to change the law on safety manslaughter[70]. For many involved in the movement, the new law was not as effective as hoped, a board member reflected that the success of the Centre should not be judged by that law, but that the model for achieving justice was still sound (13).

He noted that the families benefitted from the centre but:

> so did everyone who was involved in it as a social movement…notably, Hazards became a stronger force with the unions following the work of the CCA (13).

He commented that each group that worked alongside the CCA had similar aims and so they strengthened each other and increased the likelihood of success (13). The CCA firmly placed itself with other interest groups:

> we have stood shoulder to shoulder with bereaved families, trade unions, and other health and safety organisations…As part of a broad coalition campaigning for increased accountability following

[69] http://www.corporateaccountability.org.uk/press_releases/1999/23Nov.htm
[70] http://www.corporateaccountability.org.uk/press_releases/12Nov02.htm

> deaths, CCA has never acknowledged any separation of these deaths from other occupational fatalities[71].

Countering political obstacles and suppression of safety crime was an ongoing project for all of the groups involved in the corporate accountability movement. One of the largest successes most of the groups had is in the ways in which they have supported other families through the de-humanising process. Rather than being isolated and confused, the groups detailed here provided family members with a structure of what to expect from the official processes and assisted them through it. Rather than being denied as secondary victims, they found support through the members and/or workers of the groups detailed in this research.

The success that the groups had in countering political obstacles is difficult to measure. The Corporate Manslaughter and Corporate Homicide Act (2007) was enacted and was influenced by many of the groups featured in this chapter. The extent to which it is what people had hoped for is doubtful. Their influence on the current government depends upon how well placed they are to respond. For example, whilst open, the CCA were well mobilised to counter the government on a day to day basis. Funding allowed them to do this. After the centre shut, any impact on future legislation and vital support offered to families stopped. Too many of the groups depended upon the actions of the members and devoid of funding, it was only the will of individuals that maintained resistance.

All of the individuals in these groups worked for hours, either throughout the entire operation of the campaigns or prior to their creation. Gaining long term funding is a task that has to be at the forefront of any group as families return to lives taken up with family and work. As was the case in the CCA, they had a wealth

[71] http://www.corporateaccountability.org.uk/press_releases/2007/may09corpmanstat.htm

of experience and knowledge but had to close due to issues with funding. Whereas other groups, such as Victim Support are co-opted by the government (Mawby and Walklate, 1989), it is inconceivable that any group related to safety crime will ever achieve the same status or that this would be conducive to their aims. Instead the groups were started by the families of workers and depended wholly upon their efforts as they worked through their own cases whilst coping with sudden bereavement.

Conclusion

Whereas the previous chapter focused on the ways the families were wounded by existing social and legal practices, this chapter focused on the ways in which some families altered the ways they were harmed following the death of their loved one at work or through a work-related activity. Through their membership to a group they rejected the suppression and the de-humanisation that had been inflicted upon them.

As Chapter Three showed, the social and legal obstacles the families of victims of safety crime faced meant that companies were exonerated. They were not judged to be criminal, but the process that enabled this, hurt the family members both during the process and in the years after. The victim was made to be 'nothing' and the voices of mothers, fathers and brothers were silenced. The lack of control and suppression of the truth was far from the justice the family members expected, deserved and needed.

Each of the families knew what would have constituted justice in their own cases. There was a large gap between this and what they left the process with. They felt most informed and prepared

towards the end of their own case and they recognised, whilst the experience they had gained could not help them, it could help the future victims they knew would be created. The injustice they suffered and, in the name of their loved one that had been forgotten in the official process, they were spurred on to put this knowledge to good use and to fight for change with other families.

Once they connected to others who had been similarly bereaved, family members found a number of similarities. Together, the plight of the families and their desire for change was strengthened and they were driven onwards to address the injustice. Each subsequent campaign group had a series of common aims, which they approached in different ways. Some campaigned directly against the government, whilst others worked with government agencies. All attempted to positively change the processes and stereotypes they had experienced.

The degree to which success could be measured could be seen in three effects. Firstly, the benefits the groups offered to individuals righted some of the de-humanisation they experienced through the legal process. Secondly, the various groups offered support and advice they had found lacking for other families as they began the legal process. This minimised suppression of the truth and may also have reduced the personal responsibility the families took on after justice failed. Thirdly, the groups pushed for political change. For some groups, they played a part in the strengthening and creation of new legislation, such as the Corporate Manslaughter and Corporate Homicide Act. For others, their tenacity was in the day to day counter hegemony they offered to the various agencies involved in safety crimes. For one group, this ended when the funding ran out, leaving behind a wealth of valuable information and halting an essential service to the bereaved. The remaining groups faced a choice to either work with the government utilising funding to continue, or to continue to function on the will and effort of families that have been bereaved. It was their choice to

continue to dedicate their own time and resources to the movement and/or continually recruit new members.

Groups such as these were and are, the main hope for countering the suppression, the silencing and de-humanisation of victims of safety crimes. The implications of this for the future position of safety crime will be the discussed in Chapter Five.

Chapter five

Suppression and challenge

Introduction

Chapter Three focused on the development of the safety crime victim and how they were blocked socially and legally through an examination of the experiences of the families. Chapter Four focused on the families that created or joined various groups to fight for change. This chapter will explore the findings of the previous two chapters and revisit the original aims of the research, with insights from the literature review.

The discussion that follows will be organised around the original research questions:

1. What social, legal and political obstacles does safety crime face that prevent it from becoming defined and treated as a crime?
2. How are the victims and families of victims of safety crime treated by law and key institutions of the criminal justice system including an examination of the police, Inquest , Health and Safety Executive, Crown Prosecution Service?
3. What effects does this have on the families of victims?
4. Under what circumstances do families of victims seek to develop more general campaigns, with what aims, and with what degrees of success?

Invisibility: social and legal obstacles

No crime: the role of the state in official accounts of safety crime

As discussed in Chapter One, there is now a body of literature that reflects the seriousness of safety crime. Research has referred to

cases such as the sinking of the Herald of Free Enterprise and the Paddington train crash. Whilst these cases are better known, many more individuals are affected by mundane cases such as those featured in this research. Reconstruction of fatality data estimate that up to 1,474 individuals were killed at work (or immediately after) in the UK in 2014/15 (Hazards, 2016). The cases are almost 'routine' as according to data from Hazards (ibid.) approximately four individuals are killed in the workplace or because of work-related incidents every day in the UK.

The crime that is committed by corporations is not reflected in statistics collected officially (Nelken, 1994) and as seen in chapter one, where it is counted by the HSE, the official statistics are flawed (Tombs and Whyte, 2007). One of the ways safety crime is shown to be resistant to detection (Croall, 1992) was in the case where the victim was not a worker, but a member of the public. Weeks after his death, his wife was informed that her husband's death had been recorded as a road traffic incident (RTI). The wife responded with a letter co-written by her father, a retired police inspector, to state their objections and outline their reasons as to why the case should be subject to a police investigation (4). The death of her husband was duly investigated by the police and was the only case in this research to secure an unlawful killing verdict at the subsequent inquest. Yet it was only included in the HSE data and merely reached the coroners court because of the undeterred will of two family members. It is impossible to know how many other cases of safety crime have been wrongly defined and recorded as road traffic incidents, excluded from HSE data and not subject to a police investigation.

However the death is counted officially, safety crime affects many individuals beyond the 1,474 killed as the event spreads out, reaching family members and friends in ways that alter their lives irrevocably as Rock (1994) documented in the case following homicide. Yet this widespread harm is barely reflected in

criminology or the media. Families in this research were previously unaware of the existence and potential of safety crime. Fear of crime, defined as the "anticipation of victimisation" (Smartt, 2006: 27) has demonstrated how in general, women are more fearful than men, the elderly are more fearful than the young and that crimes such as robbery and attacks on the person invoke more fear than other crimes (ibid.). Fear of crime is felt most by those individuals likely to fit into the 'ideal victim' mould, which does not typically include victims of safety crime (Christie, 1977; Whyte, 2007).

Families had not feared for their loved ones at work. For example, upon seeing the police officers at the door, more than one family member expected their loved one had been in a road traffic incident. As Steven Box (1983) noted in *Power, Crime and Mystification,* "There is more to crime and criminals than the state reveals. But most people cannot see it" (Box, 1983:15). Families were not fearful but happy, proud their loved ones were working and earning money. Many referred to what hard workers they were, for example, "he was a good worker, I mean we had loads of people come forward and say how helpful he was" (5) and "someone knew [the victim's] reputation…he wanted him because he was a good worker" (3). Being a worker was a positive act, working hard for a living was aspirational and something to be proud of.

Unforeseeable and routine

The trust the families put in the companies was implicit, most did not question their loved one would be looked after and not put in harm's way. Companies are inevitably placed in a position of trust. One victim was an apprentice who had taken employment as part of his college placement. At 18-years old, he was inexperienced and the words of his father echoed sentiments previously discussed about what it meant to be a respectable worker, "[he]

had worked with me for a year before he went into that garage…he was a good little lad" (11). Crucially, as a young apprentice, his father expressed, "Whatever you asked him to do, he would get on and do it. He just wanted to please." Once put into a risky situation, the desire to be a good worker and being keen to please as a teenager starting out work, his father recognised he "wouldn't have questioned…if he was told to give this manager a hand, he would have gone off and done it" (11). Doing what was asked of him and helping his manager who assumed a position of trust, led to his death.

One victim did question his employers. On the day he was killed he had suspected he and his colleague were not safe and stopped the work. He was wrongly reassured and, with his colleague, was sent back to his death. The victim had done everything reasonable to protect himself but ultimately had to trust his employers in his subordinate position as an employee. Another victim was working his notice due to his concerns about the lack of regard for safety shown by his employer. Companies "affect or…*infect*" every part of our lives" as the costs fall on the most vulnerable (Tombs, 2015: 18, emphasis in original).

Families might not have feared that harm would come to their loved ones at work but after their deaths, all of the families reflected that it was not a random event or as a result of circumstances that were wholly unpredictable. For example, prior to his death, one victim had brought home a piece of paper in his wages that provided information about the death of another employee in an almost identical incident that was to kill him. The two victims who were killed as members of the public were involved in an incident that had happened many times before and many times since. The two youngest victims were hours and days into working on jobs of which they had no prior experience in or training for, and the act that killed them both was obviously risky. Their deaths then were not 'acts of God' but were caused by acts

and decisions taken in the interests of the employers rather than the employees (Gottfredson and Hirschi, 1990). The company is created to make profit with a "dehumanising structure of irresponsibility" that is a "necessarily a-moral, calculative rationality" (Tomb and Whyte, 2015: 158). The reasons for the deaths could be attributed to a number of decisions taken to create short cuts and in order to maximise profit, thereby suggesting safety was not a corporate priority. For example, in one case the company had successfully won a bid to complete the work for half the price of competitors. They were able to slash the bid by forgoing the safety of the workers. In another case the director had modified the grab himself to make it more 'efficient'. Such decisions were not viewed as criminal by the companies themselves and attributed back to the victims. The families had been proud of their loved ones for being good workers for the companies, above and beyond what was required to receive a wage. When those workers became victims, they were only useful to the companies as they sought to avoid blame.

Workers in general are largely unaware they are potential victims of safety crime, which increases their vulnerability. For example, they are unaware that union representation is worthwhile and for many, a necessary protection, something groups such as FACK have attempted to raise awareness of. This is also one of the functions of Workers Memorial Day, which takes place annually on the 28th February. When families were faced with the death of a loved one, when the trust they put in the companies failed them, they expected the state to defend their loved one and to punish.

State intervention is facilitated through its institutions and agents, for example, the people who work within the criminal justice system and in the case of responses to safety crime, the HSE. The way they respond reflects how seriously the state views safety crime. The response of those working in the criminal justice system featured in this research expressed the view that the deaths

of the victims were accidents and not criminal. This was explicitly voiced in more than one case and widely unchallenged by the institutions themselves. This is an obstacle for families who are bereaved as a result of a workplace killing – the construction that the death is automatically an 'accident' and not criminal. This trickled down through every institution the families came into contact with. This will be evidenced in the following sections.

Numerous opportunities to reject the label of 'criminal'

The companies rarely considered the thoughts and feelings of the families or the victims after the deaths and often acted in poor taste, focusing on the needs of the companies. One director ordered that work continue around the body of the victim so the work would be completed in a timely fashion. He advised employees who had witnessed the death of the victim, to wash his blood off the materials that were to be sold (*Hansard*, 3rd March 1999 col. 1046). A common occurrence shared by the families and felt as a great insult was that the employers sent wages to the families of their loved ones omitting to pay the victim for the day of their death, actively failing to think about the feelings and grief of the families. Geis observed that safety criminals are devastated when treated like traditional criminals (cited in Gobert and Punch, 2003). This was reflected in the research when one director reacted furiously when the coroner referred to him as partly responsible for the victim's death to the extent that his barrister had to have him removed from the court (3).

In the immediate aftermath, some families were dealt with respectfully. For example, one family was invited to the workplace (10) and another company set up a young apprenticeship award in the name of the victim (1). However for the majority of families, the conduct of the companies worsened as time passed. Families were moved around the court (6), legal representatives were thanked in front of the families for 'getting them off' (10) and

companies bargained for a reduction in fines that the families were already disappointed with (11). Ruggiero observed that "Powerful offenders develop their own collective super-ego informing their practices, their views, expectations and interactions with others" (2015: 53). The powerful offenders in this research were emboldened by the court procedures to pursue profit. For example, it is standard practice for fines to be reduced following a guilty plea and for plea bargaining to take place. When families witnessed this, they were disgusted and insulted, partly because the fines already seemed paltry to them and to argue over them was a further insult. Yet any decision taken by the company not to enter into negotiations in the court would have been outside of the realms of what the law encourages and expects. Had the individuals in the companies chosen not to attempt to reduce the fine imposed by the court, they would actively have forgone profit, which is against the central goal of any company. It might be argued that restorative justice might be preferable in this context. However, that is not something raised by any of the victims or groups working in the area of safety crimes, nor was it raised by any of the families.

