Triennial Review of the Health and Safety Executive. Submission to the Department for Work and Pensions

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Triennial Review of the Health and Safety Executive
Submission to the Department for Work and Pensions

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By

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Introduction

In this response we have chosen not to address the guided questions specifically, but rather to respond to the general coverage of the document, not least that set out at Annex E, “Background to the Health and Safety Executive”, where it is stated that:

HSE’s functions are undertaken in the pursuit of four headline aims that support delivery of its mission. These aims, set out in the HSE’s Business Plan for 2012-15, are to:

- Lead others to improve health and safety in the workplace;
- Provide an effective regulatory framework;
- Secure compliance with the law; and,
- Reduce the likelihood of low frequency, high-impact catastrophic incidents.

(Department for Work & Pensions, 2013: Annex E, 14)

Our response addresses many of the claims made in that Annex regarding enforcement and inspection.

We welcome this review of the HSE since, as the evidence set out in this response demonstrates, it is clear that the regulator is increasingly unfit for purpose. It is presently unable to provide either minimal inspection coverage or a credible threat of enforcement, and is therefore in no position to secure compliance with the law.

Risk-based targeting and the decline of inspectorial presence

During the course of the last decade, a series of initiatives within the HSE placed targeted enforcement, based upon a risk-based model, on an ever more formalised basis. We have discussed these initiatives and this process extensively, elsewhere (James et al., 2013, Tombs and Whyte, 2010, 2013a, 2013b).

It is an obviousness – albeit one that needs emphasis – that the corollary of targeting is the assumption that, for the most part, most businesses can be left, safely, with minimal or no intervention. Thus, we find that inspection has reached a plateau of relatively low inspection coverage. In 2012/13, HSE records show a 37% decline in inspection records since 1999/00. In terms of the absolute data, in 1999/00, there were 75,272 such records, compared with 27,849 in 2012/13 (see Figure 1). This long term trend is due, according to the HSE, to changes in ‘strategies, intervention targeting, internal procedures, guidance and operational information systems’¹. In particular, the HSE notes that as the method of undertaking and recording inspections changed from 2004/05, then data before and after this change are not strictly compatible. However, if we break the period at 2005/06 when the method of recording changed, we still find that the steepest fall in inspections occurred prior to a major change in recording. Between 1999/00 and 2004/05, inspection records fell by 39% and have reached a consistently low plateau since 2005/06. In other words, whatever changes have been made to the logging of inspection activity, a downward trend since the start of the last decade is very clear. It is also important to note that this is a downward trend which has a longer history. The Robens Report (1972) noted that in 1970 there were 300,000

factory inspections (cited in Nichols and Armstrong, 1973). By 1975 there were 481,000 “visits” by all HSE enforcement agencies (Dawson et al. 1988).

**Figure 1: FOD Inspection Records**

Targeting and the Intelligence Deficit

If the trends mapped out in Figure 1 are, as the HSE has argued, a product of targeting, it is also important to recognise that those trends in fact make targeting less feasible. Indeed, the very premise upon which this ‘strategy’ was based has been questioned in a Better Regulation Executive and National Audit Office (2008) report. The report rated the HSE ‘highly’ in terms of its working within the ‘Hampton principles and Macrory characteristics’, endorsing the fact that it ‘works well with business, including recognising the need to minimise burdens on business’ (2008: 5, 12). However, this assessment of the HSE’s enforcement activities revealed the fundamental contradiction at the heart of a targeting strategy. The report’s central criticism of HSE practice – the first of five ‘issues to be addressed’ – was the fact that the HSE needed to make ‘better use of intelligence’ ‘in order to improve its targeting of business’ (ibid: 7). Now, within the terms of a targeting approach to inspection and enforcement, this is clearly perfectly logical, a crucial requirement. That said, the reasons revealed for the intelligence deficit are significant. The conclusions on the weaknesses in the intelligence underpinning targeted intervention were threefold.

