

# A crisis of enforcement:

## The decriminalisation of death and injury at work

Professor Steve Tombs and Dr. David Whyte

The Centre for Crime and Justice Studies (CCJS) at King's College London is an independent charity that informs and educates about all aspects of crime and criminal justice. We provide information, produce research and carry out policy analysis to encourage and facilitate an understanding of the complex nature of issues concerning crime and related harms.

The *What is crime?* project aims to stimulate debate about what crime is, what it isn't and who gets to decide. The project is focused on the themes of violence, finance and the environment.

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Fax: 020 7848 1689  
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### Editorial

**As Professor Steve Tombs and Dr. David Whyte illustrate in this briefing, fatalities and injuries caused through work are far more prevalent than the Health and Safety Executive (HSE) currently reports. For example, they find that more than 80 per cent of officially recorded work-related fatalities are filtered out from the HSE's headline figure and remain buried in other categories in the official data. The official data made available by HSE reporting methodology may thus only serve to mask the true quantity and quality of harm that takes place during work processes. After re-assessing the scale of the harms caused, Tombs and Whyte conclude that being a victim of a work-related fatality or injury is far more likely than experiencing conventionally defined and measured violence and homicide.**

**While such siphoning seems an inevitable and inherent characteristic of legal and regulatory systems, this briefing suggests that it may be only through the acknowledgement of 'safety crime' by agencies such as the Home Office, the police, the courts and the Scottish Government that safety crimes can be recast as 'real' crime and thus dealt with more appropriately.**

**The authors' conclusion, that most safety crimes are either undetected or filtered out from official channels of resolution, begs the question whether burdens have been displaced to employees and members of the public.**

**In our view, 'organisational violence' in the form of safety crimes is clearly worthy of greater acknowledgement owing to the harm caused and the contexts within which they occur. Such crimes are 'socially mediated' in the sense that they are brought about by particular institutional and organisational operations which place human life and physical safety at risk.**

**In the end, what gets defined as crime and what doesn't – and who gets to decide – are predominantly political questions. The *What is crime?* project at the Centre for Crime and Justice Studies hopes to create a space for critical thinking about such questions.**

**Rebecca Roberts and Will McMahon, Centre for Crime and Justice Studies**

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## INTRODUCTION

Despite the fact that deaths and injuries suffered at work usually result from infractions of the criminal law,<sup>1</sup> those deaths and injuries remain unacknowledged as 'crimes', and are only very rarely processed by the criminal justice system. The decriminalisation of safety crimes has been encouraged by recent government policy developments.

This briefing:

- Estimates a more accurate figure for the deaths and injuries caused by working and compares it to official statistics provided by the Health and Safety Executive (HSE).
- Examines how such deaths and injuries get filtered out from the official statistics and the processes by which these incidents are decriminalised.
- Sets out the policy environment within which trends towards further decriminalisation are unfolding.
- Indicates how this process of decriminalisation is reaching crisis point.

Reference throughout this briefing is made to injuries – fatal or otherwise – resulting from traumatic or acute incidents. We do not discuss deaths from occupational illness and cases of chronic ill-health, which run into tens of thousands, are grossly under-recorded and warrant their own consideration.

## THE SCALE OF DEATHS AND NON-FATAL INJURIES

### Fatal injuries

In 2006-2007, the HSE recorded a total of 241 fatalities suffered by workers in Great Britain (HSE, 2007). However, the data collated by the HSE on which this figure is based are so incomplete that they need to be reconstructed to provide a more accurate indication of the scale of the problem.

First, the data that the HSE presents refer only to fatal injuries to employees and the self-employed. This excludes the deaths to members of the public sustained through working environments which are recorded by the HSE. In 2006-2007, this total was 369. The HSE points out that some two-thirds of

fatal injuries sustained by the public in any one year are the result of suicide or trespass onto railway systems. If we apply this estimate, 246 deaths for 2006-2007 in this category can be excluded. When the resulting figure of 123 is added to the HSE baseline figure for workers (241), this produces a new running total of 364 deaths caused by work during that year.

Second, the most common measurement of occupational 'safety' is that used to record injury under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), (HMSO, 1995) introduced in 1995. RIDDOR continues to exclude significant numbers of occupational deaths for which officially collected data exist. Numerically, the most significant is the exclusion of road traffic incidents – fatal injuries involving 'at work' vehicles – which account for at least 1,000 deaths per annum (HSE/Department for Transport, 2003). RoSPA has indicated that the underlying causes of these incidents are similar to those for occupational fatalities and injuries more generally (RoSPA 2008).

Therefore, incorporating data on the public (excluding suicides and trespass on railways), road deaths and categories of deaths caused by working not recorded under RIDDOR<sup>2</sup> increases the total of occupational deaths from the HSE's 'all workers' figure of 241 for 2006-2007 to a figure of at least 1,400. In other words, to obtain a more accurate figure of officially recorded occupational fatalities, we need to apply a multiplier of between five and six to the HSE's headline figure.

### Non-fatal injuries

If we turn now to non-fatal injuries our research shows that each category of non-fatal injury data provided by RIDDOR also suffers from significant under-reporting. A comparison of the non-fatal RIDDOR data with the more authoritative Labour Force Surveys, published by the Office for National Statistics (see below), indicates that only about a quarter of reportable non-fatal injuries to employees, and probably about 5 per cent in the case of self-employed workers, are actually reported by employers. This indicates a widespread failure on the part of employers to meet their legal obligation to report incidents, itself an offence under safety law.

