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# A Corporate Dilemma: To be a Learning Organisation or to Minimise Liability

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## Abstract

Companies are faced with a dilemma when it comes to information about safety problems. Should they seek out such information and learn from it, so as to reduce the risk of accidents, or should they suppress it, so that when an accident occurs they can not be held liable for failing to act on information in their possession? The disadvantage of suppressing such information is that it creates organisational learning disabilities. It also promotes public outrage that may turn out to be very costly. Many companies in the US view information about safety failures more as a legal liability than as a learning opportunity. This paper argues that in Australia concerns about legal liability are misplaced. The paper takes the explosion at Esso's Longford gas plant in 1998 as a case study and shows that so called "guilty knowledge" played no part in the record fine imposed on Esso. Furthermore, guilty knowledge was irrelevant in the subsequent compensation cases brought by both the workers and their families and by businesses affected by the loss of gas supply.

## Introduction

Large companies face a dilemma with respect to information about safety problems. Should they seek out such information and attempt to learn from it, or should they suppress this information in order to be able to plead ignorance if something goes wrong? Should they be as open as possible, disclosing whatever information is available and accepting the legal consequences, or should they limit the availability of this information as much as possible in order to be able deny responsibility? This paper seeks to examine what is at stake and to draw some conclusions. It uses the experience of Esso Australia following the explosion at the Longford gas plant in 1998 to illustrate some of the issues.

## A culture of safety

It is now widely accepted that workplace safety depends not only on safety management systems but on the development of a culture of safety. This term is open to various interpretations. Some writers see culture as referring to the attitudes and behaviours of employees. Improving the culture of an organisation thus requires changing the way employees think and act. Companies seeking to do this adopt a variety of behavioural safety programs.[1] However, those who have written most extensively about organisational cultures argue that the focus should on organisational practices rather than the behaviour of employees[2]. Perhaps the best known writer in this area, Jim Reason, defines a safety culture as consisting of constellations of practices, most importantly to do with reporting and learning. A safety culture he argues is both a reporting culture and a learning culture. Let us deal with these in turn.

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[1] For a critique see Hopkins, A "What are we to make of safe behaviour programs?" Working paper #36, www.ohs.anu.edu.au

[2] Reason, J. (1997). *Managing the Risks of Organisational Accidents*, Aldershot: Ashgate, chapter 9.

Reporting is crucial to safety. This is not simply a matter of reporting injuries and near misses. The issue is far broader. Studies of accidents, both major and minor, routinely show that the there was information available prior to the accident which, had it been reported and analysed, would have enabled the accident to be averted. In short, there are always warning signs. The organisations which are most committed to accident prevention recognize this fact and put a great deal of energy into collecting this information. It should be stressed that a reporting culture is not limited to reporting occurrences. Employees in such cultures are also encouraged to report unsafe conditions, hazards, ineffective procedures, process upsets, certain kinds of alarms and so on, in short, anything that could potentially lead to an unwanted outcome.

A learning culture is a natural extension of a reporting culture. It is one which gleans information from various sources, extracts whatever lessons there are and applies them. The major airlines do this very well. Qantas, for example, has a unit consisting of five people whose job is exclusively devoted to analyzing reports, responding to reporters and discussing with relevant areas of management how they might rectify any problems that may have been revealed[3]. The five full time staff are assisted by various experts who can be called on as the need arises. The strategy of the unit is not simply to thrust the information at local managers, leaving it to them to identify and implement the lessons. That is far from the optimal way to promote organisational learning. Rather, the unit works with local managers to develop agreed and feasible solutions. In this way the lessons are effectively embedded. In part because the organisation responds to reports the way it does, employees feel encouraged to report and the result is a very effective reporting culture.

Internal reporting systems are but one data source from which it is important to learn. A second internal source is the information which becomes available from systemic analyses of accidents that occur within the organisation. Such analyses invariably identify root causes lying deep within the organisation, far removed from the activities of front line personnel. Learning from one's own accidents in this way is a crucial concern of safety conscious organisations. A third source of information is accidents occurring outside the organisation. This is particularly important for the prevention of rare but catastrophic events, the like of which may never have occurred within the organisation in question but which may have occurred elsewhere in the industry, perhaps in other parts of the world. Learning organisations are sensitive to lessons from elsewhere. They have staff whose job is to analyse information from elsewhere, identify the implications for their own organisation and ensure that the lessons are learnt.

As can be seen from this discussion, where safety is the top priority, the aim is to assemble as much relevant information as possible, circulate it, analyse it, and apply it.