First, the report noted the failure of many businesses even to register their existence with the HSE, leaving the regulator to expend resources even trying to identify premises before their risk could be assessed – yet what is not mentioned is that the requirement to register is a legal one. So what we have here is a targeting strategy, premised on the assumption (above) that most businesses are responsible, undermined by the fact that many business premises remain unregistered – that is, are violating the law.

Second, the report found that the Fit3 strategy for targeting was being undermined by the focus on high-risk issues, rather than duty-holders’ ‘past performance and other factors’, which it stated were inadequately taken into account (ibid: 21). This was explicitly attributed to the relative lack of inspections (ibid: 23). Now, given the
significant decline in preventative inspections since this report was published, it is difficult to avoid the conclusion that the intelligence generated by such inspectorial presence has declined further, and considerably – in other words, one of the key bases upon which targeted, proactive inspectorial presence is justified is in fact undermined by the precipitous decline of proactive inspectorial presence. The low and declining absolute number of inspections – however ‘deep’ these may now be – creates a contradiction at the heart of the HSE’s strategy that cannot be resolved. There is an urgent need here for the HSE to consider, first, a minimal level of preventative inspections required to maintain adequate levels of intelligence and, second, to determine an appropriate balance between proactive and reactive inspections, a consideration effectively abandoned in the now rigid application of distinctions between low and high-risk sectors – on which, see below.

Third, the BRE/NAO report bemoaned the level of RIDDOR\(^2\) reporting, again something which significantly undermines its intelligence base. Moreover, this is a longstanding issue (of widespread non-compliance) which the HSE really should prioritise. It was highlighted over 40 years ago by the Robens Committee (Robens, 1972: 135, and chapter 1), and despite there having been various attempts to improve reporting levels, rates of mandatory reporting have recently been noted as being, again, in decline (Daniels and Marlow, 2005: 2-3). They remain low, perhaps even as low as 30\%(Davies et al., 2007: v). This context makes recent changes to RIDDOR even more difficult to comprehend, not least in relation to a risk-based enforcement model. The first tranche of these changes, first mooted in Lord Young’s *Common Sense, Common Safety*, came into effect in April 2012, when the period of employee absence from work following an injury which should be reported under RIDDOR changed from three to seven days – in effect, this removes a vast swathe of intelligence on ‘minor’ incidents, and patterns of these, from the HSE. Then, in July 2013, the HSE announced plans for further changes to RIDDOR, again under the guise of simplifying requirements upon employers. These are even more worrying, removing intelligence on major injuries, occupational illness and dangerous occurrences, since in summary, the changes include proposals that,

> The classification of ‘major injuries’ to workers replaced with a shorter list of ‘specified injuries’; the existing schedule detailing 47 types of industrial disease to be replaced with eight categories of reportable work-related illness; fewer types of ‘dangerous occurrence’ will require reporting. (Health and Safety Executive, 2013c; see Health and Safety Executive 2013b)

Given these changes to RIDDOR, coupled with the decline of proactive inspectorial presence and – as we shall see in the next section – key forms of reactive presence, it is difficult to comprehend how HSE can consider its intelligence to remain sufficiently robust for appropriate targeting. Indeed, it is clear that if a low level of inspections continues, the HSE will need to conduct its work with a significant intelligence deficit. As we shall now see, a further key factor undermining this intelligence base is the level of investigations following reported incidents. This is worth emphasis – for such investigations are part of the HSE’s reactive role, rather than the preventative functions which have been so thoroughly and explicitly abandoned for many sectors and most

\(^2\) The Regulations requiring reports to be made of specific classes of injury and incident.
businesses. The absolutely low and rapidly declining levels of investigation into reported incidents represents an inexcusable failure to use ‘hard won’ data.