<sup>1</sup>The Health and Safety at Work Act (1974) is the principal criminal law statute that applies here.

<sup>2</sup>Also excluded are: injuries reportable under separate merchant shipping, civil aviation and air navigation legislation; injuries to members of the armed forces; and fatal injuries to the self-employed arising out of 'accidents' at premises which the injured person either owns or occupies (source: <http://www.hse.gov.uk/statistics/sources.htm>).

Workplace injury is far from an uncommon experience. Typically the HSE records that 30,000 major injuries are sustained by workers and 15,000 non-fatal injuries are sustained by members of the public each year (Tombs and Whyte, 2007). Around 120,000 injuries to workers which result in more than three days off work are also typically recorded in any given year. It is important to recognise that injuries are likely to be under-reported and under-recorded to a much greater degree than fatalities. Thus, for example, HSE data show that self-employed workers are twice as likely to be killed but four to five times less likely to sustain a major injury when compared to other workers. This reporting anomaly can only be explained by an appreciation of the relative difficulty with which fatalities as opposed to injuries can be hidden. Put very crudely, it is more difficult to hide a body than it is to hide a broken wrist. A similar reporting effect – if for different reasons – can be found in the figures for injuries to the public caused by working.

In order to reconstruct the data on injuries usefully, then, we would need to apply a multiplier of much greater than five to six times HSE's headline figure.

In the majority of cases, deaths and injuries incurred as a result of working should be viewed as crimes of corporate violence. This has been defined by Hills as:

*'Actual harm and risk of harm inflicted on consumers, workers, and the general public as a result of decisions by corporate executives or managers, from corporate negligence, the quest for profits at any cost, and wilful violations of health, safety and environmental laws.'*

(Hills, 1987:vii)

A focus on occupational injuries indicates that corporate violence is much more widespread than is appreciated, and remains widely under-reported.

## Box 1

### Labour Force Survey

The Labour Force Survey (LFS) is a sample survey of households in the UK carried out by the Office of National Statistics. The survey is organised quarterly and seeks information on respondents' employment and labour market status. It is regarded as being more reliable than RIDDOR data in some respects since it relies upon confidential self-reporting of injuries, rather than the willingness of employers to report to the authorities. The level of around a quarter of all injuries being reported is supported by recent research into hospital patients commissioned by HSE (Davies, Kemp and Frostick, 2007), which indicates that 30 per cent of all injuries sustained at work leading to hospital treatment are reported to the HSE. If we assume that less serious injuries, not requiring hospitalisation, are more vulnerable to under-reporting, this research confirms reporting rates of less than 30 per cent for all injuries sustained at work.

### Major injuries

According to RIDDOR reporting criteria, reportable major injuries are: fractures, other than to fingers, thumbs and toes; amputations; dislocations of

the shoulder, hip, knee or spine; loss of sight (temporary or permanent); chemical or hot metal burn or any penetrating injury to the eye; injury resulting from an electric shock or electrical burn; injury leading to hypothermia or heat-induced illness requiring resuscitation or requiring admittance to hospital for more than 24 hours; unconsciousness caused by asphyxia or exposure to harmful substance or biological agent; acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin; acute illness following exposure to a biological agent or toxic or infected material.

### Over-three-day injuries

An over-three-day injury is, according to RIDDOR reporting criteria, one which is not 'major', but results in the injured person being away from work or unable to do their full range of normal duties for more than three days.

### Non-fatal injuries to members of the public

These injuries are those which arise from work activity which result in the injured person being taken directly to hospital.

### The hidden violent crime problem

Despite the problems of working with the death and injury data available to us, comparisons can be drawn, no matter how crude, between violent crime recorded by the Home Office and occupational deaths and injuries.

First, in terms of deaths, we can compare the number of people killed at work with those recorded by the Home Office as homicides (that is, murder, manslaughter and infanticide).<sup>3</sup> The data in Table 1 allow us to make several observations. Initially it appears that one is twice as likely to be a victim of homicide in England and Wales than to die as a result of an acute workplace-related incident. However, against this, we need to bear in mind that the fatality data here are incomplete – at best they only capture between one-fifth and one-sixth (a range of 17 to 20 per cent) of occupational fatalities. As we can clearly see in Table 1, when we apply this multiplier, being a victim of a work-related fatality looks several times more likely than being a victim of homicide.

Second, a similar comparison can be made in relation to occupational injuries. According to the 2006-2007 British Crime Survey (BCS), there were a total of 2,471,000 violent offences in England and Wales, and 3.6 per cent of people experienced a violent incident. Of these, 49 per cent resulted in no injury to the victim, about one in ten (12 per cent) required medical attention, and one in 50 (2 per cent) resulted in a hospital stay (Jansson, Povey and Kaiza, 2007). In absolute terms, this equates to some 49,420 BCS recorded incidents of violence resulting in a hospital stay. Now, we cannot disaggregate from HSE injury data those which similarly require a hospital stay. However, we do know that the kinds of injuries defined under RIDDOR as 'major' (see Box 1) are

serious enough to warrant at least hospital treatment, while the definition of an injury to a member of the public is one that requires the injured person going straight to hospital. Thus, we can reasonably set against BCS data on violence resulting in a hospital stay HSE data for major injuries to workers and injuries to the public which, for 2006/07, stands at 29,450 and 17,483 such injuries respectively. Combining these two figures produces a total - 46,933 – which is virtually the same as the figure for BCS recorded violence requiring a hospital stay. And this is not even to begin to estimate the numbers of over-three-day injuries – 114,222 in 2006/07 – which resulted in hospitalisation (nor, of course, to account for the high levels of under-reporting).