Tombs and Whyte note that "corporate executives are unlikely to shame themselves for corporate crime or to experience shaming through their peers" (Tombs and Whyte, 2003: 66). The intervention of the process and the professionalism of the court (Christie, 1977) appeared to increase 'cognitive dissonance' (Gobert and Punch, 2003: 29). For example, a director who was injured in the incident expressed remorse in the immediate aftermath. He had cried and hugged the mother of the victim, expressing it was his fault and apologising. This changed by the time of the court case when he claimed he had been unaware of what the victim had been doing and that his own injuries had been caused by trying to save the victim. There was little evidence of a corporate conscience that prioritised the wellbeing of employees over the need to make a profit. In the cases in this research, the actions of the companies in firstly committing the crime, and

secondly distancing themselves from the event afterwards, were enabled by official processes. Further, in a "society that embraces…the increasing commodification of all human relationships" the distance the court creates increases the likelihood of future occurrences of safety crime (Wright and Hill, 2004: 117).

In the majority of cases state agencies did not treat the companies as criminal. The police officers did not approach the scene of death of the victims as they might the suspected scene of a crime. Criminal activity was linked to whether there appeared to have been any 'foul play' and once this had been discounted, the police initially withdrew from every case but one. In managing the site as an 'accident', or a matter for the HSE, a regulatory body, the police often blocked opportunities for the deaths to ever be framed as criminal, for example, by failing to collect evidence. This view was so persistently held by police officers that they overrode their own protocol.

The Protocol for Liaison was enacted in 1998 and was in operation in all but one of the cases. It applies to "cases where the victim suffers injuries in such an incident that are so serious that there is a clear indication…of a strong likelihood of death" and compels that "Each fatality must be considered individually" (HSE, 1998: 5). The police should take a central role and "assume primacy for an investigation and work jointly with other relevant enforcing authorities" (ibid.: 5). As demonstrated in Chapter Four, the police can have a huge impact on the future success of the case in court. Two of the companies were treated with suspicion by the police in the immediate aftermath. A further two companies were treated this way by the police after they were compelled to do so, in one case because of an appeal made by the wife and father-in-law of a victim and in another case, by a campaigning group set up to pursue justice in the name of the victim.

The police are useful for examination as they have increasing power over the victim as the case progresses (Davies, 2003). The families of victims of safety crime in these cases were not aware of their substantive rights and were unable to demand the police applied policies rationally (Sanders and Young, 2000). Access to the scene was not restricted in three of the cases and individuals were able to enter and leave the premises, which meant that the victims were not protected. Parents in one case discovered that for insurance purposes, two individuals had taken pictures of the scene, including their son after his death and had developed them at the local chemist (8). This was only revealed to them when an employee of the chemists came forward after recognising the victim once a campaigning group became active.

Not sealing the scene also meant it was open to manipulation, which had the potential to interfere with the facts and the truth. When the police set up an incident room months after the death and returned to the workplace to collect a key piece of evidence, they found it "wasn't there anymore" (8). This goes beyond the actual scene when part of the evidence needed to convict is in the offices of companies. In more than one case, risk assessments were lost, one ex-partner of a victim was told by her solicitor that this is commonplace (2). Similarly, as covered in Chapter Four, many of the families felt documents had been completed after their loved one's death. In many cases, the delayed police involvement against protocol meant that statements were taken months and years after the death of the victim. Anniversaries, Christmases and birthdays passed without any contact from formal agencies. Many family members assumed these delays were a sign that a thorough case was being put together, some were told (wrongly) this directly (1). This suppressed the facts of the situation and was the first step in the construction of the event as not criminal but an 'accident' caused by the victim.

This research did not explicitly attempt to uncover how the police approached the companies in each of these cases, for example, whether they approached them as potentially criminal. However, the fact that in the majority of the cases the police failed to secure the scene to maintain the integrity of any criminal evidence portrays that the scene was treated differently to the scene of conventional crimes or for example, in road traffic incidents (RTIs). In RTIs, the road is shut until the victim has been removed and evidence has been collected. It is not unusual in cases of safety crime for work to continue around the victim and as mentioned previously, work continued around the victim in at least two cases. For RTIs, it is the death that triggers an investigation before the scene has been analysed, the opposite was true in the cases in this research.

Culpable worker, innocent company

Through a failure to restrict access to the scene of the death and therefore to collect evidence for further investigation, the reaction of the police indicated to the company that they were not under suspicion. The majority of the companies were given the benefit of the doubt by the authorities who then began working in co-operation with them, rather than approaching them with suspicion. The companies were given rights by virtue of the prevailing discourse. The dominance of this discourse over ruled official guidance. After finding an employee had died, the first encounter that the companies had with an official body failed to treat them as potential criminals. Instead in most cases, the police framed the company as incapable of being complicit in the death of the victim. This had two main effects.

Firstly, any shame or responsibility the company may have felt in the immediacy of the victim's death was quelled by the reaction of the police. The police approached each scene to investigate whether there had been 'foul play' equating only that with

criminality. In the words of David Bergman, an example of 'foul play' is "whether the deceased worker was pushed from scaffolding or into dangerous machinery by an angry workmate" (1991: 18). In the majority of cases once it had been established no 'foul play' had occurred, the police left the scene. The open scene was an indication from the police that the workplace death did not warrant criminal suspicion and confirmed to companies that they were innocent of any criminality.

Secondly, the lack of formal action taken by the police in failing to seal the scenes and in taking evidence, effectively suppressed evidence. The companies were unlikely to take it upon themselves to treat their workplaces as potential crime scenes but instead to take the opportunity given to them to continue as normal. With no evidence, the cases were almost impossible to prove in a process that would eventually lead all of the families in this research to fail to secure justice in the crown court. With no one held responsible, each case became officially perceived as many police had initially viewed it: an accident.

The law as 'lex imperfecta'

Blocked: the inquest

Although not the place to apportion blame, the inquest was approached carefully by the companies who all sought an 'accidental verdict'. This was achieved by being selective of the truth from the experts chosen to represent them and the evidence they presented. Families were surprised that 'experts' and 'facts' which to them had gaps, were often inaccurate, went unchallenged and instead became part of the official narrative. In a similar manner to the police, some coroners appeared to think what had happened to the victim was an accident and focused only on 'how' the victim died (Bergman, 1991). The lack of evidence was not a

barrier in the lead up to a narrative of 'accidental death'. Many coroners accepted the lack of evidence as 'fact', worked within the self-determined limits of the corporation (for example, accepting that witnesses were unavailable) and took the 'accident' label, which the police had applied and made it official. Coroners selected information and witnesses to support this presupposition and in doing so, disregarded the families.

Of the seven families that had an inquest, all but two ended with an 'accidental death' verdict. All of those families felt that this was not an appropriate verdict and referred to the truth being misrepresented. Evidence in Chapter Four showed how the facts were selected and suppressed. Of the two cases to secure an unlawful killing verdict, it is difficult to pinpoint with certainty how they avoided verdicts of accidental death. However, the following peculiarities were noted.

The first case was unique because it had a full investigation by the police who went to the headquarters and charged board members (after the wife of the victim had appealed the original decision that her husband's death was an RTI). At the inquest, where the wife of a victim represented herself, she was able to question every witness and prior to the jury's decision, the coroner did not sum up. The wife in this case reflected that she thought that this was because the coroner was new. In the other case to secure an unlawful killing verdict, the mother of a victim utilised the fact that jury members shared toilet facilities with the people in the gallery and used this as an opportunity to ensure they were aware of the "rules and regulations of what juries can and can't do" (9). This led jury members to assert their rights to the coroner. She had taken the decision to do this because she had previous experience with the coroner whom she described as "unscrupulous…extremely unkind and ruthless", which led her to "fight fire with fire" (9).

In both of the cases above, the women intervened in the process, they used the rights that existed but were not automatically given, rights that relied upon their intervention. Without the intervention of the first woman, her husband's death would have been counted as a road traffic incident, it might not have been subject to an inquest or certainly an inquest with a jury (Roadpeace, 2009). The second woman featured in the previous paragraph had already had negative experiences with the coroner and so had taken it upon herself to research coroner law. She spotted an opportunity to force the coroner to adhere to the rules by affecting the jury. Many family members would ordinarily not know how to do this, nor have the opportunity to. Further than this, they would not *expect* to have to do this.

Blocked: the crown court

Not all of the victims featured in this research had an inquest because their cases went straight to the crown court. Although this is an option, the harms that companies cause are not the focus of the criminal justice agenda in general. This can be seen in the strategies the government use in order to reduce conventional crime. The strategies focus on a particular type of offender and offence and crucially on individuals committing crime. The law is a significant discourse and although it has continually altered, it continues to be presented "as an authoritative, unitary, unchanging entity, a neutral, objective tool" (Naffine cited in Bittle and Snider, 2006: 472). For example, when Tony Blair and the New Labour government talked about being 'tough on crime and tough on the causes of crime' (Blair, 1995), they focused on achieving this via policies such as the New Deal, Surestart, OfSTED, the National Strategy for Neighbourhood Renewal and the Anti-drugs Co-ordination Unit (Home Office cited in Cook, 2006). These measures were not aimed at powerful, corporate offenders but relatively powerless, poor individuals.

The state discovers many crimes annually, crimes that process:

> our contemporary catalog of "monsters," including sex offenders, gang members, drug kingpins, and violent-crime recidivists, forms a constantly renewed rationale for legislative action (Simon, 2007: 77).

The difference between traditional and safety crime is presented as such for good reason, because the "conditions are as they are" and demands respect from the wider public (Mathiesen, 1980: 86). Relatedly, the government responded to the 'war on gangs' by using the joint enterprise doctrine. This allowed groups of people to be prosecuted when they were not present at the offence but had a 'common purpose' (Williams and Clarke, 2016). The enactment of this law disproportionately affected and criminalised young Black, Asian and minority Ethnic men (ibid.). No such law was evoked to deal with safety crime. The criminalisation of old white, rich men was avoided.

Unsurprisingly, the families of victims were previously unaware of the concept of safety crime, in spite of the fact that becoming a victim of safety crime is not a distant threat for people, either through their employment or as members of the public. It is more surprisingly however, that many of the agencies tasked to help them were also untrained, unaware and novices in responding appropriately. The law in action was continually interpreted by officials in the criminal justice system that the family came into contact with (Snider, 2003). In the absence of training and awareness, many relied upon 'common sense' notions and as the police officers did, immediately framed the death as accidental. The framing of the deaths as accidents and self-caused had continued consequences throughout the process that handicapped the case from ever achieving justice.

This research supports Punch (2009: 66) when he branded the laws that relate to safety crime as '*lex imperfecta*', designed not to work. The law is created to exist in theory but not to work effectively, so that few companies are ever punished or prosecuted. This outcome is not accidental but as a result of a number of processes. As a construction, it is designed and enabled by the state and fortified with every case that takes that path.

The burden of proof required to prosecute companies is high (ibid.), and in this research this was affected by the failure of the police to collect evidence. It was coupled with a lack of, or delayed, investigation, which fatally affected the likelihood of any case. It cannot be known if the cases featured in this research should have had justice at the crown court because the opportunities for justice were blocked before they reached that stage. It was insufficient evidence that stopped the majority of the cases from getting to the crown court, according to the CPS. The three cases that reached the crown court to hear manslaughter charges failed because of the pervasiveness of the narrative that workplace deaths are all accidents. This was demonstrated in three ways, through the suppression of evidence, the presumption that the director was innocent of criminality and the complicated law created to respond to safety crime.

Firstly, the families of those whose cases reached the crown court had similar experiences to the families who attended the inquest in that evidence was suppressed and selected. One of the cases that reached the crown court failed because the CPS failed to build a strong case. For example, they did not refute the company's claim that no other workers had been killed on the site, despite the victim's brother having discovered that this was a lie following a web search. In another instance in the same case, the defence attempted to argue the victim had been killed by a bang to the head prior to the explosion. The family were incredulous that the company were trying to argue this but were unable to counter the

claim. The cause of death could not be ascertained because the victim's organs had been lost. Like any other member of the public, the family could not have foreseen this malpractice nor had they any control over this. Even if they had foreseen it, they had no option but to put their trust in the official bodies that ultimately failed them and went on to insult them, when challenged.

Secondly, another case failed because the officials first called to the scene of death assumed it was an accident and presumed the innocence of the company and director. The family had a solid case, built by a thorough police team and the CPS and had seen the owner of the company convicted and sent to prison. However, on appeal three judges acquitted and subsequently released the director from prison because officials at the scene did not treat the director as a suspect and failed to caution him under (1984). The director was told by the appeal judges to leave the official process as innocent and with his reputation intact. Since the case had been dealt with in court, the family did not have any right to an inquest.

Thirdly, the nature of proving *mens rea* years after the offence proved too large an obstacle to overcome in the final case. This was a case that according to the CPS was not initially deemed to be strong enough to get to crown court. Through a group started by friends of the victim, the family successfully won a judicial review that overturned that decision. They reflected they "were on a high" (8) and began to gather evidence retrospectively in the six months they had prior to the court case. Once again, delays were crucial as the length of time between the death of the victim, the investigation and the court case was mentioned in the summing up, in favour of the director:

> Remember the events were a long time ago. There may be danger of real prejudice to the defendant. Memories fade, and people can't remember with

> crystal clarity the events of years ago…The delay of three and a half years may affect some witnesses' memory Are they lies, or are they genuine mistakes? Remember the time lapse…If there are innocent reasons for lies, then you must ignore the lies (SJMMC, 2001).

In another case, the report of an inquiry held back from recommending any disciplinary action against the person in charge because of the amount of time that had elapsed, and on human rights grounds (9).