Trends in HSE investigations

Investigations are a key element of enforcement activity. Certainly they are the basis upon which any accountability can be derived: only by having investigated the circumstances of any incident can the HSE reach any sensible determination of what kind of action, if any, ranging from the provision of advice through to prosecution, is appropriate in the light of any specific incident. However, post-hoc accountability is not the only – or perhaps even the most important – rationale for investigations. As the Centre for Corporate Accountability noted in its evidence to a Select Committee inquiry, investigations have a significant preventative role, that is:

An important part of any investigation must be to rectify the circumstances that resulted in the harm (or, in the case of a dangerous occurrence, that resulted in the risk of harm) occurring in the first place. At the very least an investigation should ensure that any future risk of a similar incident taking place is very low. The absence of an investigation will mean that a risk of a repeat incident will continue to exist. (Centre for Corporate Accountability, 2004)

Over the past decade, investigations of RIDDOR reports have fallen at a much steeper rate than the reports themselves. While there was a decline in RIDDOR reports to the HSE of 23 per cent between 1999/00 and 2008/09, we find during this period that the proportion of reports investigated since 1999/2000 has halved. In total, if we look at those RIDDOR reported incidents that are investigated by the HSE, we find that between 1999/00 and 2008/09, there was a 63% decline in numbers of HSE investigations; this is a decline from 11,462 in 1999/00 to 4,272 in 2008/09.

Now, in contrast to much of the other data utilised in this paper, data on RIDDOR reports in this section is available up to and including 2008/09 only. But there is no reason to believe that the trends – the general decline – in investigations have changed since that end point. Quite the opposite in fact: by 2012, just one in 20 reported major injuries were subject to an investigation. (O’Neill, 2012)

This sharp decline is replicated in further detail in the data on investigation type. The HSE continues to investigate 100% of (the limited subset of) employee fatalities reported to it, a constant over the past decade. However, during that decade, we also find that investigations of reported major injuries declined by 55%; of over-three-day injuries by 83%; and of dangerous occurrences by 37% since 1999/2000. By 2008/09, less than 1% of over-three-day injuries that were reported to the HSE were actually investigated. Less than one in 10 (8 per cent%) of reported major injuries were actually investigated. In 2008/09, the HSE did not investigate the following: 66% of amputations; 84% of major fractures; 96% of major dislocations; 84% of major concussions and internal injuries; 90% of major lacerations and open wounds; 83% of major contusions; 75% of major burns; and 66% of major poisonings and gassings.

Table 1: HSE Investigations of Major Injury by Type
<table>
<thead>
<tr>
<th>Injury Type</th>
<th>1990/00</th>
<th>2008/09p</th>
<th>% Fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputations</td>
<td>42.9</td>
<td>33.6</td>
<td>22</td>
</tr>
<tr>
<td>Major Fractures</td>
<td>10.5</td>
<td>6.2</td>
<td>41</td>
</tr>
<tr>
<td>Major Dislocations</td>
<td>4.9</td>
<td>4.4</td>
<td>10</td>
</tr>
<tr>
<td>Major Concussions &amp; Internal Injuries</td>
<td>15</td>
<td>16.1</td>
<td>(+7)</td>
</tr>
<tr>
<td>Major Lacerations and Open Wounds</td>
<td>21.9</td>
<td>9.9</td>
<td>55</td>
</tr>
<tr>
<td>Major Contusions</td>
<td>23.3</td>
<td>17.4</td>
<td>25</td>
</tr>
<tr>
<td>Major Burns</td>
<td>34.6</td>
<td>25.4</td>
<td>27</td>
</tr>
<tr>
<td>Major Poisonings and Gassings</td>
<td>47.4</td>
<td>33.7</td>
<td>29</td>
</tr>
</tbody>
</table>

There are two issues we would wish to raise in relation to the significance of such high levels of under-investigation. First, in the case of fatalities and major injuries, one might reasonably expect particular consideration to be given to investigation in order to detect any safety system defects which either caused or contributed to loss of life or major injury. Indeed many specific categories of major injuries noted above correspond very closely to categories included in the HSE’s incident selection criteria – those which determine the incidents, injuries and cases of illness that the HSE inspectors should investigate. Many of those categories are barely investigated, indicating that the HSE currently cannot get close to fulfilling its own performance standards. This is hardly a basis for sound intelligence about offending behaviour. Second, in relation to over-three-day injuries, whilst not to dismiss the effects of any injury, by definition these more minor injuries offer important opportunities for learning in terms of defects in or violations arising out of safety and health systems, and thus, in the HSE’s own preventative terms, should form potentially crucial data for the prevention of future, more serious, harm. This point can be made even more strongly, of course, with respect to ‘dangerous occurrences’; one of a series of categories of incident defined as where something happens which does not result in a reportable injury, but which clearly could have done. As near misses, these should be treated as key opportunities for learning. These points hold especially in the light of the ‘intelligence’ deficit to which so many commentators on the HSE’s targeting efforts have pointed. In the absence of either robust historic intelligence or the ability to maintain existing levels of intelligence regarding safety and health performance as a function of a dwindling proactive inspectorial resource, it is difficult to see how a risk-based model or any coherent programme of targeted inspections/interventions could be sustained.