To make the comparison in percentage terms, again using data for 2006-2007, we find the percentage of workers experiencing a major injury stands at just under 0.1 per cent (0.097 per cent, or 97.1 in 100,000). This can be compared with the 0.072 per cent of BCS respondents (the 2 per cent of the 3.6 per cent who experienced violence) resulting in a hospital stay.

Although such comparisons can only be broadly indicative, they do lead us to the rather undeniable conclusion – that work is much more likely to be a source of violence in Britain than those 'real' crimes recorded by the Home Office.

These observations raise questions about criminal justice responses to this violent crime problem. While we know that there are a whole series of social processes which obscure and recast safety crimes, their construction as something to be acted on and counted – not by police forces, nor by the Home Office, nor by the Scottish Government - but by regulatory agencies, crucially reinforces the idea that

<sup>3</sup>The absolute numbers are not wholly compatible in the sense that HSE data also cover Scotland. However, the key point of the comparison is with regard to rates.

<sup>4</sup>The 'rate' figures in this table have been rounded up to the nearest whole number. 2005-2006 data have been used here since these are the most recent available data for homicides in England and Wales.

TABLE 1: REPORTED FATAL INJURIES TO WORKERS AND HOMICIDES, 2005-2006<sup>4</sup>

All homicides in England and Wales	765
Rate of homicides per million population	14
Fatal injuries to all workers	217
Rate per million workers	7
All work-related fatal injuries (fatal injuries to 'all workers' x 5-6)	c1,100-c1,300
Rate per million workers x 5-6	35-42

safety crimes are not 'real' crimes. The institutional segregation of safety crimes by the state therefore has profound implications for how we regard them. Further, this means that we must look at what those agencies actually do if we are to discover more about how safety crime is defined: for it is in investigative, administrative, enforcement and juridical processes that crime is recognised and defined (Alvesalo, 2003).

### Filtering out safety crimes

Of course, not all injuries, fatal or otherwise, are crimes, and, as we shall see, certainly the vast majority are never treated formally as such by the criminal justice system. That said, we also know that the vast majority of these injuries do involve violations of law. HSE evidence, for example, consistently finds that, despite the lack of formal enforcement activity, more than two-thirds of injuries to workers are the result of managements failing to meet their legal duties under criminal law (Pearce and Tombs, 1998:152-4). In other words, while we cannot quantify it with any degree of certainty, what we can be certain of is that safety crimes constitute a significant violent crime problem indicated by the data presented in this briefing.

As we have seen, processes of reporting and recording combine to filter out the majority of deaths and injuries from the official figures. A second filter arises when a decision is made about whether to investigate, or not, as the case may be. There is no way of knowing how many recorded deaths, injuries or dangerous occurrences are actually investigated, since those investigation figures are published by the HSE on a highly selective basis. However, research by the Centre for Corporate Accountability (Unison/CCA, 2002) found that, in a five-year period, 75 worker deaths and 212 deaths of members of the public were not investigated. Subsequent research found that, in 2006/7, only 10.5 per cent of major injuries resulted in an investigation by the HSE. Thus, 89.5 per cent remain uninvestigated, including: 62 per cent of all amputations; 70 per cent of all asphyxiations and poisonings; 78 per cent of all burns; 57 per cent of all electrocutions; and 91 per cent of all temporary or permanent blindness (CCA, 2008).

A third filter comes in when a decision is made about whether or not to initiate any form of enforcement action. When inspectors come across breaches of the law and they decide to act on

those breaches, prosecution is used much less readily than other types of enforcement action. Applying a very rough and ready reckoner, the ratio of administrative (improvement and prohibition) notices to prosecutions is 7:1.<sup>5</sup> If injuries are investigated, then only 11 per cent of those investigations will result in prosecution (Unison/CCA, 2002). An internal audit undertaken by the HSE in July 2006 provides a rare and revealing picture of how the HSE assesses its prosecution practice. Of 126 randomly selected investigations, only seven resulted in prosecutions. Yet the audit concluded that 19 should have been prosecuted. The incidents that should have been prosecuted, but were not, included one death, six major injuries, two over-three-day injuries and two dangerous occurrences (HSE, 2006).

In short, we can conclude from this review of the available evidence that most safety crimes – including many of the most serious crimes – remain undetected. If they are detected, they are likely to be filtered out by the processes we describe here.

## THE POLITICAL CONTEXT FOR DECRIMINALISATION

Understanding these filtering processes allows us to view the different treatment of safety crimes as rooted in the politics and practices of criminal justice rather than in the intrinsic quality of those types of offences. The decriminalisation of safety crimes can only be fully understood within its political context. Within the current political context there are two tendencies at play which particularly influence these processes of decriminalisation.