Simon Jones was working at Euromin Limited when he was killed. Euromin were/are a supplier of products used in the construction industry. Dutch owned, they are the UK operating company of the holding company De Hoop Terneuzen BV. Typical of the evolution of business in a neo-Liberal, de-regulated dock industry, Simon was working three organisations removed from the company that would have ultimately paid his wages that day (Tombs and Whyte 2007). The owners of Euromin were located outside of the UK, which complicated proving *mens rea* and confirmed Gobert's (2008) statement that only small corporations would be held criminally responsible for safety crime. The judge was clear about what was required of the jury were they to find the director guilty:

> If you are not sure of Mr Martell's guilt, you must also find Euromin Ltd not guilty. If you find Mr Martell guilty, you can only convict Euromin Ltd if you are sure that Mr Martell was acting as the company, that is, that he was the company's controlling mind. Ask yourselves if Mr Martell in reality embodied the company's operations at Shoreham…For the Defence…argues that Martell is not the controlling mind of Euromin; he is simply an employee. Euromin is not a one-man company. He reports to directors in Holland…Mr Martell speaks for the company (this is not to say that he is

> necessarily its controlling mind; you must decide this.)[72]

The law has not developed to overcome the necessity of establishing *mens rea* in the case of safety crime. The proof required to establish *mens rea* was absent in all but one of the cases even though half of the cases involved small businesses. The one case that met the criteria in court, before being quashed, involved the director being onsite and working alongside the victim on the job that killed him. There are few cases of deaths at work that ever meet this requirement. For example, five of the cases involved more than one company, either because of subcontracting or agency work. At least three of these companies were multinational corporations where the director could be located outside of the UK, far away from the scene of death. With the emphasis on locating *mens rea*, victims of safety crime are never going to be regarded as victims of real crime, according to the law (Wells, 2009).

The cases bore out that the law is about 'deniability' (Punch, 2009: 51), which is easier to achieve for companies. Deniability is achieved through suppression of the truth, as detailed later in this chapter. Details about the context of the deaths and links to wider motives of profit and gaining a competitive edge were often suppressed. Relevant details that attempted to illustrate the context that led up to the death of their loved ones and connected the death to the wider context of profit and gaining a competitive edge were suppressed (Pearce, 1990b). In order to reach an official judgement of innocence, the truth of the deaths had to be manipulated by the companies, which was enabled through state processes, from the police to the crown court. The families saw the truth denied, altered and suppressed, to suit the needs of the companies (Punch, 2009). In the absence of truth, the companies were able to control and shape past events in a rush to frame it as non-criminal in the eyes of the law (Box, 1983).

[72] http://www.simonjones.org.uk/trial/judgessummary.htm

Law is a powerful discourse and in the case of safety crime, it reproduces power (Bittle and Snider, 2006). After the Bhopal disaster, the company exercised power over the employees and silenced them, before going on to blame them (Pearce and Tombs, 2012). The company had the money to pay for legal representation, power to influence politics and were in a position to deflect blame onto those subordinate to them. The companies exercised power over the families featured in this research using those working within the legal system to deflect criminalisation and finances to utilise the legal process. This will be outlined below.

Power was wielded by the companies in the cases researched. For example, one company threatened a family by stating that if they pursued the court case they would lose civil claims for compensation for the victim's young daughter (10). Such bargaining tools are unavailable to conventional accused parties. The court case was not only stopped but to the horror of the family, the company returned to the court to be officially judged as 'not guilty' and the case was duly dismissed from court. The company left the court as an innocent party and for that family, in spite of protestations after they realised the implications, that was the end of the process. The company had successfully negotiated its innocence.

Those with power were able to protect themselves, using the law rather than being prosecuted by it, for example, in one case, three witnesses from three different companies who were involved were granted immunity from prosecution. When the family asked why this was, they were told it was necessary to "get them on side" (10). The families were shocked and stunned by the process, unable to explain the processes of the court and unable to challenge decisions that were made, they had to witness and play no part. On more than one occasion, the family believed there was something else going on that accounted for the warm reception

that the owners, as the accused, received within the court. One mother described it as, "wheels within wheels" (9). Many families commented that they were part of an unfair game, one which they could not win and which in all cases but one, ended with the public proclamation of the innocence of the company. The families had a minimal role in the proceedings and as such they were:

> not always silenced, but…how they are allowed to speak, and how their experience is turned into something the law can digest and process, is a demonstration of the power of law to disqualify alternative accounts (Smart cited in Ballinger, 2003: 221).

Punch observed that because judges have more in common with the directors in terms of class in that they benefit from 'social capital' (Punch, 2009: 51). Though part of normal practice in court, one family described how they were shocked the judge gave the director a character reference when he was unable to provide one himself. This was detailed in the judge's summing up as follows:

> You have heard that the defendant is of good character, is 59 years old, and has never been in trouble. This is evidence which you should consider in his favour. He has given evidence himself. His good character may mean that he is less likely to commit offences.[73]

The good character outlined by the judge was linked to his propensity to offend. In addition, the director was distanced from the traditional criminal (Punch, 2009) as the judge described how

[73] http://www.simonjones.org.uk/trial/judgessummary.htm

he had "found the police interview frightening and he felt himself under pressure"[74].

Not readily positioned as criminal, all of the companies involved in this research were given opportunities to deflect criminalisation and charges of corporate manslaughter. The state allowed the companies to avoid viewing themselves as criminals (Gobert and Punch, 2003). All of the companies in this research resisted legal criminalisation and continued to operate as businesses and as employers. Going through the legal process must have been, in the very least, bothersome to the companies, but it is questionable as to how much it deterred them from taking such decisions regarding the safety of their employees in the future. Not forced to see the victim and the victim's family as affected by the decisions made, dissonance between the companies and the death of the victim was perpetuated (ibid.). Indeed, a death occurred at one of the sites and in a similar manner only months after the victim featured in this research.

The affordability of justice

For the families researched, finances were a crucial bargaining tool as the companies and the families navigated their way through the criminal justice system. Many family members had lost the main breadwinner to the incident that claimed the life of their loved one, and therefore had to pay for a funeral and a wake with little or no compensation. They then faced the legal process and found they were in a difficult position of not being able to afford legal representation, access to court documents (which strengthened their ability to fight) and simple practical requirements such as the ability to pay to travel at peak times of the day during their working day. This was juxtaposed against the company, who had comparatively little difficulty in hiring legal representation secured from insurance, getting access to

[74] http://www.simonjones.org.uk/trial/judgessummary.htm

photocopies of court documents and being able to appear in court without fearing for their own economic livelihood.

One mother of a victim who attempted to take her case further commented: “It’s about what they don’t tell you” (9). When she applied for legal aid, she was not aware that this meant any assets she had were accessible, this included life insurances, saving schemes and her house. She was not told that if she lost her case, she would be liable for the charges. Even when she won, she was responsible for covering the solicitor’s costs, which amounted to £8,500. This would have cost her even more had she not asked for the receipts from the opposition’s solicitor who had claimed for taxis when he cycled everywhere. She compared herself to the position of the wealthy, “I’m absolutely broke, really have no money…and yet Maxwells and the Guinness’ have it” (9).

In the Jones’ case too, the family were granted legal aid when they raised a judicial review to challenge the decision of the CPS. However, they were still required to save and spend money. Firstly, they were advised to get funds together in case the contest was unsuccessful and damages were sought. They had to fundraise to do this, using the connections the friends of Simon had. Secondly, they were sent monthly bills, money which they reflected, “We were supposed to get that back at the end when we won but they never sent it back. Alright, it was a few hundred pounds but it would have been useful, we were pretty well on our uppers” (AJ). Unions including the T&G and Unison donated funds even though Simon wasn’t a member of any union. In another case, an ex-wife of a victim had to pay £3,800 for the solicitor, which matched the costs of the funeral that had involved paying for the travel of family members who lived outside of the UK. She expressed, “You get caught in this trap…they should have legal aid…for the…person that’s died…to appoint a solicitor to represent the person that died” (2). The availability of money meant the cases were more likely to succeed and that

accountability could be upheld. In the absence of money, the families had to get into debt, just to *participate* in the process and meet the minimum requirements of the court. Few had enough access to money to push the case further, one ex-wife of a victim reflected "To be honest, would we have gone any further? I think we would have if we'd had a bottomless purse" (2).

Money was linked directly to power and class. One owner of the companies paid for the costs of the funeral of the worker who died. When, at the inquest the prosecution attempted to prove the victim had died as a result of a mechanical and not operational fault, the owner referred to the money he had spent. The father of the victim recalled that in court the owner shouted, "I've done everything for them, I've paid" (3). For him, his ability and willingness to pay for the funeral led to outrage when his company was questioned in court.

Finances affected the families' ability to disagree with decisions that were made about their cases. The ability to circumvent and overturn decisions made by the CPS and the courts depended upon money. Many families wanted to appeal and change the outcome but were forced to walk away, and accept the official judgement because they did not have the finances to officially disagree and oppose. Mathiesen notes:

> The freedom which exists is in principle open to everyone. The point is, however, that in practice only those who in fact have the resources required to use it can take advantage of it…the freedom which exists formally is reduced to a freedom *for dominant interests* (Mathiesen, 1980: 113, emphasis in original).

An example of this was one case where a company (the largest in all of the cases) had prepared leaflets ready to distribute at the end of the inquest to inform the public of their intent to launch a judicial review (4). This was juxtaposed with another family who was told launching a judicial review would be 'foolhardy' (1). Whereas the company could take that decision knowing they could afford it, the family knew that taking such action could jeopardise their economic wellbeing and the future security of their family. The unequal access to justice reflects the lack of recognition that safety crime has received in the law, what does exist is symbolic, "Even if the law is broken, it is clear whose law it was" (Gusfield, 1970: 11).

The state and business as inextricably linked

It is the state that put the company above the victim in the eyes of the law yet it was the state that the families turned to for justice. They were unaware, or unable to identify, that the state and the company were inexplicably linked. State institutions continued to present themselves as "independent, free and detached from the material conditions to which it actually adjusts" to maintain its "matter-of-course authority or prominence" (Mathiesen, 1980: 92). To quote Box:

> ordinary people [are made] even more dependent upon the state for protection against 'lawlessness' and the rising tidal wave of crime, even though it is the state and its agents who are often directly and indirectly victimizing ordinary people (Box, 1983:14).

The belief of the families in the neutrality of the state and faith in its ability and willingness to represent their loved one had a number of consequences for the cases and the families themselves.

Firstly, the families trusted in the process, though they had no knowledge of what to expect, they automatically relied upon the state to fight for their loved one and to mobilise against the corporation. By the time they realised the state was not representing their interests, and in many cases not following the procedure that did exist, the case had gone too far to be retrieved. The majority of the family members blamed and chastised themselves for trusting official agencies or not doing more, for example, "I put all my faith in our justice system and that was so ignorant of me" (10) and even though many realised "there was nothing else you could do" (2), the guilt that they felt in hindsight, that they ought to have realised earlier and acted differently on behalf of their loved ones, remained long after the companies had been found innocent.

The criminal justice system plays a crucial part in denying the existence and seriousness of safety crime. The victims were denied by the state and filtered out of the legal system. Each case in this research shared the official judgement that the companies were innocent of corporate manslaughter. Cases were acknowledged but importantly, they all failed publicly. The failure of each case in the legal arena is a success of the criminal justice system in creating, rather than reflecting crime (Reiman, 1998). It is crucial that this is acknowledged for safety crime when boundaries of offences:

> shift according to factors such as media preoccupations; prevailing popular or political perceptions of social problems, risk and danger; availability of resources; bureaucratic and other constraints on police and prosecution (Lacey, 1998: 7).

Were we to rely upon definitions of law, the subsequent lack of justice would discount these experiences from ever being relevant at all (Tappan, 1977).

Emasculated health and safety law

The 'war on crime' has never included families or victims of safety crime (Whyte, 2007). The unthinking war imagery that is waged on criminals where rationality can be dispensed with (Sontag cited in Best, 1999) has however, been declared on red tape:

> Conservatives in government are winning the war on red tape….like the Red Tape Challenge, which has now seen over 1,000 regulations scrapped, we've saved firms £1.5 billion a year…we've freed thousands of businesses from unnecessary health and safety inspections, prevented responsible employers from being held liable for those workplace accidents that are outside of their control (Hancock, 2014: para one).

It is clear what a war on red tape entails, it is the arbitrary reduction of regulation that saves businesses money, fewer inspections and the assurance employers will not be held liable.

By choosing to respond to safety crimes with regulation and policing via regulators, there is an acceptance that these crimes require a different, lesser approach (Slapper and Tombs, 1999). For example, regulation would never be suggested for burglary. Regulatory responses play a clear part in failing to recognise those killed as victims of crime. A regulation has been breached and, although the consequences are grave, they are far removed from the cause and the actions of an offender. The meta-physical gap is a significant feature of regulation, the companies might have made a mistake but it was just that, an oversight and not a crime (Wells, 2001).

The discourse that the health and safety culture has "gone way beyond what was intended" (Grimsby Telegraph, 2014: para 1) is pervasive. The government actively support the 'elf and safety' ideology by decrying the lack of 'common sense' as affecting responsible employers (James *et al.*, 2012). This is reflected in the continuous cuts to funding of the HSE and the reduction in the number of inspectors (Tombs and Whyte, 2013). In support of enterprise, successive governments have encouraged the use of compliance where an increasing number of prosecutions are viewed as a bad thing. What the statistics do not show are the victims and the families who are affected by this ideological assault. For every breach of health and safety and death at work, there is a victim created due to weak and non-existent regulation. For every victim of safety crime, there is a family who are bereaved. These are the individuals whose needs are never prioritised and who live with the consequences.

Regulation has been reduced to a symbolic gesture offered to the families, a lesser sanction that acknowledges harm has, but should not have, taken place (Carson, 1974). For the families in this research, formal justice in the crown court failed in all of the cases and fines became a consolation prize. The fines were low enough to insult the families further, which more than one judge recognised. Judges apologised that the fines they handed out to the companies were determined by factors outside of their control. The symbolic gesture was not adequate enough to show public disapproval and its lack of rigour in either deterring or punishing the companies, harmed the families of the victims who had died. They felt wronged and without any public show of disapproval or agreement, many felt isolated further, compounding bereavement.

Regulation was often led by the assessment of risk, the degree to which the company had foreseen and acted upon risk. The judgment of risk was assessed in the court by the presentation of

risk assessments. It was a low threshold that proved adherence to health and safety regulations, which was checked after the deaths but not interrogated (Tombs and Whyte, 2013). Many of the families expressed doubts about either the location of the lost risk assessment or whether it had been completed or seen by their loved one at all. This paper based proof had little impact on the court and was easily circumvented, rendering it a tool only for the corporations. For example, training was said to have been done, which for one ex-partner of a victim, she was sure it had not (2), and it was acceptable for one manager to say that he noted the risk assessment in his head (10).

