DISASTERS: A FAMILY GROUP'S VIEW

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Families bereaved by the 1987 Zeebrugge ferry disaster set up a voluntary organisation to help them come to terms with their losses. To further that objective they embarked on two studies. The first was concerned with what was perceived to be serious flaws in the design and operation of roll-on,roll-off ferries; the second with the shortcomings of the legal system in holding companies accountable for policies and practices that caused needless loss of life. The Association believes that what it learnt from both studies has a relevance far beyond the major disaster that brought its members together.

INTRODUCTION

After every major disaster people ask the same questions: Why did it happen? Could it have been forseen? How can we make sure it never happens again? No-one does so with greater intensity than the victims' families. Others want to know; they have to know. It is part of the grieving process.

What they see, think and say is inevitably driven by grief and anger. They lack the objectivity of those formally investigating a disaster. On the other hand, whatever professional and technical skills they have are reinforced by their personal involvement and reluctance to accept glib explanations. They can make a valid, and possibly unique, contribution to the search for higher safety standards. .

That is certainly the belief of the Herald Families Association (HFA), a voluntary support group still active more than eight years after the maritime disaster that brought it into being.

SETTING THE OBJECTIVES

The Association was founded in September 1987, just a few days before a coroner's jury unanimously returned verdicts of 'unlawful killing' on 187 of the passengers and crew who died when the cross-Channel ferry Herald of Free Enterprise capsized at Zeebrugge six months earlier. Both the inquests and the court of inquiry that preceded them had thrown up disturbing facts about the cause of the disaster. These had added to the pain of bereavement. The primary aim of the HFA's founders was to provide a form of group therapy. They thought that simply by getting together and sharing their feelings the bereaved

families would help one another to come to terms with their losses.

That aim, they soon realised, was not enough in itself. Grief and anger cannot be thrown off when the damage to family life is irreparable; they have to be directed into some constructive activity. So the association set itself two campaigning objectives. The first was to seek fundamental improvements in the design, construction and operation of roll-on, roll-off ferries; the second, to make corporations more readily accountable if their operations resulted in people being killed or injured.

What the association decided not to do was to campaign for higher levels of compensation -- the popular perception of victims' support groups. Compensation claims were left to individuals and their legal advisers. The communal task was to salvage something worthwhile from so many avoidable deaths.

It would be foolish to to claim, eight years on, that the two campaigning objectives have been achieved. Unsafe ferries still cross the English Channel and other seaways; the laws affecting the criminal liability of corporations still seem out of touch with way large business enterprises are directed and managed. What can be claimed, however, is that in both cases important changes are beginning to materialise, and that the families of the Herald's victims have played some part in bringing this about.

I will fill in some details later. First, I wish to emphasise that in my opinion the lessons of Zeebrugge, many of them still to be acted upon, are not confined to one disaster or even one industry. They have relevance in every area of activity where lives are liable to be put at risk by incompetence or lack of care.

I also believe that the drama of a major disaster, together with the media attention it commands, can do much to illuminate failings that are more easily passed over in individual cases of death or injury caused by corporate activity.

Lessons from other disasters

In the course of its work (which has included a corporate responsibility study funded for two years by the Joseph Rowntree Charitable Trust) the HFA has examined the records of a number of man-made disasters before and after the Herald's capsize in March 1987. It found more than enough similarities to make a mockery of that all-to-familiar pledge, 'We will make sure this could never happen again!'. The sad fact is that it could and did.

Time and again a disaster was attributed to an 'unforeseeable breakdown' of a properly constituted safety system. What nonsense! Is that really what caused the Aberfan coaltip slide in 1966, the explosion at the Flixborough plant of Nypro (UK) in 1974, the King's Cross underground fire in 1987, the Piper Alpha oil rig explosion and the Hillsborough football stadium disaster in 1988, or the Clapham Junction railway crash and the Marchioness riverboat disaster in 1989?

The truth is that in those and other cases the safety systems that broke down appeared to have been poorly designed and ineffectively supervised, or had failed to take account of changes in operating conditions.

There was also a tendency for the investigators, as well as those being investigated, to look for a scapegoat. When they found one, as they generally did, it relieved them of the task of digging deeper and possibly unovering failings that were either commercially or politically embarrassing.