Notices and prosecutions
If we now shift from HSE inspection and investigation to other formal enforcement action, we again find consistent declines in levels of activity since 1999/2000. This is the clearest conclusion to be reached from an initial examination of data for all forms of enforcement notice, as well as prosecutions of both offences and duty holders (both data are included, since one duty holder may be prosecuted and convicted for one or more offences)

Thus, on enforcement notices (Figure 2), we find:

- Total notices issued by HSE declined from 11,144 in 1999/2000 to 8,480 in 2011/12 – a decline of 24%
- Improvement notices – the least serious form of notice – declined from 6,972 in 1999/2000 to 5,350 in 2011/12 – a decline of 23%
- All Prohibition notices - the most serious form of notice – declined from 4,368 in 1999/2000 to 3,130 in 2011/12 – a decline of 28%

Figure 2: All Enforcement Notices

On prosecutions of offences, we find that both the number of offences prosecuted and thus the number of convictions declined from between 1999/2000 to 2011/12. Thus,

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3 Health and Safety Executive, 1999/2000-2011/2012 (Great Britain). Sources for data presented in Figures 2-4 are: Freedom of Information Request Reference No: 2010020046; Enforcement action taken by enforcing authorities in Great Britain where region is known, 2001/02 - 2009/10p; and Enforcement action taken by enforcing authorities in Great Britain where region is known 2007/08 – 2011/12p; and Health and Safety Executive (2012)
- Prosecutions of offences fell from 2,115 in 1999/2000 to 969 in 2011/12, a decline of 54%
- Convictions for offences fell from 1616 in 1999/2000 to 780 in 2011/12, a decline of 52%

**Figure 3: Prosecutions: Offences**

And, finally, on prosecution of duty holders, we find that both the number of duty-holders prosecuted and thus the number of convictions declined from between 1999/2000 to 2011/12. Thus,

- Prosecutions of duty holders fell from 991 in 1999/2000 to 584 in 2011/12, a decline of 41%
- Convictions of duty holders fell from 965 in 1999/2000 to 537 in 2011/12, a decline of 43%

**Figure 4: Prosecutions: Duty Holders**

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4 Health and Safety Executive, 1999/2000-2011/2012 (Great Britain). From 2007/08, data is presented by the HSE as 'Number of offences for which legal proceedings have been instituted'; from 2007/08, data is presented by the HSE as 'Number of offences resulting in a conviction'. Data on prosecutions are not provided for 1997/98 to 1998/99 as the HSE was in the process of a transition from one operational recording system to another. Data refers to prosecutions heard in the relevant year, and where a result has been secured, i.e. the prosecution has been completed. Prosecutions taken by the HSE exclude those taken by Local Authorities and, from 2005/06, prosecutions taken by the Office of Rail Regulation (ORR). In Scotland, the HSE and local authorities investigate potential offences but cannot institute legal proceedings. The HSE and local authorities send a report to the Crown Office and Procurator Fiscal Service (COPFS). COPFS makes the final decision whether to institute legal proceedings and which offences are taken.

5 Health and Safety Executive, 1999/2000-2011/2012 (Great Britain). Data for 2010/11 data refers to 'Cases for which legal proceedings have been instituted' and 'Number of cases resulting in conviction for at least one offence; data for 2011/12 refers to 'case level prosecutions' and 'case level convictions'.