The inadequate responses from the HSE continued in the sanctions that were delivered and for some of the families recommendations made were mitigated further and produced confusing messages. In adhering to regulations, the companies worked within the limits that were set for them (Box, 1983). In one example of this, a family was told the company did not and would not alter their working practices as a result of their son's death because that would mean they were working to 'best practice'. 'Best practice' was beyond the statutory duties that were required of them.

The majority of the families acknowledged the health and safety inspectors had a difficult job to do, to the extent that one of the families spoke to a Cabinet Minister on their behalf (8). Companies were able to thwart investigations (Croall, 1992). For example, evidence failed to be gathered promptly by the HSE and the involved parties refused to give statements when they were approached 18 months after the victims' death (2). Families, with grace, considered that old work colleagues of their loved one would have nothing to gain from giving statements that may implicate their employers. When families found themselves waiting over two years, many attempted to ask questions about the progress of their cases. Such enquiries were largely met with

frustration and their enquiries were dismissed as a nuisance. Families in two of the cases spoke very favourably of the inspectors assigned to them, describing them as thorough and close enough to consider them as a friend of the family.

Of the 11 cases, five ended with fines under the Health and Safety at Work Act (1974). Due to the nature of subcontracts, across these five cases, ten companies were involved. After bargaining for a reduction in sentencing, for example, after companies were shown leniency for pleading guilty to health and safety charges, the average fine across these ten companies was £34,000. The extent to which the fines reflected the seriousness of the death or reduced future risk taking is debatable. For example, one company who was prosecuted under health and safety offences received a fine that was 0.000432% of its reported turnover for 2015 (the company was fined a few years earlier). This is the equivalent of a person who earns £26,500 per anum being fined £11.46.

Prosecution was seen as a last resort (Hawkins, 2002). Two families were wrongly promised that their cases would be heard on health and safety offences. One ex-wife of a victim was told by the HSE that although they had tried to get more statements, without additional evidence from the corporation "they didn't feel they could go any further" (2). The HSE in this case, "apologised for it taking so long, but said they'd tried to keep the continuity up" (2). One family was informed that a senior figure in the HSE had taken the decision not to prosecute because it was "not in the public interest" and because he was worried it would cause 'knee jerk' reactions in companies across the country if they attempted to resolve the fault that had killed their son (1). Another father of the victim was told the HSE had met with the company, he hoped they realised the implication of "how close they came to prosecution". The father of the victim was left to hope the company took safety more seriously after his son's death reflected in "a [safety] record

that's gleaming". He reflected "…but I have no idea" (3) because he had no further contact from the HSE.

In another case that was not prosecuted by the HSE, a health and safety inspector visited the home of the mother of a victim and informed her that the death of her son was an accident that was self-inflicted (5). This immediately and devastatingly for the mother, diverted all attention away from the scene of his death or the reasons that led up to it (Tombs, 1991). It was common for the victim to be implicated in their death, for being risky (2), for doing something no one was aware of (3) and for not being conscientiousness enough (7). The person who died was treated as the main source of risk (Pearce and Tombs, 1989; Tombs, 1991) and after their death, the HSE saw raising awareness as the best solution, rather than shutting down the companies or imprisoning the directors. The truth was suppressed and companies were able to "bow out of the scene", their responsibility fading as the victims were implicated in their own deaths.

Not in the public interest

The main reason given for lack of action was that the cases were "not in the public interest". 'Not in the public interest' was a phrase often repeated by the agency when questioned by the families. What the families desired was against what was good for business and therefore, good for the public in general (Tombs and Whyte, 2009). Business was good, justice for the families was too much of a risk and expensive to pursue when the cases were not considered winnable (Hawkins, 2002). There is an irony that the lack of immediate involvement of the police and the ability of the companies to eradicate, change or conceal evidence leads to protracted investigations where the required proof becomes more elusive (Croall, 1992). This increases the cost of any subsequent investigation and provides enough reason for the HSE not to pursue the companies for health and safety offences. The ability of

wealthy companies to use the best legal teams they can afford to exploit the ambiguity of the law that relates to safety crime offences only increases the costs (ibid.). It is 'not in the public interest' because the limited powers and finances afforded to the HSE by the government are no match for many comparatively powerful perpetrators.

The companies were able to continue their business and make profits with few negative consequences. There is value in the maintenance of what is criminal, and uncovering the truth in workplace incidents could harm the company and its ability to meet its financial goals and maintain profitability (Tombs and Whyte, 2015).

The rhetoric of regulation and 'red tape' had a reinforcing effect. Regulation has not been prioritised by the government, but continually reduced. It is likely the current government will continue its neo-liberal campaign in the same manner it did as part of the coalition. The symbolic gestures of fines and probationary orders that the families in this research were offered may be more than families of future victims will see. The way the victims and families of the victims of safety crime were treated at every stage of the criminal justice system, slowly and incrementally filtered them away from justice. As Tombs and Whyte note:

> none of the various mechanisms whereby safety crimes are rendered relatively invisible are particularly remarkable in isolation. What is crucial, however, *is their mutually reinforcing nature* – that is, they work in the same direction and to the same effect, removing these crimes from 'crime, law and order' agendas (Tombs and Whyte, 2007: 69, emphasis in original).

In this way, the criminal justice system enables business goals that prioritise profit over the safety of individuals (Slapper and Tombs, 1999).

The next section will examine the forgotten effects this has on the families of the victims. These are 'unofficial' accounts, not publicly validated, unlike the verdicts given to the companies.

The state as a suppressor

Numerous opportunities to be blamed

Though the victims had been killed and were not present during legal proceedings, the official processes were, on their behalf. When the victim is dead and physically unable to make their own case, the accounts that remain are:

> constructed for a purpose…to diminish the defendant's culpability and inflating that of the victim to blur moral differences (Rock, 1994: 25).

For the victims of safety crime, they were implicated in their own death. How this happened and the reasons why this continues to happen will be explored in this section.

It is by the nature of their death that the victims are unlikely to see justice. The victims were in a legitimate place carrying out a respectable activity in paid work, and those that had the chance, attempted to defend themselves. Yet this status was denied to them and when faced with a perpetrator more powerful than themselves as a respectable company, they were blamed (Whyte, 2007). In their absence, the victims had their motives, reputation and actions

questioned. They had chosen to be in that position, and the exchange of their labour for wage was a crucial factor (Whyte, 2007). Rynbrandt and Kramer (2001) make the point that as in rape trials:

> she [female victim of corporate crime], rather than the corporation, is on trial…forced to defend her choices and even her reputation (Rynbrandt and Kramer, 2001:171).

Rynbrandt and Kramer (2001) question whether women who were given dangerous silicon implants really had informed consent. The same question could be asked of many of the victims in this research. More than one was working their notice because of concerns about safety and one was on a work apprenticeship, sent by his college who were said to have approved the workplace, when no one had performed any checks or visited the site. The extent to which the individuals made informed decisions about the risks is questionable as they were not aware of the risks. Such a low burden of proof and risk was required that it barely featured in decisions about work. Neither the company nor the individual made this a priority, a decision that was supported by the law. The need to protect vulnerable young people is pertinent as the current government plan to create three million apprenticeships in the next five years (Hazards, 2015b).

The process of the criminal justice system and coronial procedure led questions to be asked of the families that sought to implicate the victims in their own death. For example, families were asked whether their loved ones were suicidal or regularly drove their cars recklessly. These were standard questions, but unnecessarily hurtful and seemingly an irrelevant part of an already complicated process which the families had to endure. For many of the cases, it was clear what had caused the deaths of the victims. The outcome

of this process and line of questioning placed the victim immediately in a position of mistrust. Evidence that did not exist was sought whereas evidence that did exist in the workplace was discarded.

At the Coroners Court, the victims became culpable and were positioned at the centre of an 'accident' where every person is potentially involved (Bittle and Snider, 2006). The powerful narrative that a person who is killed at work is the victim of misfortune or a result of their own risk-taking led to victims being blamed for their own deaths using far-fetched explanations, which were considered and not refuted by the court. In the case where a victim was killed in an explosion because he had been told the use of cutting gear to dismantle a chimney was safe, the defence tried to argue he had not been killed by the explosion. They contested they had found a plastic lighter at the bottom of the chimney, which they suggested the victims had used to dismantle the chimney. This was in spite of the fact plastic would not have survived the fire and the victims had already left the chimney to question the safety of using cutting gear at all. It is beyond the limits of possibility that two trained steeplejacks would attempt to dismantle a chimney with one plastic lighter between them. As Mathiesen notes:

> questions to which ordinary people appear as obvious totalities, are unravelled into their individual conceptual components, and decisions which from a popular point of view appear quite unreasonable, are made reasonable by the emphasis on the precise legal content of the words (1980: 107).

It was far easier for the victim to be blamed after their death than to meet the high burden of proof required to blame the company. When summing up a case that reached the crown court, the judge outlined that the director had "concluded that [the victim] must

have put himself in danger" that he "[relies] upon people being sensible". The judge went on to recall "He [the director] says, 'How could I know this was going to happen? There was a freakish combination of circumstances'"[75]. The pervasive notion that the victim had caused their own death in a random accident was enabled by the law and encouraged by those with the power to influence (Tombs, 1991). The victim was dead and unable to defend their actions and whilst they were de-humanised in court by the process that sought to blame them for their death, they were not personally harmed by it. Instead, it was the families, as secondary victim who bore witness and were de-humanised by the official process.

The experience of being invisible: de-humanised

As in the case of Scraton's (2009) research, the families of victims were tortured by the official process they had no choice but to enter. The law did not deliver the truth or justice to them, but additional pain and humiliation. The expectations the families had of the legal system were crushed by the "theatre of law" (ibid: 246). What was normal procedure to companies and legal professionals was bewildering and confusing to the families in this research. Rights that families did have, for example, being able to view their loved one at the morgue, were often denied, which led families to blame themselves, "I don't know why I didn't stand there and say I need to see him properly" (8).

As this research evidences, the long-term effects of losing a loved one to safety crime were harmful, horrifying and wounded families irreversibly. Blaming the victim suited the needs of the company where the costs were passed to the families in this way, families of victims of safety crime experienced double victimisation which was exacerbated as they endeavoured to defend the memory of their loved one (Shover *et al*, 1994). For the

[75] http://www.simonjones.org.uk/trial/judgessummary.htm

families, their desires were not linked to recovering financial loss or protecting a corporate reputation, but as the last action they could take for their dead loved one. One mother articulated (whilst very upset) "you're slapped down…you always think, this is the last thing I can do for him… [crying] sorry" (5). The emotions they had to deal with as a result of their bereavement were amplified as the memory and intentions of their loved one was attacked. This supports research that highlighted the way victims and families of victims of Hillsborough were denied rights and had their reputations attacked (Scraton, 2009).

Denied by officials, the families of the victims chastised themselves for trusting the authorities, considering their individual case might have ended differently, had they taken more control. This added to the frustration, hopelessness and fear victims feel following traditional crimes (Spalek, 2006). Any attempts to compel officials to act were met with contempt. In almost all of the cases, efforts were made by the agencies to silence the families, they were encouraged not to ask questions. The state agencies put their priorities ahead of the needs of the victims and their families (Scraton, 2009). For example, long delays were caused by the HSE in the name of continuity. This was not an imperative, when police officers go off sick or take annual leave, cases are not postponed for two to four years, but for the families of victims of safety crime, they had to accept this situation, even when attempts at continuity still did not lead to prosecutions for health and safety (1).

As in Scraton's (2009) research on Hillsborough, the quick decisions made by state agents caused the families to blame themselves for not challenging enough. The state agents may not consider the decisions they made once that day is over, whereas the families were left to mull them over. When called to account for those decisions, officials showed their lack of understanding further, unapologetically placing additional blame onto the

relatives and discrediting their needs. For example, a mother who wanted to touch and see her son after his death was described as ‘obsessed’ by the coroner (9). The lack of empathy shown by the police led to one wife moving house and feeling petrified the police would return to her house (7). A brother of the victim said he would never return to England after the court made his brother ‘nothing’ (10). This compounded the problems that came with bereavement and sudden death.

The way the families were treated in response to a safety crime and the death of the loved one had huge effects that exacerbated long term behavioural and emotional consequences (Matthews *et al*, 2011). This was at a time they had experienced a sudden and traumatic death and were vulnerable to depression, post-traumatic stress and cancer (Kaltman and Bonanno cited in Tombs and Whyte, 2006). Being treated poorly by the criminal justice system is an injustice that compounds this suffering (Scraton, 2009). Similarly to the families of victims and survivors of Hillsborough, families were tormented by:

> serious questions about the institutional, structural and embedded deficiencies in the law and its administration (ibid: 246).

The families of the victims desired a guilty verdict, as Scraton (ibid.) remarked, regarding the families of victims of Hillsborough, not necessarily for punishment but to publicly find out what went wrong and to put it right. Every family returned to the need for the truth, to know what happened that caused the death of their loved one and a reassurance it would not happen to another individual and another family. This was intangible because official bodies either failed to see the truth as important or deliberately complicated it for their own gain. The families found themselves fighting to maintain the innocence of their loved ones who were judged to be culpable in their absence after their death.

They had to navigate the obstacles built into the criminal justice system as well as the inhumanity of the company that sought their innocence through establishing the guilt of the victim.

As was reflected in Rock's (1998) findings following homicide, the families in this research were manipulated with little regard for their emotions or how this manipulation might have a long term effect on the relatives. The families were not considered by the court, for example, when they were given nowhere to sit in the court after waiting years to hear the cases (10). Their loved one had already been killed, yet the court, in the word of a bereaved father, 'assassinated' them (3). It was the family who left the process still bereaved, without justice and further wounded.

In terms of Spalek's (2006) research, there were many commonalities. For example, the families of victims were isolated from family and peers, one of which imagined they had received a large compensation pay-out and were hiding it (2). Illness was a common side effect and many of the families were in and out of hospital with diseases ranging from stomach problems to cancer, which led to premature death. Losing the breadwinner caused financial problems, especially when the jobs the victims had were labour intensive, paid by the hour and without life insurance. Sutherland regarded white-collar crime as more likely to "tear at the core of a social system" (Geis and Goff, 1983: x). Findings from this research confirmed that the long-term effects were huge, exacerbated by the denial of victimhood of the victim and families.