One very popular scapegoat was 'human error'. By dubbing this 'unforeseeable human error' the investigators could produce an open-and-shut case -- or, more precisely, a shut one. Yet was it not the function of the safety system to anticipate quirks of human behaviour, however unlikely, and to consider what might happen, not only what had happened?

Even when the basic cause of a disaster stared them in the face, some investigators were inclined to dilute that finding by devoting too much time to peripheral matters.

Sometimes a court of inquiry was presented with misleading evidence that it was constitutionally unable to check. The inquiry into the 1966 Aberfan disaster provided an example of this. One high-profile witness from the National Coal Board asserted that there had been no knowledge of the geological condition that caused the tip to slide, killing 116 schoolchildren and 28 adults. Later, it emerged that he was referring only to the colliery's local management; the condition (and risk) was known to head office specialists but had not been passed on.[1] (Ironically, the witness in question, Sir Alf Robens, went on to chair the committee that did so much to shape today's health and safety legislation!)

To those adversely affected by a disaster there is probably nothing more infuriating than a bland assertion by a politician, regulator or senior businessman that 'safety is paramount'. It never is and never could be. A price is put on human life in activities as diverse as the provision of medical facilities, the installation of traffic-calming devices, and the operation of commercial services. All that the general public can hope is that those counting the cost and making policy decisions do not set the price too far below society's reasonable expectations!

Almost equally infuriating is the mis-use of statistics in calculating risks and determining how much can be spent on either eradicating or reducing them. There was an example of this in a recent press release by the British Chamber of Shipping (which represents the ship owners) following media stories about 'unsafe ferries'. In order to compare the safety records of various forms of passenger transport, the Chamber selected the five-year period from 1988 to 1993, thus eliminating the massive death tolls in two major ferry disasters, the Herald and the Estonia.

Another questionable practice in risk assessment is to treat all deaths as equal, just as employment statistics take no account of massive differences in jobs and job-holders. What this quantitative approach ignores is a factor that might be described as the 'quality of death'. To slowly die of hypothermia after a ferry capsize, or to suffer years of pain and incapacity in a 'creeping disaster' caused by an

inadequately tested pharmaceutical product... such fates are arguably more distressing to both the victims and the bereaved than instant death in a road accident.

Many bereaved relatives also point to a small but hurtful omission by those companies whose activities have, albeit unintentionally, resulted in death or injury - rarely, if ever, do they say 'sorry'.

ZEEBRUGGE: THE REAL ISSUES

I maintain that as a case-study the Zeebrugge ferry disaster can be of immense value to risk managers, safety executives and senior businessmen. It encompasses most of the fundamental weaknesses that have contributed to disasters in a variety of industries during the past 50 years.

The Herald of Free Enterprise capsized within sight of land on a calm, clear night when, in theory, nothing could go wrong. It did so because the assistant bosun, one of whose duties was to close its bow doors, was still asleep in his cabin when the vessel sailed. That was the 'unforseeable human error' blamed by company spokesmen. To look any further, they implied, would be a waste of time as well as unfair. As the chairman of P&O, which owned the ferry, argued in a radio interview on 9 October 1987, 'It gets a bit far-fetched that somebody sitting on shore should be hauled up' for what members of the crew had failed to do.[2]

The truth, of course, was that 'somebody sitting on shore' had also failed. The door-closing procedure laid down by the company was crude, further weakened by the complacency of those implementing it, and poorly supervised. It relied on 'negative reporting -- the captain assumed that the doors had been shut unless told otherwise. Surprisingly, the ship's standing orders required the positive reporting of the non-critical operation of securing the bow anchors!

At the public inquiry[3] conducted with exceptional skill by Mr Justice Sheen (later Sir Barry Sheen) much time was spent on discussing the company's failure to fit warning lights on the bridge to show whether the doors were open or shut. Winesses argued about the reliability of such devices under seagoing conditions. This produced a positive shoal of red herrings! The facts are that:

-- An inspection by Kent police, at the coroner's request, disclosed that the bow doors, when open, could be seen from the extremities of the bridge of a sister-ship.