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Taking the above data together, we find that, during the period under examination, while all forms of formal activity declined – by between one half and one-quarter – there is a direct correlation between the higher declines being in the more serious forms of enforcement response. Thus, the greatest declines during this period were for prosecutions; then, within overall notices, we find that the greatest declines were in the more serious forms of notice, prohibition notices, than for the least serious form, improvement notices. Finally, it is also worth noting, as revealed by the two sets of prosecutions data, that the fall in prosecutions for offences is some 20% sharper than that is the fall for prosecutions of duty holders – indicating that while fewer duty holders are being prosecuted, they are also being prosecuted, on average, for fewer offences.

There are of course variations within these overall trends which require analysis – and we have undertaken this elsewhere (Tombs and Whyte, 2010). Most notably, as the figures indicate, the period of the most acute decline in the use of enforcement notices and prosecutions is either between 2001/02 and 2005/06 or between 2002/03 and 2005/06. This is a period in which already declining levels of enforcement and investigation were forced even lower by the HSE’s effort in anticipating the Hampton agenda. (Ibid.). At the same time, each set of data indicates some upturn in activity towards the end of the period under examination – upturns which, given the institutionalisation of ‘low-risk’ (below), the formal shift from inspection activity, and the significant, further reductions in HSE resource, are unlikely to persist. Indeed, this is now a matter of policy as, from 2011 onwards, a series of reforms designed further to ‘target’ resources of all kinds on the part of the HSE have been introduced under the guise of ‘low-risk’. It is to a discussion of these that we now turn.
The institutionalisation of ‘low-risk’

Since coming to office, the Coalition government has made it clear on several occasions that it intends to remove altogether what it calls ‘low-risk’ workplaces from inspection regimes. Such indications have featured regularly in public comments on health and safety regulation by both the Prime Minister David Cameron and the Employment Minister Chris Grayling. The removal of the burden of ‘low-risk’ workplaces also featured centrally in Lord Young’s report on health and safety. On health and safety enforcement, it proposed: “simplification” of risk assessment procedure for low-hazard workplaces such as offices, classrooms and shops, and the HSE to develop an online risk assessment tool for these businesses; exemptions from risk assessments for home-workers and the self-employed in low-hazard businesses; making “open the delivery of inspections to accredited certification bodies, reducing the burden on local authorities and allowing them to target resources at high risk businesses” (Young 2010: 16-17).

Central to this centre-staging of ‘low-risk’ was the Lofstedt Review – “an independent review of health and safety regulations to identify opportunities to simplify the rules” (emphasis added) – and the report which followed (Lofstedt, 2011). The Lofstedt Report uses the phrase ‘low-risk’ in four senses: ‘low-risk’ work activities, ‘low-risk’ businesses, ‘low-risk’ sectors and ‘low-risk’ workplaces. Now, although the report notes the difficulty of defining what constitutes ‘low-risk’ (Ibid.: 36), none of these concepts are actually defined in any useful sense – curious, given that Lofstedt is Professor of Risk Management and Director of one of the UK’s foremost University Centres of Risk Management. Unfortunately, such a lack of precision is highly useful for a government which wishes to use a vague, flexible concept of ‘low-risk’ to justify regulatory withdrawal. For example, before the Review was published, the Department for Work and Pensions had applied a very wide-ranging use of the concept, to include low-risk manufacturing (e.g. textiles, clothing, footwear, light engineering, electrical engineering), the transport sector (e.g. air, road haulage and docks), local authority administered education provision, electricity generation and the postal and courier services (Department for Work and Pensions 2011: 9). The classification of docks as low-risk, for example, simply cannot withstand scrutiny: official data records the fatality rate therein currently running at between five to 20 times the all-industries average (O’Neill 2012). More generally, a Hazards analysis of worker fatalities shows that “of the 258 deaths recording in HSE statistics for 2011/12 and for 2012/13 up to the end of October 2012, over half were in sectors no longer subject to preventive, unannounced HSE inspections” (O’Neill, 2013) – hardly indicative of low-risk. This is not even to mention ‘hidden’ problems of occupational exposure and disease which are prevalent in many so-called ‘low-risk’ sectors – a previous review of health and safety had sought to redefine all schools and offices as “low-risk” (Young, 2010: 28), notwithstanding, for example, the increasingly apparent problem of asbestos in the greater part of the schools, universities and offices that millions of people work or learn in on a daily basis.