First, there has been a consistent erosion of HSE staffing numbers that we can pinpoint to the beginning of the second Blair government (see Figure 1). In each of the years following 2001-2002, the HSE began to face real-terms cuts in funding from the government's grant-in-aid budget.<sup>6</sup> The HSE is grossly under-staffed. At its peak, in 1994, the number of HSE staff in post was 4,545. Since that time, numbers have fluctuated, but there has been a clear decline in the total number of staff employed by HSE since 2001-2002. On 1 April 2002 there were 4,282 staff in post and on 1 April 2006 there were 3,991 staff in post.<sup>7</sup> Of those staff, 1,543<sup>8</sup> are currently deployed as frontline inspectors (there were 1,625 on 1 April 2002). To put this in perspective, the number

<sup>5</sup>This ratio is based on figures available for the most recent available year, 2006-07.

<sup>6</sup>See HSE data supplied to the CCA, <http://www.corporateaccountability.org/HSE/resources/table97to06.html>.

<sup>7</sup>180 staff were transferred from HSE to the new rail regulator, ORR, on 1 April 2006 (HSC, 2006-2007). We have included 180 'lost' staff in this figure to allow for comparisons to be made across time.

<sup>8</sup>95 inspectors were transferred from HSE to the new rail regulator, ORR, on 1 April 2006 (Hansard, 15 January 2007, col. 888W). We have included 95 'lost' inspectors in this figure to allow for comparisons to be made across time.

of frontline HSE inspectors equates to less than 9 per cent of the number of new police community support officers that the government has pledged to fund by the end of 2008.

The steady erosion of HSE resources has certainly had an impact on the morale of the organisation and its confidence to lobby government for the resources it needs. One indication of this lack of confidence is that the HSE has, in recent years, refrained from making any budgetary demands upon government. The following exchange between Geoffrey Podger, HSE chief executive, and Michael Jabez Foster, MP at a sitting of the Department for Work and Pensions Select Committee, in May 2006, is instructive:

**Foster:** ... in 2003... you had 1,651 frontline inspectors, in 2004 1,604 and in 2005 1,530. What is the best number to have? Is it better to have 1,600 or 1,500?

**Podger:** The honest answer to that is that nobody actually knows, and if I may say so, having worked in other enforcement areas...

**Foster:** So why do we not have 300?

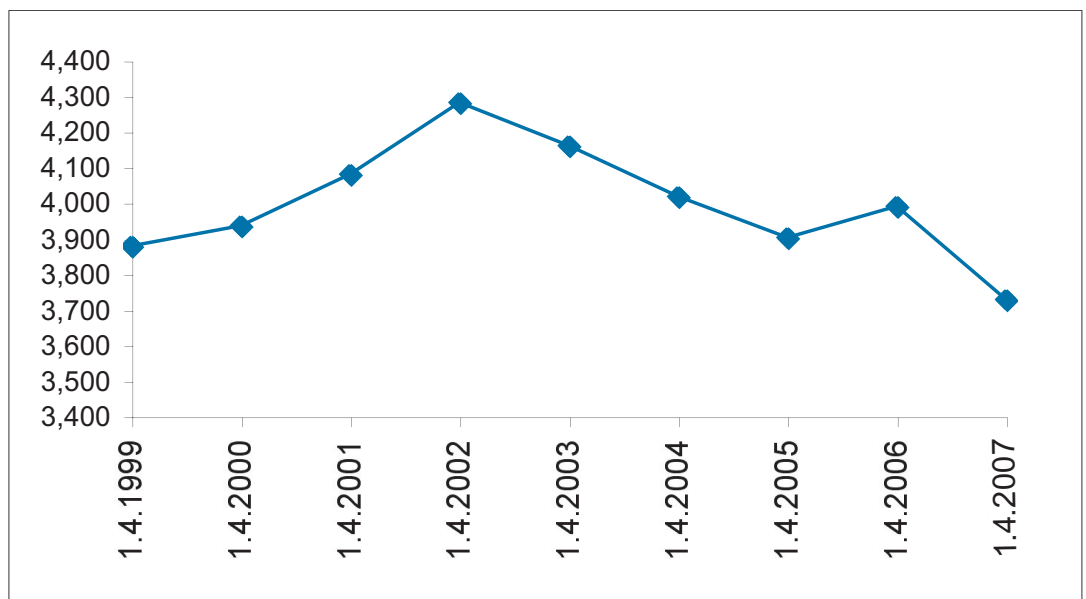
**Podger:** Why indeed?...

(Cited in CCA, 2007)

This exchange shows how far senior HSE figures are prepared to go to assert that no extra resources are needed to 'do the job'. It is a measure of its own demoralisation, while also confirming HSE's own assessment (no matter how misguided) that to argue for increased resources from the current government is futile. It is hardly a view shared by Prospect, the union that represents frontline inspectors. Back in 2004, Prospect recommended to the Department for Work and Pensions Select Committee that the number of field inspectors should be doubled – a proposal which the committee endorsed (House of Commons, Work and Pensions Committee, 2004, recommendation 9); thus last year Prospect claimed that the HSE 'cannot meet its public expectations to advise, inspect and enforce workplace health and safety' (Hazards, 2007).