-- Ship's orders ambiguously required the first officer to supervise the closing of the doors and to be in the bridge at the same time. In practice this meant that he merely saw that a member of the crew (not necessarily the assistant bosun) was in the vicinity of the doors just before the ferry was due to sail.

-- There was a telephone link to the bridge at the bow doors station. Had the standing orders required the captain to receive a three-word report, 'Doors closed, sir', before sailing this elementary safeguard would have spared nearly 200 lives.

-- Ferries had sailed with their doors open on previous

occasions but there was no evidence of this being reported to the directors with ultimate responsibility for safety.
-- The door-closing procedure had been laid down when the company's vessels were fitted with 'visor' doors which, when open, blocked the forward view from the bridge. It was not reviewed when the fleet changed to 'clam' doors.
-- There is some evidence that the operators did not fully understand the behaviour of their vessels. Immediately after the disaster, when various causes were being suggested, a company spokesman denied that at normal speeds the bow wave would have risen as high as the doors to the car deck. On the same day, newspapers published photographs showing this happening to one of the Herald's sister-ships.

These shortcomings provide a check-list that could profitably be used by safety managers in many industries -- if they have enough imagination to translate them into the context of their own company's operations.

The instability problem

The assistant bosun's failure to close the Herald's bow doors was, unarguably, the immediate cause of the capsize. But the underlying cause -- and the reason why so many died as a result of that failure -- was that because of its unorthodox construction a ro-ro ferry becomes unstable and liable to capsize very rapidly if for any reason water enters its large, undivided car deck.

That assessment of the disaster clearly has much more serious safety implications than a simple, one-off human error, since it affects thousands of vessels plying their trade all over the world. It pinpoints a hazard that cannot be put right by re-writing ship's orders, fitting indicators on the bridge, or supervising crew members more closely. No wonder that ship owners are reluctant to act on it!

The instability problem was recognised, at least by many naval architects, long before it was so tragically demonstrated at Zeebrugge. But the use of large, undivided car decks -- which cut loading and unloading times -- had gone too far for anyone to call a halt, even though the vessels were getting bigger and bigger.

There are various ways in which the damage-stability of an existing ferry could be improved, thus allowing it to remain afloat and more or less upright for a reasonable time after being involved in a collision or some other serious mishap. They include the fitting of either sponsons (additional buoyancy chambers) or movable bulkheads. It is unlikely that the cost of implementing them would greatly impair the ferries' competitive position against other transport means. Many authorative voices have called for their adoption. Yet their acceptance by those in a position to do so -- as well as those who could legally enforce this -- has been disappointingly slow. It is typical of the ferry operators' attitude that during a Lords debate in 1994 Lord Sterling, P&O's chairman, warned his fellow peers against 'acting precipitately' -- hardly a valid contribution to the safety debate almost eight years after the Herald capsized!

During that time government spokesmen have congratulated themselves on introducing a series of operational requirements that many observers would have assumed were in place long ago. The main thrust of the Herald Families Association's safety campaign has been to bring about the structural changes outlined above. That issue has been pursued with renewed vigour since the disastrous capsize of the Baltic ferry Estonia, with the loss of some 900 lives, in September last year.

High-level lobbying

One of the Association's first moves, in the year of the Zeebrugge disaster, was to challenge the Royal Institution of Naval Architects to make public the concerns that had been expressed in private by many of its members -- a form of 'outing' that may be seen as rather more commendable than the one that has attracted so much media comment in recent months! The Institution responded by issuing a clear statement, since repeated several times, that ro-ro ferries are 'unacceptably vulnerable' if damaged for any reason. Further confirmation came when the findings of exhaustive tests commissioned by the Department of Transport were released two years later.[5]

The HFA has put its case in face-to-face discussions with four of the seven Transport Secretaries who have held that post since the Zeebrugge disaster and with several of their shipping ministers.. It has tackled the International Maritime Organisation; lectured to various specialised audiences; lobbied MPs of all parties; and made sure that the rapid capsize problem is regularly covered by the media. It has also given both written and oral evidence to a Parliamentary Select Committee on cross-Channel safety.

Despite the disappointments and delays previously referred to, some progress has been made. How far the Association has influenced this is open to conjecture. It is, however, significant that in the Queen's 1992 Birthday Honours its founding chairman was awarded the OBE for 'services to maritime safety'.