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6 For an extended critique of this document, see James et al., 2013.

7 Depending upon which employment figures are used as the denominator (O’Neill 2012)

8 The Department of Education estimates that over 75% of schools contain asbestos (The Asbestos in Schools Group 2011). It is likely that offices in Britain also have an equally high level of asbestos. This is a
It is our contention that there is a high degree of political expediency at work here. For the use of this vague concept of 'low-risk' workplaces in the Löfstedt Report has a similar function to the way it is used by government ministers: it is used to square the circle of regulatory disengagement. This is a concept that has been used to justify the reduction in regulatory resources and the general withdrawal from regulatory scrutiny that has been occurring for at least the past ten years. In fact, the Löfstedt Report quotes the Better Regulation Executive to show clearly that the strategy of withdrawal from a growing range of sectors that are rather arbitrarily deemed 'low-risk' is purely about the allocation and targeting of resources. This is not hidden. And so we have here another circular logic: that low resources require that workplaces are defined 'low-risk' to enable regulators to manage low resources! This logic is made more curious by the fact that since the publication of the Report, Löfstedt has subsequently raised concerns in public about the reduction in site inspections (Hyde 2012). The majority of employers will be effectively left to self-regulate and will most likely only come into contact with the regulator when a death, injury or incident is reported (Taylor, 2012), while the phenomenon of actually reporting is, as we have seen, not only low but now subject to considerable relaxation.

In short, the definition of sectors as “low-risk” which is currently being operationalised by the government and the HSE has little or no empirical nor conceptual rationale. What is stated very explicitly is that only a small core of government-defined hazardous industries are likely to remain under the scrutiny of HSE inspection regimes. It is to this claim of focused regulation and enforcement that we now turn.

The ring-fencing of ‘high-risk’?

This redefinition of ‘low-risk’ work has been partly premised on the claim that the corollary of this withdrawal of regulatory scrutiny would be a focus on areas where risks remains greatest – that is, that the inspection regimes for hazardous workplaces would be ring-fenced. Thus, the government’s announcement last year that low-risk workplaces would no longer be subject to inspection included an assurance that the scrutiny of businesses operating in higher risk areas would not change. (Department of Business, Innovation and Skills, 2012)

However, inspection data for hazardous industries appears to undermine this claim. For example, there have been dramatic falls in inspection activity in some spheres of activity between 2006/07 and 2012/12. Those appear to be most pronounced in the Chemicals Industry Division, in Mines, and in the Offshore Safety Division. In contrast, it must also be noted that in other areas there have been apparent rises in activity: inspection records in gas and pipelines, for example, have risen by 45% since 2006/07.9

Interpreting the actual situation is rendered complex by the fact that declines in inspection cannot necessarily be interpreted simply as reflecting a decline in inspection

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9 Freedom of Information Request Reference No, 2013040452, 16 May 2013

particular problem in the UK due to our very high rates of asbestos use in public buildings up until the late 1970s/early 80s. The HSE estimates that the rate of mesothelioma in the UK is probably the highest in the world (The Asbestos in Schools Group 2011).
activity. Since 2006/7, HID inspection records have been logged as intervention plans. Certainly this means that there are likely to be problems of easy comparability between data which precede and follow the year 2006-2007. But the major implication of this change is that individual inspection records now capture multiple visits and exchanges with the same duty holder at the same site. For this reason, data for inspection records are more likely to provide an indication of the aggregate number of duty holders subject to inspection, rather than the extent to which individual sites or duty holders are scrutinised, since multiple visits or contacts may be logged in one record. We therefore use those figures as an indication of the coverage given to the range of hazardous sites for which the HSE is responsible.

Indeed, the HSE maintains that there has been no significant decline in HID inspection hours measured as ‘front-line activity’ during this period. But the term ‘front-line activity’ represents a more difficult indication of inspection coverage, since a very wide range of activities are subsumed within the category of such hours.  