**Minimising liability**

The competing view is that the kind of information described above is potentially incriminating. The concern is that if an organisation assembles information about

[3] Interview with the unit manager

potential problems and fails to act on this information, and if something subsequently goes wrong, its liability will be increased. The assumption is that being ignorant of what might happen is not as culpable as being forewarned and yet doing nothing. Put another way, companies fear "evidence of a recognized hazard that is uncorrected"[4] will be especially damaging. The knowledge concerned is sometimes described as "guilty knowledge".

Furthermore, there is a fear that if, following an accident, it is revealed that organisational failures contributed to the event, the organisation will incur greater liability. It is therefore in the interests of the organisation to suppress evidence of its own failures and to write accident reports which do not identify organisational defects.

These concerns about minimizing liability are widespread in the United States. The American Institute of Chemical Engineers gives the following advice to its members.

> "Legal concerns are now an integral part of every major incident, or whenever a non-employee is involved in an incident. In many states it is becoming easier and more common for employees to be litigants. Legal access to documentation of the (incident investigation) team deliberations and findings is becoming an increasingly complex issue… Often the (incident investigation) team is placed in a position between two conflicting forces. The company's legal department may endorse a position of minimising the retention of documents that have the potential to cause financial damage. Incident prevention specialists and process safety managers may, on the other hand, endorse a policy of thorough documentation and proactive sharing of lessons learned, including disclosure of actual specific causes of an incident... Since most incidents have legal implications and some have regulatory reporting requirements the (incident investigation) system should include a legal department review of reports required by regulatory groups and other reports for form *and content*"[5]

Part of the reason for this high level of concern in the US is that the US OSH Act imposes its highest penalties for what are called "willful" violations, and evidence that a company has been forewarned but failed to act increases the risk that violations will fall into this category[6]. This concept of willful violation is basically absent in Australian OHS legislation.

The concern in the US about potentially incriminating information is also influenced by the fact that workers may sue not only for compensation but also for punitive damages[7]. This can result in multi-million dollar payouts in circumstances where a purely compensatory approach might yield payouts orders of magnitude lower.

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[4] Baram, M. (1997). Shame, blame and liability: Why safety management suffers organisational learning disabilities. In A. Hale, B. Wilpert, & M. Freitag (Ed.), *After the Event: From Accident to Organisational Learning* (pp. 163-177). Oxford: Pergamon. p 172

[5] Quoted in Rosenthal, I (1997) "Major event analysis in the United States Chemical Industry: organisational learning versus liability". Pp179-195 in A. Hale, B. Wilpert, & M. Freitag (Ed.), *After the Event: From Accident to Organisational Learning* Oxford: Pergamon. p 186. Emphasis in Rosenthal

[6] Rosenthal, op cit, p 187

[7] Baram, op cit p 173

Punitive damages are not a realistic possibility in Australia in most industrial injury cases.[8]

## The impact of liability fears on organisational learning

In the Unites States, the fear of liability creates learning disabilities in the organisations concerned[9]. We shall see below that Australian companies that give priority to limiting their liability suffer the same disabilities.

There are at least three ways in which a concern about liability can impede organisational learning. The first is that it undermines reporting.

Esso Australia is one Australian company in which this appears to have happened prior to the 1998 explosion. One of its former employees described how he and others were advised not to put anything in an email which might be used against the company at some later stage. He also recounts an occasion on which he was discouraged from logging a near-miss incident[10]. An audit report done for Victorian Workcover some time after the accident observed that Esso employees had no faith in the company's safety management system because it seemed directed to protecting the company from liability rather than detecting possible failures and preventing injury. The report went on to say that some staff were reluctant to pass information up the hierarchy because they didn't trust senior managers and that staff believed that senior managers did not want comments on how things might be improved.

A second consequence of the concern about liability is the distortion of a company's own internal audit reports. The legal advice provided to report writers is to write in such a way as to avoid identifying anything that could be regarded as an organisational failure[11]. When auditors identify deficiencies they are often encouraged to describe these as "challenges" or "improvement opportunities", rather than failures or defects. These linguistic subtleties are intended to reduce liability. It is hard to see how they achieve this end, but one thing is clear: they reduce the urgency of the matter in the mind of any reader and therefore contribute to the possibility that nothing will in fact be done.

This problem has been highlight in the US, where "firms often discourage technical people from generating written audit reports about unsafe items or a near-miss, until the firm decides whether it will remedy the item noted, or if not, whether it can generate a credible written report as to why the firm chose not to take any action" [12] Such a strategy systematically impedes organisational learning.