The position adopted by senior management at the HSE appears even more remarkable in the context of debates on resources for policing. It is difficult to imagine any police officer in any police force area in the country relinquishing a claim to more officers or a larger budget – despite the fact that numbers of police officers are at an all-time high.

FIGURE 1: HSE STAFF IN POST



Sources: HSC, 2002; HSC, 2007; HSC/HSE, 2004; House of Commons Work and Pensions Committee, 2004

The second tendency that has influenced the decriminalisation of safety crimes is the post-1997 consolidation of the government's 'burdens on business'/'anti-red tape' agenda. In 1997, the Conservative's flagship Deregulation Unit was renamed the Better Regulation Unit, with the Better Regulation Task Force established in the Cabinet Office, a strong indication that things were not going to get better for the victims of corporate crime. Regulatory Impact Assessments (RIAs) were introduced the following year. In 1999, the role of the Better Regulation Unit (renamed the Regulatory Impact Unit) was extended with a remit to ensure that RIAs were being implemented across government departments. RIAs aim to measure the costs and benefits of reforms on business, consumers, third-sector organisations and public authorities of all proposed policy and legislative reforms. However, their emergence and inclusion at the heart of the government's burdens on business agenda is a clear indication that the primary function of RIAs in practice has been to pre-empt and minimise legislative and regulatory cost impacts upon business. The effect has been a disciplinary one: to formalise a pro-business/deregulation frame of reference for policy making across government. In November 2007, a new system of impact assessments replaced RIAs. The new system was aimed explicitly at embedding the principle that all new regulation is to be carried out with minimum burdens on business (Cabinet Office, 2007).

In March 2004, a HSC internal document noted tellingly that 'there has been deregulatory pressure from within government to reduce burdens on business... HSE has responded positively' (Hazards, 2004). Figures released recently following a freedom of information request to the HSE by Hazards Magazine indicate that the burdens on business agenda had initiated a gradual decline in regulatory interventions in the HSE. For example, according to the Field Operations Directorate figures, the largest division of the HSE, there was a 26 per cent fall in inspections and a 19 per cent fall in regulatory contacts between 2002-2003 and 2004-2005 (O'Neill, 2006).

It is clear, then, that in the early 2000s, the HSE found itself under pressure on two fronts: first, in terms of the momentum given to the burdens on business agenda, and second from a real-terms cut in resources that is clearly indicated by the reduction in staff in post. This is the political context within which we can appreciate

the reduction in inspections and changes in the form of regulatory intervention, features of the regulatory climate to which we will return.

### The Hampton agenda

It was in 2004, towards the end of its second period in office, that New Labour's long-term plans for a reconstructed system of corporate crime regulation became fully apparent. In March of that year, the Treasury under Gordon Brown established the Hampton Review to 'consider the scope for reducing administrative burdens on business by promoting more efficient approaches to regulatory inspection and enforcement without reducing regulatory outcomes' (Hampton, 2005). The report – tellingly entitled *Reducing Administrative Burdens: Effective Inspection and Enforcement* (ibid) – called for more focused inspections, greater emphasis on advice and education and, in general, for removing the 'burden' of inspection from most premises. Specifically, Hampton called for the reduction of inspections by up to a third (across all regulatory agencies, this would equate to one million fewer inspections) and in their place recommended that regulators make much more 'use of advice' to business. Also, in March 2005, the Cabinet Office's Better Regulation Task Force published its review of regulation, *Less is More: Reducing Burdens, Improving Outcomes*. This proposed a crude mechanism for controlling the regulatory 'burden', a 'one in, one out' approach to regulation, whereby all new regulations were to be accompanied by the withdrawal of existing regulations (Better Regulation Task Force, 2005).

The recommendations of these reports came together in the Legislative and Regulatory Reform Act, which passed into law in November 2006. The aim of the law is to 'enable delivery of swift and efficient regulatory reform to cut red tape' (Cabinet Office, 2006). The Act itself is therefore framed by 'burdens on business' rhetoric, a rhetoric that juxtaposes economic success with overbearing investigation and enforcement. Thus, section 1 of the Act creates a remarkable new power for a minister of the Crown to make an order that removes from government a 'regulatory burden', defined in the Act as a 'financial cost', an 'administrative inconvenience' or 'an obstacle to efficiency, productivity or profitability'.

The impact of Hampton was an intensification of an already fiercely anti-regulation political climate. And

nowhere was its impact absorbed more consciously than in the health and safety regulator. In July 2005, the HSC launched its own review of regulation under the rubric of 'a debate on the causes of risk aversion in health and safety'. HSE deputy director general Jonathan Rees noted, 'HSE's approach to regulation is very much based on sensible risk management. Risk is ubiquitous. Some degree of risk, whether financial, environmental or in terms of safety is necessary for progress.' The HSE's draft 'simplification' plans, published in November 2005, promoted a 'risk-based, targeted approach to enforcement' that was to be supported by a 33 per cent reduction in inspections (Hazards, 2006).