The repercussions of a work-related death were long-term as children were traumatised and began to struggle at school, families thrown into poverty and insecurity. They had to respond to bereavement, experience the lack of justice and some took on the

responsibility for themselves. “Just like other victims of crime … our hearts have been torn out of our chests. The difference is we are not seen as, not acknowledged as, and not supported as the victims of crime that we are” (Families Against Corporate Killers, 2006). Families found their voices restricted and controlled, they articulated that they felt disempowered when their opinions were not considered and the truth was left unexplored (Williams, 1999). In some cases, the families of victims fought back, for their own cases and for the rights of future victims.

Invisibility: political obstacles

Collective struggle and refusal

The pain that the families experienced was unnecessary and cruel. In order to save the company from an unlawful killing verdict or the directors from a manslaughter conviction, the family had to be forgotten. The truth they desired had to be suppressed to find the company innocent. This increased the pain they experienced as their loved one was misrepresented and blamed. The legal system they had expected to represent their interests took control further away from them (Walklate, 1989; Christie, 1977). They found little comfort in official state processes and many left the legal system stunned.

Rather than finding out their experiences were unique, some of the families discovered there were many other victims and families who had experienced the same or worse. Not all of the families affected by safety crime created or joined groups, but there were a proportion in this research who met with others to work for a common cause to counter the suppression they had experienced (Williams, 1999).

Many families found the extreme emotions they experienced as a result of their grief and anger were too huge to do nothing, that they were “inescapable” and left untreated could have “become destructive” (Eyre and Dix, 2015: 21). Bereaved families spoke to others and campaigned out of a need to refocus their feelings into something that would otherwise be unbearable alone. For all of the groups, they acted in direct response to the justice system. All felt the legal system had not delivered appropriate justice and joined with others to change the system for future victims. Had the justice system represented their interests, the movements would not have been created or would have had very different aims.

The aims of collective action

The aims of the groups were centred on changing the social, legal and political landscape to prevent other people being victims. As with support and campaign groups in general, the legal system had failed or was failing their loved one, they were under represented, which they sought to change (Goodey, 2005).

The aims across all of the groups were very similar. Firstly, they saw what had happened to those killed as a result of safety crime as preventable and wanted the law to change and to hold companies accountable. The groups used collective power to define and called on the criminal justice system to respond (Miers, 2000). Secondly, for many of the groups, this meant ensuring the current law that existed worked to its full capabilities. Thirdly, the majority of the groups wanted to support families emotionally who were bereaved. These three main aims represent what had been lacking for the bereaved families. These aims will be examined below in terms of the success they had in meeting those aims and whether they counteracted the invisibility of safety crime. Every group attempted to change the law, to ensure the law that existed worked and offered emotional support to the families of victims.

Challenging hegemony, changing the law

Together, the victims of safety crime were isolated and suffered the effects very personally (Tombs and Whyte, 2015). They remained lone voices that state agencies did not pay attention to as one mother expressed "He [an employee of the CPS] was just fobbing me off and we knew this" (10). This altered when families combined with others who confirmed and legitimised their struggle. With others they found themselves in a position where they could demand more. A member of one group reflected, "It is much easier for the Government to fob off single individuals than family groups with a clear and determined purpose" (Dix cited in Eyre and Dix, 2014).

Groups such as the CCA, DA and the SJMC were active in the 1990s when the Corporate Manslaughter Law was proposed until it became legislation in 2007. As groups they represented the interests of families and friends of victims and survivors, which included those created in the high-profile disasters in the 1980s and 1990s. These disasters raised public awareness and press interest, which the groups responded to and together, as part of the corporate accountability movement, called for a change in the law (Tombs and Whyte, 2003).

Though promised when Labour were in opposition, the Corporate Manslaughter and Corporate Homicide Act (2007) took 13 years to become law, what Tombs describes as a "13-year struggle" (2013: 65). During that time government regularly consulted those who could be prosecuted by the law such as the Confederation of British Industry (CBI) (ibid.). The groups featured in this research existed as a counter to this, even though their views were not sought officially. In particular, the CCA followed the law closely, writing to the agencies directly, raising issues in the press and continually trying to engage the government. The CCA effectively pressurised the government often through the HSE, they highlighted the truth using statistics and the testimonies of families

as well as comments ministers had previously made to attempt to hold them to account, for example, David Bergman commented in the national press, “The government agreed four years ago to reform this archaic law” (Bergman, 2001: para 11).

When the Corporate Manslaughter Law caused conflict between groups because of the proposal to introduce immunity for crown bodies, groups that included the CCA, worked together. The centre sought legal advice and stood in solidarity with other groups rather than splintering and dividing the individuals involved. Such stances cut across not only individuals, but across groups. Together, they were a strong opposition to government and business groups who supported de-regulation. For a time they challenged companies and government claims of science and fact and engaged in crucial counter-hegemonic research that interest groups are rarely able to do. Their existence set an alternative to dominant narratives that attempted to attack and undermine opposition (Snider, 2003).

As part of a dominant group, companies were able to deny facts and claim legitimacy over workers and families (Tombs, 1991). This was lessened by the visibility of the corporate accountability movement who in numbers, called for change and raised awareness. The groups were:

> knowledges from below…it is the reappearance of what people know at a local level, of these disqualified knowledges that [make] the critique possible (Foucault, 2003: 7/8).

This is drawn in parallel to the testimonies of the families in the interviews in this research that “brings into play the desubjugated knowledges” (ibid: 11) rediscovering truths that have been lost,

truths the victims and families of victims have had to bear. Though the state may refuse to acknowledge they exist and resist legislation, their appearance and presence countered this. As a collective, they were better able to represent the interests of the victims that continued to be created through state inaction.

The focus on the experiences of the victims and families of victims were "knowledges from below" that fought against being "masked" by "systematic organizations" (ibid: 7).

"Recent social movements opposing corporate capital are important, and may signify an end to quiescence" (Tombs and Whyte, 2003: 64), notably in the ways their existence posit against common sense notions that are presented. For example, even though the government did not consult the groups featured in this research, it was notable that they did *not* and questions were asked about how this could be justified.

The influence of campaign groups has been noted by researchers following the collapse of the Rana Plaza factory in Bangladesh in 2013 where over 1,100 people were killed (Reinecke and Donaghey, 2015). In the aftermath, a coalition of groups were created that supported the unions. This led to the creation of an agreement between brands, unions and the campaign groups that should increase the safety of workers, which only came about because of "the heat they feel from unions and campaigners" (Hazards, 2015: 8).

Ensuring the current law works

Groups such as FACK and DA operated to ensure the law as it existed, worked as intended. By understanding and interrogating rights, they attempted to ensure that lack of power of individuals

and lack of knowledge of state agents would not lead to further injustice. A large part of this was raising awareness of safety crime and countering the invisibility many families suffered from. To change the construction of workplace deaths as accidents, groups tried to be as visible as possible (Williams, 1999).

The most visible group was the SJMC who made activism a central part of their campaign, scaling cranes, shutting down major roads and handing out literature that attempted to raise awareness of recent issues related to safety crime such as the dangers of working for a subcontractor. Their visibility was loud and expressive at various points, for example, on the victim's birthday when they forcibly shut down the agency and company who employed him. In similar ways, FACK campaigned on workplace deaths in general. They tried to reach workers, namely through encouraging employees to join unions. As part of a group, they were doing exactly the opposite of what they had been encouraged to do as individuals, remain silent and connect with others.

Providing emotional support

One of the biggest successes the individuals involved in various groups had was reducing some of the de-humanisation they experienced going through the criminal justice system. Families met with other families who had had similar or worse experiences. Isolated as individuals, most did not know of anyone who had had similar experiences. Many families became excluded from their previous lives in numerous ways as their families and friends failed to understand what they were going through. The opportunity to create or join a group offered the families a chance to create new bonds after their lives had been irrevocably changed (Williams, 1999). Together they could influence the process in ways they were marginalized from previously, "What I have gained is a sense of satisfaction for being able to use my own

tragic experience to make a difference to the lives of others" (Watkins quoted in Eyre and Dix, 2015: 116).

They did not need to explain to the people in the group how they felt and were not expected to have moved on. They were not judged or silenced by friends who grew uncomfortable, they were able to discuss what had happened to their loved ones without shame and could share their memories without worry. The families found the way their loved one was portrayed in the court was not unique, it was not personal to them, it was personal to the nature of the crime committed against them. There were other families who had all experienced much the same process, which was of comfort to some members of the groups but also increased feelings of anger and hurt.

Measuring success

Success is difficult to measure. The members had given up large amounts of time, money and their own emotional wellbeing to be part of various groups. None wanted to belong to such groups, they were compelled to become members because of their experiences. Individuals can campaign for years, attract new members and grow in influence (Best, 1999) all but one of the groups featured in this research are now inactive.

The opposition the groups pose last as long as they are active, which causes a problem to long-term resistance. The CCA were a force in the ten years they operated, more so as they grew in experience. They ran conferences that facilitated a wide network of people who connected and shared experiences, creating a wealth of information that was not being collected anywhere else, including the gathering of information on individuals killed at work. Connections with press, the HSE and ministers, all halted once they closed and the knowledge and experience of the case

workers, who had cases still open of families dealing with bereavement, gained employment at other organisations. That niche expertise could never be applied and utilised within other organisations as it had been wielded in the CCA.

The SJMC had much success in pushing forward the case of one victim, it was because of the collective effort that the case was heard in the crown court. It had been taken as far as possible and the parents of the victim recognised this when they concluded, "It is no surprise that James Martell waddled away; the miracle is that he was ever in the dock" (Hodge, 2002: para 18). It was unique because it was a highly active group made up of the victim's friends who were of a similar age (in their twenties and thirties) and created out of a pre-existing network that the victim had been a part of. The members were sure that the victim would have approved of their campaigning methods and would have done the same in their position. However that level of campaigning would have been very difficult to maintain. Being a member of a highly active group takes a huge amount of effort, emotionally, physically and financially. For some, it delayed grief, one member expressed after the SJMC had ended, "Looking back, I wonder if I didn't get much chance to grieve because I kept on fighting…at points it was knackering" (Brooks, 2002: para 20).

Disaster Action started every annual meeting with two questions, "has Disaster Action met its objectives?" and "Should the organisation continue to exist or is it time to call a halt?" (Eyre and Dix, 2016: 167). Presumably the members of Disaster Action decided in 2015 that the answer to the second question was "no" and the publishing of *Collective Conviction* in 2014 was a significant part of their legacy. Although it may also be the case that as with the CCA, that Disaster Action was forced to close, they reflect in *Collective Conviction* that out of 276 funding applications, only three were successful. As Dix states in 2015, "Disaster Action had accomplished all it could, especially given

constraints around volunteers' time, availability of funding and the need for individuals to make changes in their lives" (Dix, 2015).

For members of such groups, this was not an issue of delaying 'closure', families talked about how their lives would never be the same and nothing would change that. For example, one father of a victim said, "Even when we're enjoying ourselves…there's this guilt" to which his wife interrupted, "we don't really ever enjoy ourselves, nothing is the same" (The Human Face of Workplace Killing, 2010). However, being part of a group does require being around other people who are bereaved, other people who have been through a de-humanising process and the feelings of anger that injustice evokes. For example, one father of a victim said whilst he is involved in FACK, his wife has always been reluctant to share her feelings and to commit time to such a group in the long-term (9). Many, very naturally, move away after a period of time.

Those groups which had success in altering procedure could be linked to the extent they are connected to the government, as in Rock's (2002) study where the methods of two groups were very different. One group in Rock's (ibid.) research encouraged the use of marches whereas one worked with those at the Home Office. In the groups in this research, clear differences could also be seen. For example, DA maintained neutrality and were invited by the government to advise authorities on emergency planning response (14). In contrast, the campaigning nature of the SJMC was successful and raised visibility of the case of the victim but it also meant its members were never going to consult with or act in conjunction with the government (nor did they want to).

In different ways, both DA and the SJMC reached the government. On a singular issue, the SJMC did so very quickly, for example,

on one occasion thirty members of the campaign blocked Southwark Bridge in London until the then head of the HSE agreed to speak to them[76]. DA were "consulted by the statutory and voluntary services on how people's practical and emotional needs can best be met in the aftermath of disaster", described by a retired assistant chief constable "as that of 'critical friend'" (Eyre and Dix, 2014: 141). Whilst both groups had victories, neither were able to affect the government to stop politicians "brushing away" deaths like Simon's[77] or see "fundamental changes in the law and in business attitudes" (Eyre and Dix, 2014: 38). This was not a reflection of how hard the groups worked or what they sacrificed to support others, but an indicative of the political obstacles between a safety crime and justice.

In a newspaper article and their book, members of Disaster Action point to a success of the new law governing corporate manslaughter. When the Home Secretary introduced the second reading of the Corporate Manslaughter Bill in 2006, the passing of Maurice De Rohan, was marked (Eyre and Dix, 2014):

> The degree to which Maurice de Rohan, [the chairman and one of the founders of Disaster Action] personally, and Disaster Action as a whole, succeeded in influencing government thinking is reflected in the remarks made by the then Home Secretary (ibid.: 97).

It is lamentable that what became the Corporate Manslaughter and Corporate Homicide Act 2007 has been described as a, "disappointment" (Gobert, 2008: 413) and "conservative in form" and crucially, "unlikely fundamentally to change efforts to hold corporations legally to account for workplace killing" (Almond and Colover cited in Tombs, 2013: 65). Evaluation of the Act is detailed in Chapter One but to add to this, there is evidence that

[76] http://simonjones.org.uk/campaign/index.htm
[77] http://simonjones.org.uk/campaign/index.htm

"one form of liability is being exchanged for another" (Tombs, 2013: 70) as companies offer to plead guilty on corporate manslaughter charges if impunity is granted to individual directors (ibid.). Since the act came into force, 21 *small* companies have been convicted, all of whom could have been convicted under gross negligence manslaughter (Tombs, 2017b).