A third consequence of the concern to minimize liability is that reports which are written in no-holds-barred fashion may be treated as confidential and kept secret from the very employees who cooperated in providing the information in the first place.

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[8] H Luntz *Assessment of Damages for Personal Injury and Death, Fourth Ed.* (Sydney: Butterworths, 2002), pp71ff

[9] Baran, op cit, p 169; Rosenthal, op cit, p188

[10] *730 Report*, 3/5/99 transcript p 3, 6

[11] personal communication

[12] Rosenthal, op cit, p 188

This strategy breeds discontent and disillusionment among employees and a reluctance to cooperate in fact-finding inquiries.

A recent inquiry into BHPBilliton's OHS practices in Western Australia provides direct evidence of this. The Inquiry was instituted following a major accident at a BHPBilliton process plant in that state[13]. Shortly before the accident I had carried out a small study of attitudes and practices at the site, but my findings had been kept confidential and not passed back to the workforce. The Inquiry made the following comment:

> "Some employees and former employees expressed disappointment to the Inquiry that they had had no management feedback after Dr Hopkins' work. The Inquiry received information that some employees were reluctant to assist the Inquiry as it was perceived as possibly being a similar "waste of time" as the work with Dr Hopkins"[14]

**The problem of outrage**

The preceding discussion has focused on the way in which secrecy and the denial of responsibility can impede organisational learning. Such behaviour can also have another very damaging outcome – public outrage[15]. Parker describes the public outrage generated by Shell's proposal to sink a disused oil platform, the Brent Spar, in the North Sea. A campaign was mounted against the proposal, on environmental grounds, resulting in damage to fifty Shell service stations in Germany and a drop of 30 per cent in Shell's retail sales in continental Europe[16]. Shell's insensitivity to public opinion on this matter cost it dearly.

A recent Australian example of what can happen is provided by James Hardie, the former asbestos producer. For years the company had tried to minimize it liability to asbestos victims. Eventually it decided to restructure its affairs to achieve this end. It relocated its place of corporate residence to Holland leaving behind in Australia a trust to take care of its liabilities. It rapidly became apparent that the funds available

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[13] Ministerial Inquiry: Occupational health and safety systems and practices of BHP Billiton Iron Ore and Boudarie Iron Sites in Western Australia and related matters. November 2004

[14] page 273

Not all large Australian companies are motivated by a need to suppress potentially incriminating information. I was recently asked by another company to take part in an investigation of a major accident which had interrupted production for a prolonged period and cost the company perhaps $100 million. As it turned out, this accident was a carbon copy of an accident which had occurred at a similar plant overseas. Employees at the Australian plant knew of the earlier accident and an email had been circulated warning about the possibility. The warning was not however heeded and the accident duly occurred. Our analysis highlighted this email pointing out that the company had no means of ensuring that information provided to the site from elsewhere would be effectively assimilated. The company accepted our recommendation that it needed to set up a special unit to receive information from elsewhere, analyse this information and draw specific implications for action, much as did the Qantas group described earlier. All these matters were communicated to staff. Arguably, the email was a piece of incriminating information which a fearful company would have done its very best to suppress. Had it done so, a crucial piece of organisational learning would probably not have occurred.

[15] See the work of Peter Sandman, available at www.psandman.com. His simple formula is Risk=Hazard+Outrage

[16] C Parker, *The Open Corporation :Effective Self-regulation and Democracy*, Cambridge: Cambridge UP, 2002 p160ff

in the trust were nowhere near sufficient to meet the claims of sufferers. The company's transparent legal manoeuvre sparked public outrage and a union campaign, culminating in a government inquiry which concluded that the restructuring was indeed a blatant attempt by the company to evade its responsibilities[17]. Public reaction was intense and the state government enacted special legislation to force the company to pay out $4.5 billion over 40 years. It is clear that public outrage swept away all company attempts to limit its liability. No company can afford to provoke such outrage.