These anti-regulatory initiatives reached their high point in the new Regulatory Code (DBERR, 2007), published by the newly formed Department for Business, Enterprise and Regulatory Reform, one of Gordon Brown's first initiatives when he finally made it to Number 10 in the summer of 2007. This code was introduced to address how 'the few businesses' (para. 8) that break the law should be handled. In general, regulators, including the HSE, were advised: 'By facilitating compliance through a positive and proactive approach, regulators can achieve higher compliance rates and reduce the need for reactive enforcement actions' (para. 8); they 'should seek to reward those regulated entities that have consistently achieved good levels of compliance through positive incentives, including lighter inspections and less onerous reporting requirements' (para. 8.1); they should also 'take account of the circumstances of small regulated entities, including any difficulties they may have in achieving compliance' (para. 8.1).

If the rationale for these new realities of regulation was not clear enough, the document formalised the emerging conflict of interest for regulatory bodies when it emphasised that '[r]egulators should recognise that a key element of their activity will be to allow, or even encourage, economic progress and only to intervene when there is a clear case for protection' (para. 3).

The Hampton Review and the reforms that followed have extended considerably the scope and reach of the burdens on business agenda into the day-to-day work of inspectors. Regulators are increasingly pressurised into prioritising the interests of the regulated above the protection of the workforce. The post-Hampton agenda has therefore further

marginalised the enforcement role of the HSE and given renewed momentum to New Labour's pro-business trajectory.

## Trends in under-enforcement

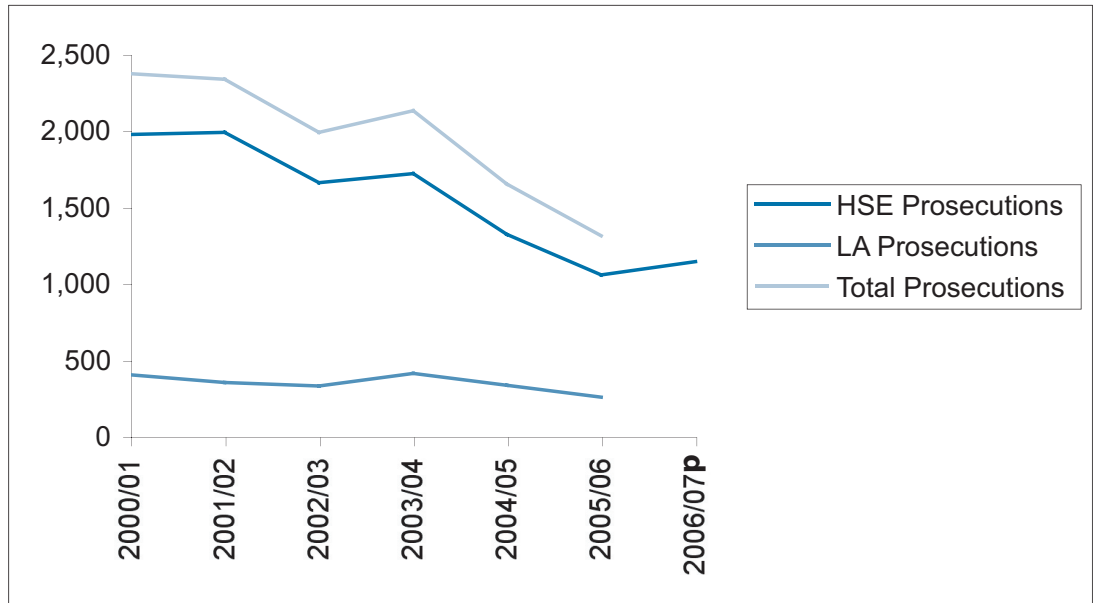
It would be difficult, and we believe unwise, to construct an argument that directly links the fluctuations in enforcement policy to particular political decisions or events. We do not attempt to do this here. However, we can draw conclusions from the general patterns that can be observed across enforcement data; and we can only understand those patterns in the context of the unfolding political strategy outlined above. We have already noted that there are clear signs of a general decrease in HSE resources, and frontline inspector numbers in particular, around 2002-2003, as well as a downturn in inspection and particular forms of regulatory activity since 2002-2003. Figure 2 indicates two clearly differentiated periods of decline in prosecution, following an initial rise in the period after the election of the first New Labour government. The first occurred roughly between 1999-2000 and 2003-2004 (a 16 per cent fall) and the second was a sharper decline between 2003-2004 and 2005-2006 (a 38 per cent fall).

The data on enforcement notices, indicated by Figure 3, appear to tell a slightly different story. The steady rise in the number of notices reaches a peak in 2002-2003 and then begins to fall back to a point roughly around 1996-1997 levels. We can therefore make an interesting observation about the data we have looked at so far: that while enforcement notices are at roughly the same levels as they were when Labour came to power, the level of prosecution is significantly lower. Moreover, if we look at how the patterns vary between local authority and HSE enforcement, we find that HSE trends are much more volatile than local authority trends. Indeed, in so far as there has been a collapse in enforcement since around 2003, this collapse is much clearer in HSE enforcement. In the local authority sector, the clearest trend has been the shift from prosecution to the use of enforcement notices – to the point that local authorities in 2005-2006 issued more enforcement notices than the HSE.