The tenacity of the groups and their existence is a threat to social order. The extent to which they can have a voice has a positive effect on a neo-liberal landscape that puts the priorities of profit and enterprise above the lives of individuals. There is no doubt that all of the organisations detailed in this research had an impact upon this landscape, most notably, whilst they were active. The CCA is unable to challenge the HSE, it can no longer draw together key actors in the arena of health and safety or support family members in their fight for justice. Even though for ten years it answered Ann Elvin's desire for a helpline for those bereaved following a death at work, it also ended, just as the Relatives Support Group that she managed to create in the early 1990s did. Currently, there is no number for relatives to call when they need help and holding the HSE to account is now reliant upon the efforts of individuals working with charities and labour organisations such as the Institute of Employment Rights. In spite of the fact that "Regulation in the UK is under continued material and ideological attack" (Tombs, 2013: 11) the defence mounted to halt this has diminished since this research began.

Together, the groups covered in this research were part of the corporate accountability movement from 1980 to at least 2010. This has countered invisibility and reduced some of the harm enacted by the justice system. They have not overcome the huge political obstacles, which provided impetus for their creation. However, their existence was and is crucial to stand in opposition to the dominant discourse and the support they offered survivors (in the case of DA) and secondary victims, is incredible.

Conclusion

The crimes featured throughout this research had no chance of justice. The discourse that a death in a workplace is an accident was prevailing and powerful. It affected those working in the criminal justice system, from the police to the judges who were reluctant to re-frame companies as criminals and not victims of misfortune. This research argues that the judgements made or not made were not reflections of what happened that caused the death of the victims but were instead constructed as 'accidents'. The truth that might have led to a criminal judgement was suppressed.

This research has detailed how this suppression occurred and the process of the social and legal obstacles. Obstacles encountered at the initial stage, at the hands of the police included a perception no wrongdoing had occurred because there was an absence of foul play. Because companies are not routinely suspected of criminality, the scene did not need to be sealed, evidence collected or witnesses cautioned and interviewed. Instead the family of the victim were asked about the state of mind of the victim and their belongings (such as a car) were seized. Three of the 11 passed this stage and had a full police investigation. A further case had a police investigation following complaint.

In all but one of the cases, the families who did have inquests, waited years until they sat in front of the coroner. Here, the families had to defend their loved one against claims that they caused their own death, even though they were clearly told that it was not the place of the coroners court to apportion blame. Using the evidence gathered (or not) by the police and HSE, they had to prove the innocence of the victim. Finances were necessary for representation at the inquest, to access transcriptions and to be present to hear the case at all. In five of the cases, the victims were

working away from their home, indicative of subcontract work, which meant the inquests took place miles away from the homes of the families. The families had to fund travel, overnight stays and food, before they even approached paying for 'extra' court costs. In the majority of cases, the coroner summed up and directed the jury on the available verdicts based on their interpretation of the narrative. One of the eight cases to be heard at the inquest received an unlawful killing verdict, the rest all shared an 'accidental death' verdict.

The cases that made it to the crown court had to build a case with the available evidence strong enough to prove *mens rea* and *actus rea*. Finances again were needed to pay for transcripts and legal representation. It was necessary for the families to arrive early if they wanted a seat in the court. As was the case at the inquest, by this time, all of the companies were keen to prove their innocence by way of establishing the guilt and culpability of the victim. What appeared rational was contested if the evidence was not strong enough to contradict it. Three of the cases passed the test of the CPS to get to this stage (one of them by way of a judicial review). None of the cases left this stage with sentences that were upheld. Every company in this research was officially judged to be innocent of corporate manslaughter.

Five of the cases went to court to see the companies face health and safety charges, five of the cases reached this stage and saw the company fined for the breach that led to the death of their loved one, rather than the result itself. Fines reflected the sentencing guidelines and were low and as a consequence, one family was offered apologies by the judge. The Sheriff turned to the family and said, "…this should have been in the high court". The wife of the victim said the Sheriff, "apologised" before explaining the fines he gave out were "the top fines I can give out" (6). The process and official guidance had restricted the punishment and the Sheriff was only able to informally console the family of the

victim. In another example, a father of a victim recalls that when the jury returned to give their verdict, two of the members were crying “because all they could do was give a verdict of accidental death” (3).

Reactions to the verdicts and sentencing were varied, one mother of a victim stated, “I will always remember looking at that jury” (10), another wife of a victim recalled that upon sentencing there was “pandemonium, there’s no other word for it…I just kept screaming ‘murderers’” (6). One wife shielded herself from the entire process and would not allow her parents to tell her about it (7). The majority of the families were not shocked by the time of sentencing, they realised the process in the court or at the inquest was not going to lead to a favourable outcome for them or their loved one who had been killed. Any faith they had, had slowly reduced in the period of time between when they were told about the death of their loved one and the court case and/or inquest. In two out of the three cases which proceeded to the Crown Court, the families held out hope of holding the companies to account but realised during the proceedings that the sentence was not going to ‘go their way’. One mother of a victim said, “as soon as I heard his [the judge’s] closing speech, I thought we’d lost it” (8). The reactions were one of huge disappointment and trying to come to terms with what had happened and to wonder if they could have done more. More than one family expressed they took comfort in the jury members who they felt were “on our side” (5) even if that did not affect the overall outcome. The jury members might have shown they were unhappy with the verdict they delivered, constrained by the system, pushed to deliver someone else’s verdict.

More than one family member left the process with the perception and utter distress of thinking they had let their loved one down. Bereft they trusted the company in the first instance and then in the justice system, they cursed themselves for allowing their loved

one to be blamed. Incensed and nowhere to go after they witnessed that their son who had been killed was treated as 'nothing' and incredulous when the company expressed joy when legal proceedings had ended (10). Their loved one "didn't stand a chance" (10). This secondary victimisation caused long-term pain and isolation to the families.

Half of the family members went on to create or join groups to do something in the name of the loved one they had lost. The various groups that have been created by families, angry and frustrated at their own experiences, were examined. For many involved, they were able to remove or remedy some of the obstacles they had experienced as individual, bereaved family members. What they changed were the experiences of others going through the process, for example, reducing their feelings of isolation and guilt, and helping them to resist suppression at every stage. To sum up, by working in a group, the families refused to become invisible. What could not be changed was a sign of what the government permit and uphold. Change to address safety crime requires "both political will and financial investment" (Tombs and Whyte, 2003: 144), which the government shows no sign of providing. Instead, in a neo-liberal market hegemony (Tombs and Whyte, 2003), the system delivered to respond to safety crime would prefer to "sacrifice rather than realise…the principles of natural justice" (Scraton, 2009: 267). What was left - regulation - continues to fail to set the standard for justice and the fair treatment for the victims of safety crime, their families as secondary victims and in the deterrence of future safety crime victims.

Safety crime, as is the case with the presence of economic crime on crime, law and order agendas, "requires consistent effort to keep it there" (Tombs and Alvesalo, 2002: 29). The groups examined in this research put much force and determination into doing this. They were consistent at being conspicuous, refusing to sit quiet and acquiesce to invisibility, as much as they were

nudged by the official response. The groups were consistent too, for the period the groups were active, which for all but one group, has come to an end. It is the consideration of this research that the groups including those who formed part of the corporate accountability movement, could maximise the challenge they mount if they could combine with critical criminology and victimology (Williams, 1999). There is "enormous positive potential" (ibid.: 137) for the movement to continue and the need for this has unfortunately only increased in the period since this research finished. Health and safety legislation has continued to be attacked, work has become more insecure, legal aid has been slashed and the groups featured in this research have almost all ended. For the movement to continue, it requires the families work collectively with each other finding commonalities and with critical theorists who have a duty to highlight injustice and push for change, as Mathiesen observed, "It cannot take place from the writing-desk alone" (1980: 301).

Conclusion

This thesis came out of a desire to answer questions that I found confusing to me as an undergraduate in 2000 and in the years following graduation. As the introduction attested, it was an 'itch' that could not be 'scratched', even as time away from education increased. Stories leapt out of the local newspaper, small by-lines that reminded me of Sidney Rouse.

Sidney Rouse was described by his sister as "a very friendly and homely person" until he "caught the entire blast of a short circuit" and died after ten days in hospital when a skin-transplant treatment failed (Bergman, 1991: 7). This case returned a verdict of 'accidental death' at the coroners court and the HSE did not prosecute. The literature I read as an undergraduate stated that little had changed and a lack of official action was still to be expected if you were killed at work. It seemed obvious that crimes were taking place and also apparent that justice was not being delivered. In order to find out why, this entailed entering into the study of criminology and specifically, safety crime.

Gap in the literature

To my knowledge, this is the first PhD thesis, certainly in the UK, which accesses the experiences of those bereaved as a result of safety crime. This thesis has attempted to attend to this gap by generating original qualitative data about their experiences as they are processed by the criminal justice system, from the police, to the HSE and in the courts.

Further, it is the first PhD to examine the origins, methods, aims and success of the corporate accountability movement which was established in response to corporate killing. Through both accessing original qualitative data as well as creating cases studies using original, secondary and publicly available sources.

In combination then, this thesis has provided a unique insight into the experiences of families of victims as secondary victims, who are neither represented nor treated as real victims. It is an original contribution to the understanding of the details of the process that slowly renders them invisible, the personal consequences of this for the families and their collective response. To conclude, this thesis has interrogated the extent to which the collective response can be successful.

Chapter overview

Chapter One reviewed the development of the study of crimes of the powerful. This demonstrated that criminology has focused on 'traditional' crime and 'traditional' criminals. It has been "distinctly disinterested" in a criminology that places the state at the centre of analysis (Hillyard, 2003: 201). The relatively small amount of critical research that does exist has shown this focus to be disproportionate, "justified neither theoretically nor empirically" (Tombs and Whyte, 2003: 267). The study of white collar, corporate and safety crime is recognition of the space between crime and what the law recognises and crucially, *responds* to.

Moving to focus on safety crime, researchers have shown that crimes committed by companies are widespread and harmful. The law has developed, but at a slower rate than the corporation, which has evolved dramatically in ways that has made it easier to disperse responsibility whilst maximising profit, for example, through the increasing use of subcontracts. The inability of the law

was demonstrated in a number of high-profile cases in the 1990s that repeatedly failed to overcome the barrier of establishing the *mens rea* of a company. As a lesser punishment, companies are prosecuted for health and safety offences, in regulation that is rooted in consultation and acceptable laws (Carson, 1979).

Political responses have been to agree with, and perpetuate, the notion of health and safety as burdensome and requiring de-regulation. A plethora of research has attempted to counter this dominant discourse and call for change in academia and publicly. It counters continuous de-regulation as an appropriate course of action (Gobert and Punch, 2003; Tombs, 2016). This is crucial for the victims of safety crime.

Chapter One also introduced the study of the victim, bringing together safety crime and victimology, two narrow, and critical, areas of criminological study. The social, legal and political conditions are not favourable for the victims of safety crime and they are not used to support claims for increased sanctions against companies. The victims of safety crime are not 'ideal victims' (Whyte, 2007; Christie, 1986) and are denied legitimate victim status by the state. This leads to emotional, physical and financial harm (Spalek, 2006).

Chapter Two outlined a methodological approach to the data detailed in Chapter Three and Chapter Four. Research that focuses on crimes of the powerful does not benefit from a wealth of pre-existing research methods (Pearce, 2003). Unique difficulties are experienced by those wishing to look upwards rather than downwards, for example, finding funding and publishing potentially liable research. Researchers have overcome such barriers, carrying out the collection of quantitative data and

compiling case studies (Punch, 1996; Tombs and Whyte, 2007). Similar methods were chosen for this research.

In order to give voice to the victims of safety crime, qualitative data was sought through semi-structured interviews. The interviews became less structured as increasing experience allowed the families of victims to control more of the process. This led to in-depth data and for the testimonies of the families to be the ultimate focus. For the second part of the research, to detail the corporate accountability movements, case studies were chosen as the best method to observe the history and successes of the groups. As a piece of sensitive research, the methods and nature of gathering data were considered carefully. The personal impact of doing such research beyond the time of the interviews was not anticipated, which made it impossible to "keep the social world at arm's length" (Blaikie, 2004: 136).

Chapter Three was the first of the original data chapters that demonstrated the social and legal obstacles the families experienced as they worked their way through the criminal justice system. This chapter looked at the ways the families were suppressed by the police, the CPS, the HSE and the courts. Pushed towards accepting that what happened to their loved one was 'accidental', the truth was not put at the centre of the criminal justice response, but an obstacle that was suppressed. This relied upon any dissenting voices being silenced, which wounded the families as they left the process.

Those involved in the criminal justice system, from the police to the judges in the Crown Court were influenced by the perception that a death at work meant it was accidental. It disabled the cases from the start, for example, in the failure of the police to caution

prospective suspects. This made it close to impossible that the families would realise justice.

The truth was a construction, manipulated by the company and enabled by the system. The scope for justice was almost impossible and showed itself to be reliant upon a huge number of variables that inevitably ushered the majority of families out of the process. This left them to cope with their grief but also, as a result of the process, the families were left with guilt, guilt that they should have done more to defend the loved one in response to their treatment by the state.

Chapter Four examined the political obstacles the families experienced. Many resisted their suppression, as detailed in Chapter Three. They had their own ideas about what justice was and when this was not met, many focused their anger and frustration into the facilitation of various groups. This chapter looked at the aims of a number of groups that arose in the 1990s and 2000s with the methods they chose to resist.

As part of the corporate accountability movement, groups representing safety crime were one set of voices who openly countered the pro-business lobbying that attempted to make the law more amenable to companies (Tombs and Whyte, 2015). Clearly, the interests of business are set in opposition to the needs of workers in that giving protection to workers is a threat to the function of companies and the powerful. As the force of workers has diminished since the 1960s, it falls to the families of dead workers and members of the public, to fight.

The levels of success they achieved in countering their suppression and in making policy change were examined to reveal what the government permit for victims of safety crime. The corporate accountability movement attempted to engage with the government on the issue of safety crime. Their existence was part of countering the suppression they had experienced as individuals.

Chapter Five combined the data of Chapter Four and Chapter Three with the literature in Chapter One. There is a gap in the experiences of victims of safety crime, who in a small area of criminal justice and academia, are experts in their own cases. Their testimonies are witness to the existence of the victims that are continually suppressed and navigated away from the criminal justice process.