A second sobering example is the outrage generated by Esso's behaviour following the Longford accident. There were several aspects of Esso's behaviour that provoked outrage. First, Esso's own investigation of the accident was formally carried out by its lawyers, so that the company could keep the findings confidential on the grounds that they were subject to lawyer-client privilege. The Victorian government had foreseen this strategy and prior to the creation of the Royal Commission had legislated to override the claim of privilege in these circumstances. Esso challenged this in the federal court and, when it lost, in the High Court. As a result of these delays the Royal Commission was never able to uncover details of Esso's own accident investigation. The Royal Commission was clearly unimpressed, commenting at one stage that "Esso hasn't been forthcoming in its assistance to this commission with information"[18]

It could argued that though these tactics risked antagonizing the Royal Commission they might have been worthwhile, had Esso been successful in suppressing the information revealed in its own investigation. But it was not successful in this respect. A draft document prepared by an Exxon team of international investigators was seized by the coroner just prior to the team's departure. The document identified Esso's failure to carry out a detailed hazard identification exercise known as a HAZOP as a contributing factor to the accident[19]. This and many other failures were unearthed independently by the Royal Commission.

It should be noted that attempts to suppress incriminating information are sometimes effective, at least initially. Exxon succeeded in keeping certain things from a coronial investigation into a power station explosion in Hong Kong in 1992 that killed two men. As a result, the initial finding by a coronial jury was that the explosion was an accident[20]. Information that came to light subsequently led to a second inquiry. This time the finding was that the explosion was the result of lack of care on the part of the operating company. This verdict was overturned on a technicality[21], but the company's reputation was severely tarnished by these events.

There is another lesson to be learned from this case. Lawyers sometimes suggest that companies can have it both ways by writing two accident reports, one for external use, which describes *what* happened, in factual terms, and one for internal use which

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[17] D Jackson, *Special Commission of Inquiry into the Medical Research and Compensation Foundation*. See NSW Legislative Assembly Hansard 21/9/04, p 11158

[18] *7.30 Report*, 3/5/99, p 6

[19] D Dawson and B Brooks, *The Esso Longford Gas Plant Accident: Report of the Longford Royal Commission* (Victorian Government Printer, 1999), p204

[20] Ben Hills, "Slick operator – Exxon's global cover-up exposed", "Obstructing justice", "How a coroner was misled", *Sydney Morning Herald*, 24/3/99

[21] China Light & Power Co Ltd and anor v Banks *Hong Kong Court of Appeal*, 5/1/1995

analyses *why* it happened. The assumption is that being open about *what* happened will reduce the outrage. The problem is that if the public discovers that there is a second, secret report, this will be seen as a blatant cover-up, fueling the sense of outrage. This is exactly what happened in the Exxon Hong Kong case. Exxon's complete accident investigation report was kept secret and only a brief and innocuous version was presented to the coronial inquiry, leading, later, to media accusations that Exxon had been "obstructing justice" and was engaged in a "global cover-up"[22].

To return to the Longford case, Esso escalated the sense of outrage by blaming workers for accident in its submission to the Royal Commission. This was not an isolated claim; it was Esso's consistent position, repeated by the company corporate affairs manager in a later interview[23]. The unions were furious and immediately went on strike, threatening Victoria's gas supply. The premier, though normally anti-union in his politics, expressed the view that Esso's submission was "stupid" and that it amounted to character assassination of one of the workers[24].

In the subsequent criminal trial Esso pleaded not guilty to all charges. This was a predictably futile strategy. OHS law in Australia generally requires companies to do what is reasonably practicable to maintain a safe workplace and, faced with a death or serious injury, it is usually obvious that the company has not done what was reasonably practicable to prevent the occurrence. There is little point in companies pleading not guilty in such circumstances. In fact Esso's defence simply succeeded in antagonizing the judge. "The defence advanced was one of obfuscation – designed not to clarify, but to obscure" he said.[25] At one point counsel for Esso suggested that what happened was merely an accident, to which the judge reacted: "What (happened) … was no mere accident. To use the term 'accident' denotes a lack of understanding of responsibility and a lack of understanding of cause". He went on: "The events … were the responsibility of Esso; no one else. Their cause was grievous, foreseeable and avoidable."[26]

A plea of guilty and an expression of remorse will normally lead to a reduction in the penalty that would otherwise be imposed. Esso's legal strategy gave no grounds for any such reduction and the company was fined the maximum possible penalty on two counts and near maximum on several others. The result was a total fine of $2 million, the highest OHS fine ever imposed in Australia, perhaps five times higher than anything previously imposed. To this day Esso's record fine has not been surpassed. It is clear, therefore, that the company's strategy of denying responsibility and limiting as far as possible the information available to the court was a failure. The attempt to minimise liability back-fired, provoked widespread outrage, even in the mind of the judge, and resulted in a far heavier penalty than would otherwise have been the case.