If we explore these data by separating out improvement notices from prohibition notices, something very interesting happens. There appears to have been an increase in the use of improvement notices at the beginning of the first New Labour



FIGURE 2: HSE AND LOCAL AUTHORITY PROSECUTIONS

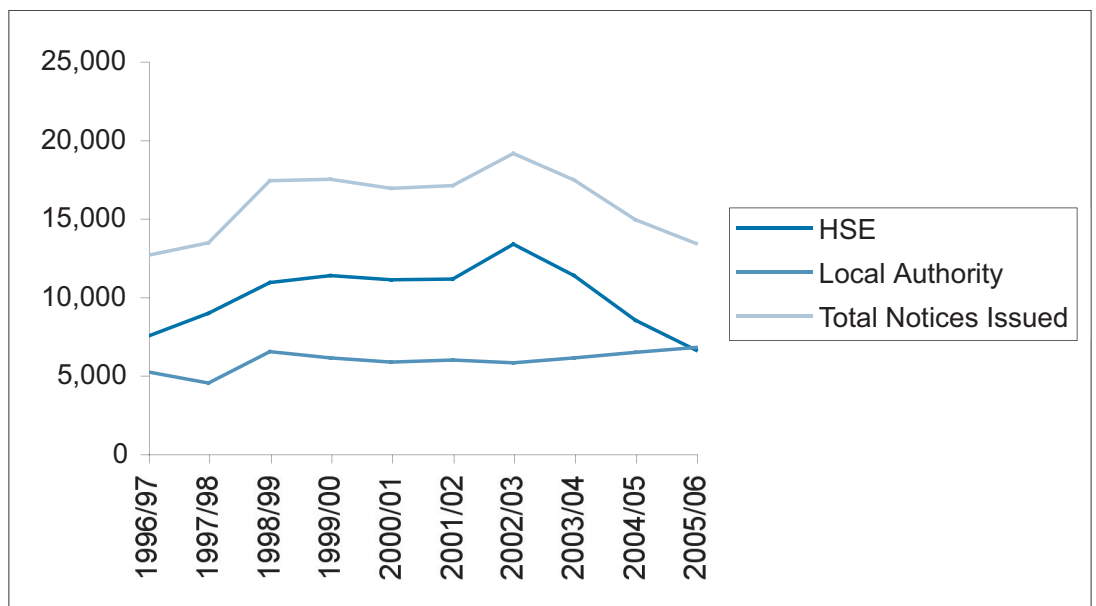


Source: HSE Enforcement Statistics, available online at:

<http://www.hse.gov.uk/statistics/enforce/index-ld.htm#table1>; p=provisional

Note that where HSE data refer to 'prosecutions', this denotes the number of breaches prosecuted, not the number of cases laid. See [http://bre.berr.gov.uk/regulation/documents/compliance\\_code/draft/compliance\\_code\\_final.pdf](http://bre.berr.gov.uk/regulation/documents/compliance_code/draft/compliance_code_final.pdf).

FIGURE 3: HSE AND LOCAL AUTHORITY ENFORCEMENT NOTICES



Source: HSE Enforcement Statistics, available online at:

<http://www.hse.gov.uk/statistics/enforce/index-ld.htm#table1>

government and then recently a sharp decline in this form of enforcement, whereas the use of prohibition notices is more or less constant. This may demonstrate two different aspects of the change in enforcement strategy over the past ten years. First, because improvement notices do not impose an immediate cessation of work unlike prohibition notices (nor are they likely to lead to criminal prosecution), HSE inspectors can be more conciliatory and less antagonistic when they uncover breaches or potential breaches of the law. It appears that the period following the election of the 1997 Labour government led to an immediate and dramatic use of improvement notices, a trend that was then reversed from 2002-2003 onwards. When considered together with the prosecution data, these figures indicate that it is the most discretionary forms of enforcement action which have been most vulnerable to New Labour's burdens on business policies.

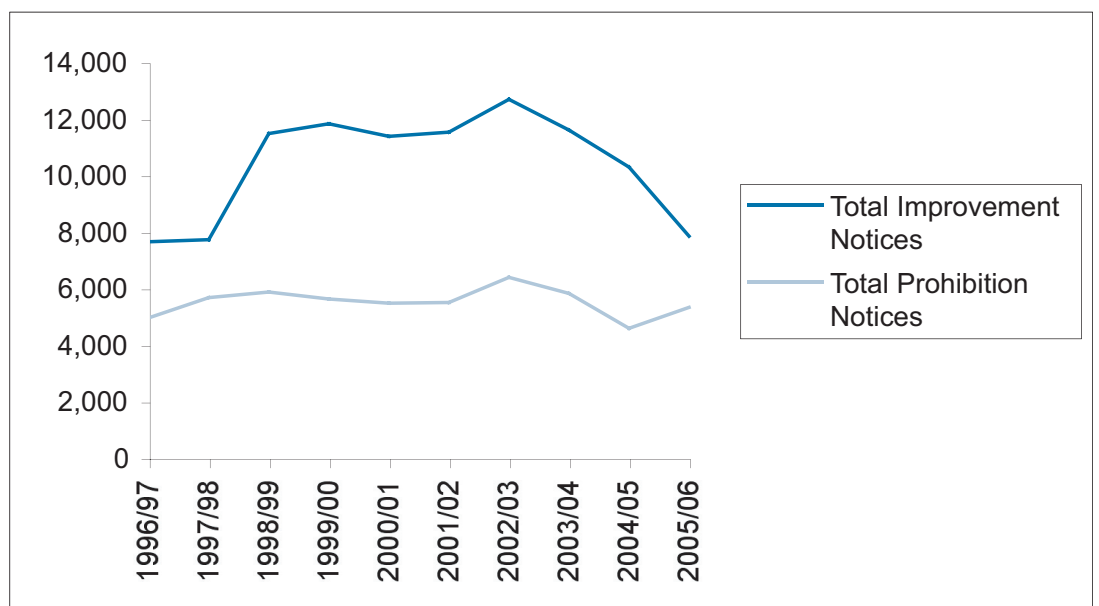
Second, the lack of movement in the number of prohibition notices issued, as indicated in Figure 4, rather than reflecting a consistent use of this form of enforcement *per se*, may actually indicate a tendency to use such notices (even in a less enforcement-minded context) in place of prosecutions. That is, where pressure on resources is intensifying, and where there is a political mood against the use of prosecutions, it may be increasingly difficult for frontline inspectors to justify the reasons for, and the costs entailed in, taking a prosecution. It is less resource intensive, and probably less politically difficult, to opt for a prohibition notice rather than a prosecution. This would account for the trend in prohibition notices holding up as prosecutions have declined. One frontline HSE inspector remarked on this trend to us, noting that, in the current period, 'being a good thief taker counts for nothing'.