In the first instance, the strength of the prevailing discourse is demonstrated in the ways we do not fear work, but aspire to be 'good' and 'hard' workers. This entails obedience, which had a negative effect on the survival of more than one victim featured in this research. As an employee or a member of the public, trust had to be given employers and those delivering services. When this trust is broken by the companies, this thesis has demonstrated that the consequences are felt by the victims and by their families, beyond the effects of immediate and long-term grief.

As the companies rushed to prove their innocence, they did so by finding fault in the victim. This was enabled by processes of the state, which failed to address the inequality between the victim and the perpetrator. Instead this inequality favoured the company in the pursuit of justice. Socially, legally and politically, the families of victims of safety crime were blocked.

Reflections of the research

This research showed the reality of the families who had been suddenly, and needlessly, bereaved. In retrospect, this is a strength of the research. The emotions of the families are not encouraged at any stage of the criminal justice process, they are actively suppressed by official procedures. The interviews demonstrated how the families had their life before their loved one had been killed and their life after. On every anniversary, birthday, wedding and death, the families missed their loved one. Whilst this is part of grief in general for many, the anguish the families felt in this research was exacerbated from the reactions of others and the way they, and their loved one was treated by the agencies who were foisted upon them. The semi structured interviews demonstrated this secondary victimisation very clearly as the families shared their experiences. As the researcher, their words and the way the families articulated their painful exasperation is impossible to forget.

A weakness of this research is the sampling and that the families were selected by the CCA and contacted first by them. As explored in Chapter Two, there are various reasons for this. However, it does focus on recording the experiences of families who had support of the CCA in common. It does not gather, or recognise the experiences of families who had no support or intervention from agencies. It is difficult to surmise the impact of this. It is noteworthy that when less than 20% of the British workforce are members of trade unions (B van Wanrooy *et al* cited in Ewing *et al*, 2016) approximately 1,179 people killed at work are unrepresented, every year in the UK. It is impossible to determine how many of those families did not feel able to question the circumstances that led up to the death of their loved one, how many deaths were not investigated at all and how many families were suppressed by the process. The change in the law and the need for recognition is absolutely crucial for these individuals too.

This research focused on deaths at work. It did not research the experiences of workers who have received life changing injuries as a result of work. In 2007/8, 32,810 fatal and major injuries were sustained at work, with a mere 7.3% of those investigated by the HSE (Hazards, 2009). With so few being examined, this is another group who are harmed by companies, yet remain invisible.

A weakness of this research is the time it took to complete. There was never any intention to spend as much time as I did, every decision I made, I envisaged would provide more time and each time, I was proven wrong. For example, moving into teaching and going on maternity leave (twice) definitely did not free up my time! As a self-funded, part-time student, writing up became a hobby that was not prioritised over the requirements of daily life as a mother, teacher and wife. That said, the fact this research spans almost ten years meant that interestingly, but also sadly, the majority of the groups who were part of the corporate accountability movement, closed. This leads to the next point.

The closure of the majority of the groups featured in this research means that families who lose their loved ones at work today are in a worse position than families ten years ago. Calling the telephone numbers of both the CCA and Disaster Action will not lead to any kind voice or crucial knowledge, support which was crucial to many of the families in this research. When asked what they would advise other families to do, an ex-wife of a victim said everyone should talk to the CCA (2), another commented “what would we have done without the CCA?” (6). The wealth of information gathered by the groups who have closed, the SMJC, the CCA and DA is available on webpages, but has been limited and there is nothing up to date. What has changed, as discussed before, is the fact that corporate manslaughter is now a recognisable term. This gives the families a discourse to utilise and they may not have to grapple with explaining their

experiences as families did in the 1980s and 1990s. However, this does not mean they are more likely to achieve justice; the same obstacles that existed in 2007 still remain in 2017. With regard to official legislation, The Corporate Manslaughter and Corporate Homicide Act is untested and at this time, has not increased the number of prosecutions or severity of sentencing following a corporate killing. The Protocol of Liaison in England and Wales (1998) was in place before the death of all but one case, yet was rarely adhered to. Further research would need to be carried out to discover whether this has started happening since 2012.

Safety crime today

The scope of the company has continued to expand. In the 1990s and accelerating after the millennium, the operations of business is "represented as *a good end in itself*" (Tombs, 2017: 41, emphasis added). Those involved in business are "seen as positive moral agents within our own society" (ibid: 36) and the entrepreneur is celebrated as a deserving celebrity, even if, as is the case with Richard Branson, they have only been profitable in businesses that had government intervention (ibid.). With the expansion of the company and its new found status in society, business needs are prioritised. For example, when the multi-national corporation Siemens, agreed to build a factory in Hull, local politicians and media expressed their delight that Hull would be "booming" again (Hull Daily Mail, 25th March 2014). It is worth noting that this celebration did not come without promises from the state. Siemens were attracted to the area because of its location in an Enterprise Zone, which entail government promises to provide discounts on business rates, simplified local authority planning, superfast broadband and tax relief (Hull Daily Mail 24th March 2014). Companies and the state are inexplicably intertwined.

As much as entrepreneurs have been viewed as the new messiahs and business takes on a higher status, there has been an increased willingness to question organisations in authority in the last ten years. In 2008, the banking crisis led the term 'banker bashing' to be used publicly (Tombs, 2017: 56). Tax evasion and avoidance schemes are common public knowledge with celebrities named and shamed in public in published articles such as *Payback for good: Take That and the other penitent tax avoiders* (Usborne, 2016). In 2013, the BBC noted "the tide of public opinion is visibly turning" against global companies including Starbucks, Amazon and Google who pay a small percentage of tax against huge profits (Barford and Holt, 2013). Although tax avoidance is legal, a number of celebrities and companies such as Starbucks paid money to HM Revenue and Customs (HMRC) in response to media coverage and widespread public condemnation. Barford and Holt note, "10 years ago news of a company minimising its corporation tax would have been more likely to be inside the business pages than on the front page" (2013: para 6). The public are more distrustful and suspicious of companies in some cases.

Trust in institutions has reduced as a result of other high profile cases, among them the Stephen Lawrence case and Hillsborough. Hillsborough is a:

> story of how those in authority sought to cover their tracks and avoid blame and responsibility…of how ordinary people can be subjected to the insensitivity and hostility of agencies that place their professional priorities ahead of the personal needs and collective rights of the bereaved and survivors (Scraton, 2009: 17).

The public perception of the families and survivors of Hillsborough has altered drastically, from the Sun headlines *The Truth* in 1989, which claimed Liverpool fans were to blame and

had attacked police as they helped the dying and *The Real Truth* in 2012, which publicly apologised and highlighted how police had deceitfully blamed Liverpool fans. The public are aware of what happened in Hillsborough, informed of the truth by the families and the survivors who were denied access to it, suppressed by 'official' accounts.

Rather than being silenced, many of those bereaved work with other families in the name of their loved ones and for future victims, to prevent similar suffering. The state reassures that 'lessons have been learnt', while the families of victims mobilise to try to make that rhetoric, a reality. Their experiences are real and their suffering is unnecessary. There are an untold number of victims and families who have no idea what has happened to them. They have not had the benefit of any support from any organisation or met with any other family to share their experiences. Those families too, need to have a voice and critical criminology and victimology is one way to do this, to make sense of their experiences and call for change. Just as feminist "principles and ideas and beliefs and commitments have flowed out" as a "self-organised politics, taking place from the ground up", interfering with the status quo and bringing about change for women (McRobbie, 2009: 2), so can critical criminology and victimology for the victims of safety crime. The Hillsborough case demonstrated how:

> the bereaved and survivors remained resilient, their resistance and their determination to honour those who died challenging powerful institutions, changing history and serving a wider public interest (Scraton, 2009: 10).

The families had their own thoughts on what should be changed with regard to responses to safety crime. Families referred to the

lack of awareness on work-related deaths in general, both on the part of members of the public and in workplaces, for example, in not marking Workers Memorial Day (3). The notion of having a person assigned to the families, akin to a FLO was mentioned more than once, to guide those bereaved and "point [them] in the right direction" (4, 5). Legal aid was referred to as inadequate, as one wife of a victim stated, "you shouldn't have to pay for legal representation" (4). Since that time the situation has worsened after a cut in spending on legal aid amounting to £350 million under the Legal Aid, Sentencing and Punishment of Offenders Act. An act which Amnesty International claims has created a "two-tier" system, "open to those who can afford it, but increasingly closed to the poorest and most in need of its protection" (Amnesty International, 2016: 3). One father stated he wanted to see companies being forced to adhere to the legislation already in place and to lay the burden of proof on the companies to prove they are safe (11).

The future of the study of safety crime

Future research should continue to dispute the processes that make safety crime invisible or 'acceptable'. This could involve looking at those individuals who sustain life threatening injuries or trying to reach families who have not had any support from agencies. It is also not a case of doing anything different, but to pick up where the groups stopped and work together to keep challenging common sense notions of health and safety. At the start of this process, I did not imagine agencies such as the CCA would close, which is a great shame for secondary victims, workers and members of the public. The work of the various groups needs to continue and be built upon rather than being forced to start anew. The only way the wishes of the families outlined in the previous paragraph can be achieved is through such groups.

From contributing to counter-hegemonic groups to supporting the families of those affected by safety crime, those working in this area are crucial. The support and campaign groups undoubtedly have a life cycle as people grow tired or move onto other jobs. But it is unfortunately true that victims continue to be made, creating secondary victims who are newly angry and willing to devote their time and to push for justice. Those families make a real difference, to the lives of other family members and in the ongoing pursuit of accountability.

Practicing critical academics have two obligations. Firstly, they have an opportunity to support such bereaved individuals, directly by communicating and working with them in support, or indirectly, by writing to counter the invisibility that is pressed upon them and revealing the families who never come into contact with anyone. The term ‘corporate manslaughter’ is now in the public domain, giving the press, but more importantly bereaved families, a language and a discourse to navigate through if their loved one is killed. A quick search on the internet reveals a world the families can enter and be instantly better informed and with substantially more knowledge than individuals were thirty years ago.

Secondly, and somewhat crucially, academics must work to entice the next generation of individuals to engage with students and members of the public so they can continue to work for widespread change. Creating critical programmes at foundation, under and postgraduate levels, participating in media campaigns and trade union conferences, in daily interactions to counter ‘common sense’ notions of health and safety and creating new research projects. This must be incessant and ongoing until the actors are irrelevant. The families and the academics may change, but the cause does not and there is much more to be done until the

experiences of the families in this research are not repeated, every day in the UK.

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Appendix 1: Letter sent to participants with pre consent form

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Dear Sir/Madam

My name is Katy Macvay and I am writing to you regarding the research project that I am undertaking as part of my doctoral degree at Liverpool John Moores University

This research project focuses on the plight of those bereaved following a work-related death or where members of the public have died where the circumstances raise questions about the working practices of an organisation. It aims to create a picture of what it is like to lose a loved one and then to have to work through our current criminal justice system. This is reflected in the project's title, '*putting victims at the heart of the criminal justice system: an investigation of victims' experiences via a critical examination of the social, political and legal obstacles faced following a corporate killing'*. By doing this I aim to determine the obstacles to and prospects for a more just treatment of the victims of "corporate crime" in general and "corporate killing in particular.

At the core of the project is the collection of information and insights from those who have experience as bereaved following a work-related death or where members of the public have died where the circumstances raise questions about the working practices of an organisation. Therefore, the project is heavily dependant upon the co-operation and willingness of people such as yourself to share your experiences.

My aim is to collect this information via semi-structured interviews; more akin to conversations, these face-to-face interviews are nevertheless structured around a number of key areas that I would like to discuss with all participants, relating to their experiences around the death of their loved one. I appreciate that this is the most sensitive of discussions, and I have taken every step, with the guidance of the University, to ensure that any interviews are approached and conducted in a sensitive and safe fashion. Thus I can be as flexible as possible as to where and when this is done and what would be best for you.

For the ease of recall and accuracy, I would prefer to tape the interview, although this is not absolutely necessary and, if you were unhappy at this, I would refrain from doing so. In the event of recording the interview, any such recordings will be anonymised (eg. the labels on tapes will be coded) and stored in a locked and secured location in the University for the duration of the research; all tapes will be destroyed once the research is completed. Your comments will at all stages of the research remain anonymous - no one will be able to identify you in my Doctoral thesis or in any articles that are to be written about the project. I would also like to reiterate that the data gathered from these interviews or any help given in the research process will be used **STRICTLY** for academic purposes. Attached to this letter is a copy of the consent sheet that you will be asked to sign in the event of agreeing to participate.

As part of agreeing to be interviewed as part of the research, you have of course the right to withdraw from the research at any stage and the University stipulates that you should do so, then any data that has already been collected will not be included in the final thesis. Any interviews that have been taped or used will be sent to you for your perusal, to maintain a high standard of accuracy and ensure that you have not been misquoted. Additionally, you have the opportunity to change or add to what you have said at a later date to make sure that you are represented correctly. There will be many opportunities where any concerns can be discussed to ensure that should you agree to take part, you are as comfortable as possible.

Please see the tear off slip below, which I hope you will complete. As indicated there, in the first instance any positive response from you will only be the basis for discussing further the logistics, content and conduct an interview. Should you choose not to participate, then may I apologise in advance for the intrusion of this letter, thank you for your time in reading it, and wish you the very best.

Sincerely Yours,

K. Macvay

Tear off here

Please tick one:

I do NOT wish to participate in this research project,

nor to be contacted again about it.

_____

I am willing to discuss participation in this project

_____

If you have ticked the option above indicating that you are willing to discuss participation, you may wish to add your contact details (one or both):

Tel.: _____

E-mail: _____

Please return this slip in the enclosed envelope. Or should you wish to discuss this further, you can contact me at **ADD DETAILS**

Appendix 2: Consent form at the time of interview

Participant Information Sheet

Name of experimenter: Katy Snell

Supervisor: Professor Joe Sim

Doctor Janet Jamieson

Professor Steve Tombs

Title of study/project: Putting victims at the heart of the criminal justice system: an investigation of victims' experiences via a critical examination of the social, political and legal obstacles faced following a corporate killing.

Purpose of study: To conduct case studies in order to access the various experiences of victims of a subset of corporate crimes, namely safety crimes and, more specifically, corporate killings.