These caveats having been entered, we turn, in the following sections, to examine trends in the inspection of various hazardous sectors. What we find across these data is such a clear indication of inspection activity having stabilised at relatively low levels that we suspect strongly that changes in recording alone cannot account for the HSE’s dramatic decline in inspection records.

HSE’s Hazardous Installations Directorate (HID)

The role of HID is the regulation of major hazard industries that are deemed to be intrinsically hazardous, and involve particularly complex industrial processes. Areas of work regulated by HID are: processes involving micro-organisms and biological agents; explosives industries; gas supply and transportation; mining; offshore oil and gas production; and the chemicals industry.

Figure 5 shows a decline in HID inspection records of 48% over the most recent seven years. There appears to be a disruption in this trend occurring in 2010/11. This disruption is explained by the HSE as reflecting a transition in the timing of the creation of new intervention plans in 2010/11.  

Figure 5: HID Inspection Records

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10 HSE measurement of “frontline activity” includes: All direct contact (in person at their site, or in the office) with either stakeholders or duty holders and preparing for visits (gathering briefing material, making visit arrangements); any form of advice specific to a stakeholder or duty holder (e.g. letters); enforcement activity – issuing notices, interviews with witnesses, preparation and conduct of court cases; preparation for and attendance at health and safety awareness days, lectures, and other awareness-raising activities; all assessment, licensing and approval activities; and standards-setting work; Freedom of Information Request Reference No, 2010050259, 18 August 2010.

Chemicals Industry Division

Between 2006/07 and 2012/13, Chemicals Industry Division inspection records have fallen 40%. The Buncefield explosion\textsuperscript{12} in December 2005 and subsequent investigations into this incident are likely to have concentrated HID resources in the early period shown on Figure 5, but any significance here is likely to have dwindled in subsequent years.

The decline in inspection coverage cannot be accounted for in any major industry-related trends. It is certainly the case that the UK chemicals industry is in gradual long-term decline, but in recent years the industry has remained relatively buoyant. Although the post-2008 financial crisis has precipitated some loss of productivity, steady growth over the next few years is projected by most industry analysts (see for example Key Note, 2011 and Chemical Industries Association, 2013).

Mines

As even the most cursory glance at Figure 6 indicates, inspection of mines is in sharp decline: between 2006/07 and 2012/13, mines inspection records have fallen by 94%. This very clear trend may to a small extent be a reflection of the decline of deep coal mining. Yet this decline cannot and does not explain such a dramatic downward trend. According to the HSE, it is responsible for the scrutiny of approximately 118 working sites employing around 3,950 personnel.\textsuperscript{13}

\textsuperscript{12} The Buncefield Investigation summarises the incident thus: “In the early hours of Sunday 11th December 2005, a number of explosions occurred at Buncefield Oil Storage Depot, Hemel Hempstead, Hertfordshire. At least one of the initial explosions was of massive proportions and there was a large fire, which engulfed a high proportion of the site. Over 40 people were injured; fortunately there were no fatalities. Significant damage occurred to both commercial and residential properties in the vicinity and a large area around the site was evacuated on emergency service advice. The fire burned for several days, destroying most of the site and emitting large clouds of black smoke into the atmosphere”; \url{http://www.buncefieldinvestigation.gov.uk/}, accessed 12 July, 2013.

\textsuperscript{13} See HSE’s website at: \url{http://www.hse.gov.uk/mining/how.htm}, viewed 12\textsuperscript{th} July 2013.
In this industry, workers have in recent years experienced a steep rise in fatality rates: between 2005/06 and 2010/11, the fatality rate in UK coal mining stood at over 60 times the ‘all-industries’ rate. (O’Neill, 2011: 4) The figures show clearly that a worsening safety record in the industry has been paralleled by a steep decline in the inspection coverage.

**Offshore Safety Division (OSD)**

If we turn now to offshore oil and gas, we find that, as indicated by *Figure 7*, between 2006/07 and 2012/13 Offshore Safety Division inspection records fell by three quarters.