**The relevance of "guilty knowledge"**

Let us consider, now, the central claim of those who are concerned about guilty knowledge, the claim that such knowledge will increase a company's legal liability. I

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[22] Note 20 supra
[23] *7.30 Report*, 3/5/99
[24] The Age, 28/4/99
[25] A Hopkins *Lessons from Longford: The Trial* (CCH Sydney:2002) p31
[26] Director of Public Prosecutions v Esso Australia Pty Ltd, [2001] VSC 263, paras 7,10

want to argue that in Australia this fear is, to a considerable extent, unfounded. Again, I draw on the case of Esso Longford which, because it was so highly litigated, affords a number of insights into the matter under discussion. In what follows I deal first with the prosecution, then with actions for damages launched by employees and their families, and finally with the action for damages launched by Melbourne businesses.

1. The prosecution

There was no evidence presented at the trial that Esso was in the possession of incriminating information. In particular there was no suggestion that Esso was aware of the problem that led to the explosion and had failed to act on it. On the contrary Esso was caught quite unawares. Nevertheless the company received the maximum possible fine on two counts - inadequate hazard identification and failure to instruct employees about the risks they faced – and 80 per cent of the maximum possible on three other counts. The Victorian OHS Act required the company to provide a safe working environment so far as (reasonably) practicable and it was evident that the company had failed to do this, in part because it had failed to carry out the appropriate hazard identification process (a HAZOP). This was the basic failure from which all other failures followed, in one way or another. It is evident therefore that the fact that Esso was unaware of the hazard, far from mitigating the seriousness of the offence, was itself almost the essence of the offence.

There is a dreadful irony here. A month prior to the incident, the Longford plant experienced a series of events (inexplicable cold temperatures and leaks) which were very similar to those that preceded the explosion. It was only by good luck that there was no explosion on the earlier occasion. These events were, however, a clear indication that the plant was out of control, and they should have been reported and analysed. They weren't, simply because on that first occasion there was no adverse outcome. Had they been reported and analysed they would have alerted the company to the problem and the accident a month later would not have occurred.[27] In short, the company's ignorance of these warning signs contributed to the explosion, while doing nothing to protect it from the full force of the law.

2 Actions for damages by individuals

A total of 51 workers and family members have successfully sued Esso. These included employees who had been physically injured, employees who had been involved in the incident and suffered psychologically but not physically, as well as wives and children of affected employees. A first group of 18 settled privately[28] but two subsequent groups totaling 33 people had there cases determined by the court and were awarded a total of $2.7 million, that is, an average of $82,000 each[29]. If we

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[27] Dawson, D & B Brooks (1999). *Report of the Longford Royal Commission: The Esso Gas Plant Accident*. Melbourne: Government Printer of the State of Victoria, page 222

[28] DPP v Esso Australia Pty Ltd [2001] VSC 401 (3 October 2001),

[29] DPP v Esso Australia Pty Ltd [2001] VSC 513 (19 December 2001;
DPP v Esso Australia Pty Ltd [2003] VSC 222 (23 June 2003);
DPP v Esso Australia Pty Ltd [2003] VSC 232 (24 June 2003)
The accident happened in 1998. The possibility of civil action for damages had been removed in 1997 and partially restored in 1999. This action was under section 85B of the Sentencing Act 1991. That Act provides for compensation for pain and suffering etc, but not for loss of income. DPP v Esso Australia Pty Ltd [20031] VSC 222 (23 June 2003), paras 4 and 5.

assume the same average for the cases settled confidentially the total payout was of the order of $4.2 million.

The question of interest here is whether the issue of guilty knowledge or more generally, degree of culpability, played any part in these determinations. The answer is: no. A threshold question for the court was whether the damage suffered by claimants was a result of negligence on Esso's part. The criminal trial had already established that the incident was a result of Esso's negligence and the court had no difficulty concluding that the harm experienced by each of the individuals was a consequence of this negligence. Thereafter the judge set about putting a dollar value on the pain and suffering of the claimants. This was obviously a subjective exercise, but the principle was that the compensation paid should be determined by the extent of harm experienced by the individual, not by the degree of culpability of the defendant. Thus, whether or not Esso was in possession of guilty knowledge at the time of the explosion was irrelevant. The proceedings distinguished carefully between compensation and punishment[30] and there was no suggestion that claimants might be entitled to exemplary or punitive damages.