Procedures and Participants Role: To participate in a semi structured interview and answer the questions as honestly as possible.

Please Note:

All participants have the right to withdraw from the project/study at any time without prejudice to access of services which are already being provided or may subsequently be provided to the participant.

Consent Slip

I understand that by signing this form, I am agreeing to participate in this research project as an interviewee under the conditions set out in the accompanying letter.

In particular, I understand that any information that I provide shall be anonymised; if stored on audio-tape, these will be safely secured and, at the end of the research, destroyed.

Signed: **Date:**

Appendix 3: University Ethics application

APPLICATION FOR APPROVAL OF AN INVESTIGATION FOR

TEACHING, TESTING OR RESEARCH INVOLVING HUMAN SUBJECTS

THIS APPLICATION MUST BE TYPED.

In designing a research, teaching or testing project involving human subjects, investigators must be able to demonstrate a clear intention to benefit society and the project must be based on sound scientific principles. These criteria will be considered by the Ethics Committee before approving a project or practical demonstration.

Applicants are strongly advised to contact an appropriate member of the Ethics Committee to discuss their project before submitting an application.

SECTION A: THE APPLICANT

A1.Full Name & Status (e.g.staff/student)	Katy Macvay
A2.Relevant Qualifications	Social Policy and Criminology BA (Hons) 2:1

A3.Address for correspondence from the Ethics Committee (it is important that you notify the Ethics Secretary of any changes to this information).

The Laurels

Barrow Road

New Holland

SECTION B: THE PROJECT

B1.What is the title of this investigation

Putting victims at the heart of the criminal justice system: an investigation of victims' experiences via a critical examination of the social, political and legal obstacles faced following a corporate killing.

B2.Is this investigation (*please tick*):

a research project? ✓ a teaching exercise? ☐

an undergraduate project? ☐ testing on members of the public? ☐

B3.Have the full details of the procedure been appended? (please tick) yes ☐ no ☐

B4.Likely duration of project and location of study:

start date 01/06 end date 01/12

location

B5.Does your research involve collaboration with an NHS Trust, participation by a member of Trust staff, access to Trust premises or patients, tissue samples or any biological material, or access to Trust information in any form including anonymized retrospective data?

☐ Yes ✓ No

If the answer is yes please complete the attached NHS Research Governance Audit Proforma

B6.Brief description of the ethical nature and purpose of investigation

During this research, willing volunteers will be used during semi structured interviews. This will depend upon recounting their experiences and re-visiting past events, which they may find distressing.

The purpose of the investigation is to gather qualitative information about the person's experience within the criminal justice system following the death of a relative/friend as a result of a corporate or safety

B7.Briefly, what benefit to society will accrue from this project?

The benefit that society will accrue from the project will be an awareness of the experiences of victims of corporate/safety crimes, an experience that is neglected in comparison to the documentation surrounding victims of common crimes, such as violent and acquisitive crime.

B8.Specify the particular procedure which involves the subjects participation

The procedure which involves the subjects participation is the collection of data used for the case study, namely the semi structured interviews.

B9.Are any novel procedures involved?

No novel procedures are involved.

B10.State the potential hazards to persons resulting from the project. Identify the level of risk to persons and the precautions to be taken. (If risks identified a Risk Assessment Form EC7 must be included with the application)

No potential hazards will result.

B11.State the degree of discomfort to persons involved in the project in terms of pain, apprehension, stress and disturbance to routine.

The recounting of painful past experiences may cause discomfort. To deal with this, the participants will be informed of their right to stop the interview at any time and will be aware of what the information they give will be used for. Care and attention will also be paid to those selected for interview and their ability to cope with the questioning.

B12. State your experience or that of the investigator/s in this type of investigation

I have experience of semi structured interviews from my full-time occupation where I conduct, on average, two semi structure interviews per week and have done so for over a year. I am aware of the different types of questioning that can be used and the advantages and disadvantages of semi structured interviews.

B13. Names and qualifications of personnel who will be supervising the project

Professor Steve Tombs

B14. The Ethics Committee needs to know if similar work has been undertaken before:

B14.1 What other work do you know of that has been done in a similar subject area and how does this relate to your proposed programme?

B14.2 Please give a brief description of the parts of your study that will be completely original

The part of the study that is original is the case study that will study the experiences of the victims of corporate killing and the use of the semi-structured interviews with individuals and representatives of, and case workers within the organisations that are campaigning in the area. This will create a picture of the victims' experiences of law and the criminal justice system and what they wish to happen in the future. This will be used in addition to interviews with key individuals in the institutions that react to corporate crime and contrasted with research already completed on the crime, death by drink driving.

SECTION C: SUBJECTS

C1.How will the subjects be recruited? (**NOTE**: If subjects are to be approached by letter, you MUST attach a specimen copy to this application)

C2.Number and type of subjects likely to be involved

C3.Age range of subjects to be recruited: 18+

C4.Are questionnaires to be used in this investigation? Yes

C5.Have they been validated previously?

C6.If yes, state by whom and when, (if no, you **MUST** include copies of the questionnaire/s with this application)

C7.Will pregnant women be excluded? ?

C8.State whether the subject's informed consent will be obtained (*please tick*):

orally:	yes	✓	no	
in writing:	yes	✓	no	
in the presence of a disinterested third person:	yes		no	

C9.If written consent is necessary, please state if form EC3 will be used. If not you **MUST** provide a copy of the consent form.

Normally, consent should be given in writing and witnessed by a disinterested third party unless the applicant can show good reason why this should not be the case. Consent forms for adults (EC3) and for parents/guardian/carers of children/adults incapable of consent (EC4) are available.

If an alternative consent form is to be used, you MUST attach a specimen copy to this application.

C10.Will the subject be subjected to any x-rays or ionising radiation?

yes ☐ no ☑

If yes, how often? ☐

SECTION D: DECLARATION

D1.Notwithstanding the declaration at the end of this form, has each investigator read, understood and accepted the Liverpool John Moores University Ethics Committee's Regulations and Guidelines?
(Please tick)

yes ☑ no ☐

(The World Wide Web address for guidance is:
http://www.livjm.ac.uk/research_and_graduate/regulations/hum_vols/index.htm*)*

D2.If the investigation is a research degree project, append a copy of the completed Section 4 of the Liverpool John Moores University Research Degree Registration Application

D3.If the investigation is a teaching exercise, append the exact practical schedule as it will be presented to the student

D4.If the investigation is a final year undergraduate project, append an exact copy of the project as presented to the subject.

D5.If the investigation is a research project, append an exact copy of the project as presented to the subject.

D6.**Declaration** (**to be countersigned by the Director of School**)

I declare that the proposed investigation described in this schedule will be carried out only as described and that at all times the Regulations and Guidelines of the University's Ethics Committee will be adhered to. Before any deviation from the investigation described or from the Ethical Regulations takes place, the written permission of the University's Ethics Committee will be sought.

Applicant's Signature	Director of School's Signature
Date	Date

The completed form should be returned to the Ethics Committee Secretary, Rodney House, 2nd Floor, Liverpool, L3 5UX.

Checklist: Please make sure the following are included in submission

- **Copy of Application Form (EC1)**
- **Relevant Consent Form(s) (EC2), (EC3), (EC4)**
- **Participant Information Sheet(s) (EC6)**
- **Copy of questionnaire (if applicable)**

Risk Assessment

Name of experimenter: Katy Macvay

Supervisor: Professor Steve Tombs

Title of study/project: Putting victims at the heart of the criminal justice system: an investigation of victims' experiences via a critical examination of the social, political and legal obstacles faced following a corporate killing.

Purpose of study: To conduct case studies in order to access the various experiences of victims of a subset of corporate crimes, namely safety crimes and, more specifically, corporate killings.

Procedures and Participants Role: To participate in a semi structured interview and answer the questions as honestly as possible.

Assessment and Mitigation of Risks

Discussing the death of a loved one with the bereaved is of course extremely sensitive, and thus the project may entail risks in terms of causing distress to interviewees. Relevant considerations include:

- the active agreement of participants to be interviewed;
- the fact that the sample is to be drawn from victims organisations, thus making it likely that amongst the total population of the bereaved from workplace killing, participants in this study are those most wiling and able to discuss their experiences.

However, it is possible that recounting the circumstances of and following the death may cause distress. To manage this potential issue, participants are:

- invited to have the interview conducted in familiar and secure surroundings, for example their home or the home of a friend or relative;

- informed that the interview may be conducted in the company of a friend or relative;
- asked as a matter of course to inform someone close to them that they are taking part in the interview, when and for roughly how long, and to ensure that s/he is contactable during the duration and immediately after the interview;
- informed that they may stop the interview, and/or cease to participate in the research process, at any stage.

Appendix 4: Interview Schedule (1)

Victim Questionnaire

Aim: - To document and detail the experiences of the families and friends of people who are bereaved following a work-related death or where members of the public have died where the circumstances raise questions about the working practices of an organisation.

Date:

Participant's full name:

County of current residence:

County where incident took place (if different from above):

Can you tell me, in your own words, about the circumstances of [name/ your loved one's] death?

When did this happen?

Thinking back to then, which of the following official agencies did you come into contact with?

a. The Police
b. The HSE
c. The Coroner
d. Hazards
e. Centre for Corporate Accountability
f. The Simon Jones Memorial Campaign
g. Families Against Corporate Killing
h. Trade Unions
i. Victim Support
j. Probation Service
k. Crown Prosecution Service
l. MP
m. Other

If so, what are your views about the nature of these contacts? Including;

- Length of contact

- First point of contact (time and why)
- Frequency of contact
- Satisfaction of contact

What contact did you have with the company or companies involved in the death?

Were you given the opportunity to write a Personal Victim Statement? If yes:

Did you do one?

Did you have any contact with the media?

If so, which organizations?

Why did they contact you?

Were you satisfied/dissatisfied with the way you/the case was represented in the media?

How has this affected yourself and others?

What has been the worst result of this crime?

What would have eased these effects (reference to the criminal justice system)?

What successes did you have throughout the process?

When were you aware that it was a crime and not an 'accident'?

What impact did that have on you (including emotionally)?

How did your family and friends react to this assessment?

What would you change about the process?

What advice would you give to others who may find themselves in your situation? What would you do differently?

What would have constituted 'justice' for you in this instance?

Are you currently involved in any process to achieve this?

Appendix 5: Interview Schedule (2)

Victim Questionnaire

Aim: - To document and detail the experiences of the families and friends of people who are victims of corporate crime.

General Areas.

1. Can you tell me, in your own words, about the circumstances of [name/ your loved one's] death?

2. Thinking back to then, which of the following official agencies did you have contact with?
(If necessary, prompt: Police, HSE, Coroner, Victim Support, Probation Service, Crown Prosecution Service, local MP, Trade Union, support or campaigning group (eg. Hazards, CCA, The Simon Jones Memorial Campaign, Families Against Corporate Killing)

If so, what are your views about the nature of these contacts?
(prompt if necessary: length of contact, first point of contact (time and why), frequency of contact, satisfaction of contact)

3. What contact did you have with the company or companies involved in the death?

4. Did you have any contact with the media? (which, how, why, satisfaction etc)

5. Were you given the opportunity to write a Personal Victim Statement? (If yes, explore)

6. How has your experience as a victim of crime affected yourself and others?

7. What would you change about the criminal justice system response?

8. What would have constituted ‘justice’ for you in this instance?

Appendix 6

NUMBER	INITIALS	AGE AT DEATH	DATE OF DEATH	INTERVIEW ADDRESS	JOB	DEATH	INQUEST OUTCOME
1	JW	20	2003	Nottingham	Electrical apprentice	Asphyxiation	2 years Accidental death
2	JD	54	2003	Weston Super Mare	Construction worker	Asphyxiation	3 years Accidental death
3	RC	43	2005	Birmingham	Lorry driver	Heart attack following asphyxiation	14 months Accidental death
4	KF	37	2002	Penarth	Member of the public	Asphyxiation	4 years Unlawful killing
5	SW	45	2005	Ikley	Window cleaner	Fall from height	7 months Accidental death
6	GM	40	2005	Glasgow	Agency driver	Impaled	2.5 years Narrative determination
7	BW	53	2006	Darley Dale	Volunteer	Asphyxiation	7 months Accidental death
8	SJ	24	1998	Sussex	Stevedore (unqualified)	Crushed	No inquest
9	SC	26	1989	Hampshire	Member of the public	Drown	6 years Unlawful killing
10	CW	23	2002	Hull	Steeplejack	Explosion, fall from height (no official verdict as organs were 'lost')	Not in public interest
11	LM	18	2004	Cornwall	Apprentice	Burns	No

Appendix 7

NUMBER	INITIALS	POLICE INVESTIGATION	MANSALUGHTER PROSECUTION	HEALTH AND SAFETY PROSECUTION	SOCIAL MOVEMENT	DATE OF INTERVIEW
1	JW	No	No	No	No CCA contact	March 2008
2	JD	No	No	No	No CCA contact	April 2008
3	RC	No	No	No	No CCA contact	May 2008
4	KF	Yes (after complaint)	No	Yes	Joined FACK, not 'active' WAY CCA contact	June 2008
5	SW	No	No	No	No CCA contact	May 2008
6	GM	No	No	Yes	Yes Own campaign, FACK	June 2008
7	BW	No	No	No	No	June 2010
8	SJ	Yes after 6 weeks, upon request of HSE Inspector	CPS refused Prosecution after 2.5 years, following a judicial review. Cleared	Yes	Yes Own campaign	Sept 2010
9	SC	Yes	Acquitted prior to inquest CPS refusal after inquest verdict Failed private prosecutions	No	Yes Marchioness Disaster Action	
10	CW	Yes	Acquitted	Yes	Yes, Linda is a founder of FACK	
11	LM	Yes	Yes, guilty manslaughter 9 months Acquitted at the appeal after 3 months served	Yes	Yes, founder of FACK	Sept 2010

Appendix 8

NUMBER	INITIALS	GROUP	INTERVIEW ADDRESS	INTERVIEW DATE
12	LC	Solicitor	Telephone interview	January 2015
13	DW	CCA	Skype interview	February 2015
14	PD	Disaster Action	Semi structured interview	April 2015
15	BR	CCA	Semi structured interview	April 2015