One advance is that last year Britain, in agreement with other European countries, passed legislation requiring all existing ferries to be brought up to the stability standards internationally introduced for new vessels in 1990 (SOLAS 90). Unfortunately this modification programme will not be completed until the year 2005, 18 years after the Zeebrugge disaster. Even worse, it is generally accepted that SOLAS 90 would not have prevented either the Herald or the Estonia from capsizing, and is not stringent enough to rule out the possibility of an even worse ferry disaster before the present century ends.

Perhaps the most encouraging progress is that the rapid capsize problem is now right out in the open and that some of our most respected professional bodies, including the Royal Academy of Engineering, have called for action to be taken.

It is now widely agreed that there should be a new damage-stability standard geared to a positive life-saving objective: that in all except the most exceptional circumstances

a ferry should remain afloat and reasonably upright long enough for its full complement of passengers and crew to be evacuated.

Earlier this year the International Maritime Organisation set up a panel of experts to investigate this need. Its proposals are about to be considered by the IMO council.

Meanwhile, the Herald Families Association has been assured that if there is further undue delay in reaching international agreement on this issue the British Government will either seek a regional agreement (as with SOLAS 90) or, as a last resort, will take unilateral action by imposing a new standard on all ferries using UK ports.

. What remains to be seen is the timetable for modifying existing vessels. We have already lost eight years since the need was so dramatically revealed at Zeebrugge!

CORPORATE RESPONSIBILITY

The Association's corporate responsibility project culminated in the publication of three books.[6] That particular baton has now been passed to the 'umbrella' organisation Disaster Action, which represents the victims of some dozen UK disasters.

The HFA's study took in business ethics but, not surprisingly, focused on criminal liability. During the Zeebrugge inquests the three families that subsequently founded the Association had applied to the Divisional Court for leave to appeal against a ruling by the East Kent coroner that a company, as such, could not be found guilty of manslaughter. Their application failed but three law lords tentatively ruled that the crime of corporate manslaughter did exist.[7]

Shortly afterwards the Association publicly stated that its members had pledged funds to start a private prosecution if the Director of Public Prosecutions, having studied the findings of a criminal investigation by Kent police, failed to bring charges against the Herald's owners.

Those charges were in fact brought. In September 1990 P&O European Ferries (Dover) and seven individuals were tried at the Old Bailey for the manslaughter of one of the Herald's passengers, the young daughter of the Association's chairman. As is well-known, this ground-breaking prosecution collapsed after 27 days, when the judge ruled that there was insufficient evidence that either the company or any one of the individuals who could be described as its 'controlling mind' had recklessly disregarded a serious risk of a ferry sailing with its bow doors open. The main reason for his ruling was that none of the directors or senior excutives had been told of occasions when this had happened. It followed -- in what the Association thought to be a somewhat dubious argument -- that because of this communication gap the risk would not have been 'obvious' even to the minds controlling a passenger ferry service!

The trial's collapse was a setback for the Association's campaign but not a complete rout. It turned a spotlight onto the ineffectiveness of the criminal justice system in dealing with what had seemed, at least on prima facie evidence, to be a serious corporate offence. This created some concern in legal

and other professional circles. People became aware that although hundreds of people die every year in workplace and other industrial 'accidents', the law seems to accept the statistical improbability that none of those deaths can be attributed to the serious criminal conduct of either a company or a company director.

The Association continued to put forward its arguments that:

1. The failure of a board of directors to make one of its members specifically responsible for safety should not become a defence when a safety system broke down.
2. Directors and senior managers should not be able to defend themselves against a charge of recklessness by claiming that they 'did not know' of a risk. The court should consider what persons in their position ought to know.
3. The law should abandon the principle that corporate culpability for an offence as serious as manslaughter can be determined only by the acts or omissions of a single individual deemed to be a 'controlling mind'. It would be more realistic to consider the combined effect of a number of individual acts or omissions that that were not necessarily criminal in themselves but amounted to reckless or grossly negligent conduct when 'aggregated'.
4. The disease of 'sloppiness' so explicitly condemned in the Sheen report ought to be treated as a serious offence by a company engaged in operations capable of killing large numbers of people.
5. The courts should take account of the consequences of a company's actions or omissions, rather than concentrate on breaches of safety regulations.