In this period, there have been regular concerns expressed in the industry about the difficulties OSD have faced in recruiting and retaining staff, and in managing workloads. A House of Commons Work and Pensions Committee report raised those problems five years ago, noting that there were fewer than 120 inspectors and that because of this urgent steps were needed to enable the OSD to “implement a robust and proactive inspection regime.” (House of Commons Work and Pensions Committee, 2008: 39). The same committee heard from the HSE Chief Executive Geoffrey Podger that the offshore industry is “getting very knife-edge in some places.”
The industry is facing a period of renewed buoyancy – perhaps the biggest upturn for a decade – and maintains ageing plants in some parts of the sector. Indeed, the OSD’s KP4 programme, which aims to improve the management of the consequences of the ageing of UK offshore installations, has been extremely resource intensive.

Moreover, the almost catastrophic gas leak and evacuation of the Elgin platform in March of last year led to the field being shut down for almost a year. Aside from this being a salutary warning to the industry, this incident has certainly been a major drain on the OSD’s resources.

Although there has been a general decline in minor and significant hydrocarbon releases, major releases last year hit a 12-year high (Health and Safety Executive, 2013a). There are also legitimate concerns about injury rates. Last year saw the first fatalities in the industry for several years, and the combined major and fatality rate, although still low compared with previous decades in the industry, has in fact been rising for the past four years.

Conclusion

It would seem reasonable, on the basis of the data presented in this section, to draw a series of conclusions relating to HID inspection records.

- Across these records, there appears to be a generalised and steady decline across the period.
- The data indicate a clear and dramatic reduction in the coverage of the full range of hazardous sites that the HSE is responsible for regulating.
- This reduction is particularly pronounced in Mines, Offshore oil and gas and Chemicals sectors.
- These declines are related both to policy changes in HSE targeting and inspection strategies, as well as to declining HSE resources.
In short, it seems reasonable to conclude that the government’s withdrawal of routine inspection from so-called ‘low-risk’ industries has not been coupled with a ring fencing of industries that government defines as hazardous. On this, while there are complexities with the data, that levels of inspectorial activity have not been maintained is clear. Indeed, the empirical evidence discussed here indicates that hazardous industries have been subjected to precisely the same pressures to reduce proactive inspection strategies and move towards a regime model of minimal inspection.

Conclusion

The trends set out here demonstrate the HSE’s declining capacity to meet its mission. The key conclusions that are supported by the empirical evidence set out in this response are summarised as follows:

- The HSE is presently unable to provide minimal inspection coverage of duty holders.
- The targeted enforcement strategy is bound to fail without a sufficient baseline of data upon which to ground this strategy.
- HSE is presently unable to provide a credible threat of enforcement and therefore is undermining any prospects for securing legal compliance.
- The abandonment of routine inspection of so-called ‘low risk’ work will make the majority of the workforce more vulnerable and will affect many who work in what are, in fact, highly dangerous industries.
- Industries defined by government as hazardous have not been ring-fenced and have been subjected to the same downward pressures.

Addressing those aspects of the HSE’s mission failure will require a significant upturn in resources and all forms of enforcement activity covered herein.

Almost ten years ago, the ongoing under-funding of the HSE, deepened by a further decline in, and a looming crisis of, enforcement, were the primary concerns of a House of Commons Work and Pensions Select Committee inquiry (2004) into The Work of the Health and Safety Commission and Executive. Its key findings included a round criticism of the HSE’s enforcement strategy:

The evidence supports the view that it is inspection, backed by enforcement, that is most effective in motivating duty holders to comply with their responsibilities under health and safety law. We therefore recommend that the HSE should not proceed with the proposal to shift resources from inspection and enforcement to fund an increase in education, information and advice. (House of Commons Work and Pensions Committee, 2004: 3 and para 142)

The Select Committee recommended specifically that the number of inspectors in the HSE’s Field Operations Directorate should be doubled (ibid.: 83), and that substantial additional resources would be needed to fund this and to reverse the “low level of incidents investigated and at the low level of proactive inspections”. (ibid.: 107). Consistent reductions in resources, staff, and all forms of enforcement activity since those recommendations only further underscore the urgency of their implementation.
References