What this indicates is that the current political climate has undermined both prosecution and less adversarial forms of enforcement – a contradiction at the heart of arguments for such an approach to regulatory enforcement.

### CONCLUSION

What we have described in this briefing is a series of filters that distort and misrepresent the figures for deaths and injuries at work. The consequences of these filters are:

FIGURE 4: IMPROVEMENT AND PROHIBITION NOTICES



Source: HSE Enforcement Statistics, available online at: <http://www.hse.gov.uk/statistics/enforce/index-ld.htm#table1>

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- A large hidden figure of crime – with at best, and on conservative assumptions, only one-fifth to one-sixth of recorded fatalities and a much smaller fraction of injuries ever being included in the headline figure.

- The vast majority of deaths and perhaps 90 per cent of reported major injuries not being subject to any form of investigation.

- Where deaths and injuries are investigated, few are prosecuted.

Yet we still end up with some quite remarkable statistics as a result of these unremarkable filters: a ratio of 125:1 for those injuries that are recorded and for which prosecutions are taken; and a ratio of more than 7:1 between notices issued on the one hand and prosecutions on the other.

What is also remarkable about these unremarkable processes is how they attract little or no popular, political or academic attention. Just as remarkable here is the contrast between this deafening silence on the one hand and the ongoing moral panic that characterises social responses to most 'mainstream'

violent crime on the other. The latter attracts censure, controversy, political dispute and is prioritised in the criminal justice system, as well as, of course, being allocated criminal justice energy and resources.

Recent trends in HSE activity all point to a crisis in enforcement. With a reduction in scheduled inspections and other visible shifts away from enforcement activity, it is inevitable that fewer safety crimes will be brought to the attention of regulatory authorities and the courts – so the filters alluded to in this briefing will become even more powerful. Low rates of prosecution for safety crimes can be explained both by a government campaign to undermine regulatory enforcement and by the acceptance on the part of the HSE of the commercial imperatives of the government's burdens on business agenda. The policy shift towards a model of self-regulation that became most pronounced in the second Blair government – of which the Hampton Review, the Legislative and Regulatory Reform Act and the new Regulatory Code are the key outcomes – is driving down levels of prosecution and enforcement. This is sending a clear, calculated message to corporate criminals that, under New Labour, they will be even freer to kill and injure with impunity.

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**Steve Tombs is Professor of Sociology at Liverpool John Moores University and Chair of the human rights charity, the Centre for Corporate Accountability. He has a longstanding interest in the incidence, nature and regulation of corporate crime, and in particular the regulation and management of health and safety at work.**

**Dr. David Whyte is Reader in Sociology at the University of Liverpool. His main research interests are in the social and legal regulation of corporate crime. He is a member of the Board of Directors of the Centre for Corporate Accountability and a member of the advisory board of Corporate Watch.**

**Professor Steve Tombs and Dr. David Whyte have recently published a new book *Safety Crimes*. Worldwide, two million people are killed by work each year. Yet with the exception of high profile cases, this crime wave fails to attract the interest of the politicians, the media or - least forgivably of all - the knowledge industry of criminology. The book concludes with an original analysis of safety crimes that allows us to understand the complexities of the conditions of their production, and develop a more realistic appraisal of the prospects for their amelioration. It will be essential reading for anyone concerned with crimes against worker safety. *Safety Crimes* is available from Willan publishing. <http://www.willanpublishing.co.uk/>**

**This briefing is available as a free download from [www.crimeandjustice.org.uk](http://www.crimeandjustice.org.uk).**

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**Some quick facts about safety crimes**

- You are two to three times more likely to be killed by a work related incident than a homicide.
- Almost nine out of ten major injuries known to the Health and Safety Executive are not investigated.
- There has been a 37 per cent decline in Health and Safety Executive prosecutions in the last four years.
- Only about a quarter of reportable non-fatal injuries to employees are actually reported by employers.

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**Tel: 020 7848 1688**  
**[info@crimeandjustice.org.uk](mailto:info@crimeandjustice.org.uk)**  
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