Corporate liability for manslaughter

Despite much fact-finding, lobbying, lecturing and discussion, the Association's corporate responsibility objective seemed as far off after seven years as it had ever been. But certain things were taking shape. They rose to the surface with the publication last year of the Law Commission's consultation paper on involuntary manslaughter.[8]

The introduction to a section on the liability of corporations articulated the misgivings that had been expressed, both privately and publicly, after the collapse of the Zeebrugge prosecution. Referring to that case, the paper said '.... the obscurities of the law of manslaughter were compounded by the law of corporate criminal liability... We should not ignore what appears to be a widespread feeling among the public that in cases where death has been caused by the acts or omissions of compararively junior employees of a large organisation... it would be wrong if the criminal law... did not also fix responsibility in appropriate cases on their employers who are operating, and profiting from, the service being provided to the public... The present position is very unsatisfactory because the technical structure of the law is in effect preventing these

very serious policy issues from even being considered.'[9]

Cutting through the cautious legal language, it is clear that the Commission's provisional proposals mostly support the Association's views on 'aggregation', on what directors and senior managers ought to know, and on the interpretation of terms such as 'recklessness' and 'obvious and serious risk'.

Commenting on the risk issue, the consultation paper says: 'Once there is evidence that employees have perceived a risk, even a small one, of serious consequence, it will then be appropriate to look critically at the company's systems for transmitting that knowledge to the appropriate level of management, and for acting on the knowledge received. Similarly, there will be cases...where it is appropriate to look at the company's management and management systems, to see whether having taken on the enterprise in the first place, it has applied the necessary skills and systems to the task, including the employment and training of operatives capable of identifying risks and responding to risks that do arise.'[10]

While the paper provisionally proposes a 'special regime applying to corporate liability for manslaughter', it suggests that the criteria for that liability should be those proposed for individuals offenders:

1. The accused ought reasonably to have been aware of a significant risk that his conduct could result in death or serious injury.
2. His conduct fell seriously and significantly below what could reasonably have been demanded of him in preventing tha risk from occurring or in prexventing the risk, once in in being, from resulting in the prohibited harm.[11]

It is tempting to speculate whether the judge would have left the verdict to his jury had those criteria been in force when the Zeebrugge prosecution took place.

At the time of writing the Law Commission is still considering submissions by a variety of interested parties, including the HFA. It is impossible to say what legal reforms will eventually materialise. The only safe prediction is that something will change, for no-one could reasonably argue for the retention of a situation so effectively damned by the consultation paper's authors. They themselves point out that corporate criminal liability usually consists not in doing something wrong but in not doing something that ought to be done. Legislators please note!

Ethical considerations

Some, neverthless, will deplore any further legal incursion into the realms of corporate governance and management prcatice. They will insist that this would be a backward step in an age of deregulation; that most corporations do behave responsibly; that shortcomings, once revealed, are quickly put right. They may also argue that whereas the law sets only minimum standards of conduct, these are soon widely regarded as maximum standards; and that lawyers will be kept busy advising clients intent on cost-cutting how far they can

safely go under any new regime.

None of this withstands close scrutiny. In every area of human activity there has to be a framework of law, acceptable to contemporary society, within which individuals or groups of individuals can develop their own codes of conduct.

I also believe that by more clearly defining a company's responsibilitiies for the wellbeing of employees, customers and general public, the law may encourage the management profession to clarify its own thinking on this issue. Despite the vast sums spent on management education and development, there is much fuzziness about the non-financial responsibilities of directors, and the role of individual managers in forming 'corporate intent', culture and ethical codes.

The need to look more closely at their broader responsibilities arises because of the rapid changes now taking place in the structure of organisations -- such as the emasculation of middle management; the growth of networking, where lines of authority and communication are not charted; employee empowerment, where shopfloor workers and their immediate supevisors are required to take more and more decisions; and the growth of outsourcing, where companies give up direct control of people producing their goods and services.

If the work of the Herald Families Association has helped, even in a small way, to draw attention to the need for the constant reappraisal of mangement's broader responsibilities, it will have achieved more than its members ever contemplated!

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