There is another irony here and it concerns the case of the operator whom Esso blamed for the accident. The very fact of being blamed had an enormous psychological impact on this man. As he said

> "I can't work in a place where I once thought I would spend the next 27 years of my life. I cannot doff my hardhat to a company that blamed me for the deaths of two of my workmates… I cannot respect a company that would gladly have me face the tearful bewildered stare of a workmate's bereaved family"[31]

This experience impacted on his mental state and forced him to quit the company and seek work in Melbourne, 200 kilometers away. His marriage broke up as a result of this traumatic experience and his two children suffered considerable psychological damage. The children sought compensation and the judge accepted that there suffering was directly attributable to the way their father had been treated. He stated that their father was in no way to blame for the incident and that "at all times he acted properly, responsibly and indeed bravely." He went on:

…(The operator) has been to hell and some but not all the way back because of the events of 25 September 1998. … his odyssey has directly impacted on his two children, upon his wife, upon their marriage..." [32]

The children were awarded $100,000 each. In this matter, then, Esso's strategy of denying responsibility and blaming others magnified the extent of human suffering and hence, far from reducing its liability, actually increased it.

3 Action for damage to customers

The explosion at Longford resulted in the loss of gas supply to Melbourne for about two weeks. Esso was sued for approximately $500 million by various categories of

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[30] Ibid, para 7: "Compensation is not punishment and proceed according to common law criteria"

[31] A Hopkins, *Lessons from Longford*, (CCH, Sydney, 2000), p149.

[32] DPP v Esso Australia Pty Ltd [2003] VSC 367 (30 September 2003), para 13

plaintiffs affected by this loss of supply. One conceivable basis for legal action was breach of contract. However Esso's contract was with a gas distribution company, not with end users. It was therefore not liable for damages to end users on this basis. A second possible argument was that though Esso had no contract with end users it had a duty of care to them which it had breached by operating the plant in a negligent manner. The court found that in general Esso had no such duty of care and was not responsible for pure economic loss, in this case, the losses incurred when businesses were forced to close down because of the failure of the gas supply.[33] This decision was in accord with a well established legal principle that defendants are not liable for pure economic loss caused by their negligent actions. Accordingly, the actions for economic damages were largely unsuccessful. The degree of Esso's negligence and in particular whether it was in possession of what might be regarded as guilty knowledge was quite irrelevant to the outcome.

This examination of the Esso case suggests in at least three respects that the issue of guilty knowledge has far less bearing on the determination of liability in Australia than is sometimes feared:

- OHS legislation is not primarily concerned with the issue of guilty knowledge and maximum penalties are possible even in the absence of any guilty knowledge;
- compensation for personal injury is based on the extent of the damage, not on the degree of culpability (once negligence is established); and
- compensation for economic loss is determined by legal criteria which again have nothing to do with the degree of culpability.

Moreover, Esso's defensive and secretive approach completely failed to reduce its legal liability. On the contrary, the evidence is that the company's liability was increased by this approach. Specifically, the criminal penalties were higher than they would otherwise have been, and the compensation awarded to the operator's children would not have been necessary had the company not blamed him for the explosion.

**The cost of defective learning**

There is one further lesson to be learnt from the Esso experience. The cost to Esso of the accident itself far outweighed the costs arising from the company's legal liability. The company lost $200 million in sales foregone and spent $100 million to restore peak gas flow. Beyond that Esso was forced to embark on a $350 million program to reduce site risks[34]. Not all accidents are as costly as this but it is generally true that the total cost of an accident to a company far outweighs the compensation costs it may have to pay. On some estimates the true cost of an accident is up to twenty times the compensation costs[35].

From a financial point of view it is therefore far more important to minimise the risk of accidents than to minimize legal liability. Given that the attempts to minimize

[33] Hopkins, A (2004) "Outcome of the civil action against Esso arising out of the Longford explosion", *J Occupational Health and Safety- ANZ*, 20(2): 127-130
[34] Hopkins, *The Trial*, op cit,p35
[35] Oxenburgh, M, 1991, *Increasing Productivity and Profit through Health and Safety*. Sydney: CCH, p14

liability will inevitably be at the expense of organisational learning it follows that companies are better off financially adopting a policy of openness, embracing information from which they can learn, rather than clamping down and suppressing information which might conceivably incriminate them.

## A final thought

Company boards that accept the preceding argument are in the happy position that their financial obligations to shareholders coincide with their moral obligation to ensure the safety of employees. Where boards don't accept this argument, believing that shareholder interests require them to do everything possible to minimize legal liability, they face a moral dilemma. Should they give precedence to the perceived financial interests of their shareholders or to the lives of their employees? The situation is as stark as this. The arguments of this paper provide a way out of this dilemma.