Accounting for Safety Crimes? HSE, enforcement data and the (shifting) politics of access

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Introduction

There have been relatively few studies of the effectiveness of the Health and Safety Executive (HSE), the body responsible for enforcing health and safety law in the UK. In particular, what is lacking is any detailed statistical audit of the HSE's enforcement activity. This significant absence is due almost entirely to the inability to gain access to the requisite statistical data, which is held by the HSE itself. The focus of this article is upon how the production of such an audit has been made possible. It begins by noting the kinds of questions that need to be asked of the enforcement activity of the HSE to assess its effectiveness in ensuring the accountability of companies that violate health and safety law, and details how such questions *cannot* be asked on the basis of publicly available data. It then discusses what needs to be done in order to obtain the information that allow one to make an informed assessment of the adequacy of the HSE's activities. Finally, the article addresses issues of wider concern for those seeking to use statistical data as a means of assessing critically the activities of state servants.

HSE, Annual Reporting, and Beyond

The HSE has a diverse set of responsibilities, including the enforcement of health and safety law. Its powers in this latter respect are extensive, and it is, therefore, a potentially important body in terms of stopping companies from causing harm to workers and members of the public, investigating corporate conduct to determine any responsibility for causing injury, disease or death, and/or prosecuting companies which it suspects to have acted culpably. But how can we assess the effectiveness of the HSE in the inspection, investigation and prosecution of companies? To even begin to make such an assessment, we need data on:

- the level, type and distribution of inspections

- the level and rates of investigations of the circumstances of injuries or deaths
- the rates of prosecution - who is being prosecuted and for what offences – and about the outcomes of these cases.

The obvious sources of data on HSE's enforcement activities are its Annual Report and annual Health and Safety Statistics publications. The most recent versions of these documents ran to a combined total of some 400 pages (with the statistical report generally containing over 100 statistical tables and up to 50 figures). Yet the comprehensiveness of these well-produced, glossy, seemingly weighty reports is more apparent than real. They provide basic data on the total of 'contacts' between the HSE and the regulated, on the overall number (and type) of notices issued, and on the numbers of prosecutions, their success rate, and their outcomes in terms of an overall average fine (1). On the basis of such data we can usually make crude comparisons with previous years – the number of contacts has gone down, the numbers of improvements notices have dropped, the average fine is going up, and so on. But that, pretty much, is that. Thus the reports omit some important, rather basic, information:

- they do not provide details on the distribution of inspections across companies, industries, areas, and so on.
- they do not indicate how many of the 'major' (or indeed the 'over-3 day') workplace injuries are subject to investigation (obviously important since, without investigations, the HSE cannot determine whether a company or senior company officer has committed a criminal offence or not, and the lower the rate of investigation, the greater the level of potential corporate immunity
- there is no information on how many of the workplace deaths have resulted in a prosecution against a company or senior company officer under health and safety law (2)
- they do not provide information on how many deaths have been referred to the Crown Prosecution Service for consideration of manslaughter and what action was subsequently taken. In short, the reports omit statistics vital to assessing key areas of the HSE's work.

Therefore it is necessary to contact either the HSE's statistical office or the Open Government unit in order to seek to obtain necessary, if basic information (3). In order to do so, there are two prior tasks: first, one must know *exactly* what questions to ask them, since the HSE tends to respond to specific queries *for* information rather than proffering general information *about* what data is available. Second, it

is important to ensure that one has enough money to pay the answers.

HSE's offices *do* hold a great deal of data on the enforcement of health and safety law, data useful for the questions set out above, in a sophisticated and user-friendly database, FOCUS, adopted in 1995/6 (4). However, 'section 28' restrictions aside (see below), much of this information held in the databases is only available at considerable cost. There are two levels of pricing. One simply seeks to recover costs of copying and postage, in addition to a "small administrative charge" (HSC, nd: 4). This applies to information "which has already been prepared and where all we have to do is photocopy it or provide a computer printout. This includes copies of entries in the public registers and copies of HSE's internal guidance and explanatory material on dealing with the public" (ibid.). Beyond this, other information incurs a charge that aims to cover "the time taken to locate and prepare for release" (ibid.). The rate varies from £25-45 an hour, and the cost is payable in advance.

Auditing HSE's Enforcement Activities

In 1999, David Bergman, along with colleagues with whom he had worked loosely around safety and health issues over the course of some 15 years, secured a £350,000 grant from the Joseph Rowntrees Charitable Trust to fund the establishment of the Centre for Corporate Accountability (CCA). A not-for-profit organisation, the CCA is concerned with promoting worker and public safety through addressing law enforcement and corporate accountability. The CCA considers that an effective inspection, investigation and prosecution policy will only improve and help to secure accountability for the bereaved and injured.

The Centre's activities fall into three main categories - advice, research, and advocacy.(5) Of interest here is the research function, and in particular the element of that function which focuses on the ways in which regulatory agencies – and primarily the HSE - enforce safety law. The focus of the remainder of this article is upon the attempts to gain that data which for years had proven inaccessible, and in so doing to indicate how it has been possible to produce a systematic audit of HSE's enforcement activities (Unison/CCA, 2002a, 2002b).(6)

It is the first time that such an audit has been undertaken, let alone one based upon raw HSE data. It examines the work undertaken by the Health and Safety Executive's 'operational inspectors' - that is to

say those inspectors who actually inspect workplaces, investigate reported injuries, and decide whether or not to impose enforcement notices or to prosecute. This report does not scrutinise the work of *all* of HSE's inspectors – it only looks at those that work in HSE's 'Field Operations Directorate' (FOD). FOD is the largest directorate within the HSE and its 419 Field inspectors (which represent two-thirds of all HSE's Field Inspectors) are responsible for enforcing the law in 736,000 premises across a range of sectors.(7)

The research uses statistical data to analyse the activities of these inspectors over a five-year period - between 1 April 1996 and 31 March 2001. It examines: the number of premises that they inspect; the number of reported incidents that they investigate; the numbers of enforcement notices that they impose; and the numbers of organisations and individuals that they prosecute. It further analyses how the levels of inspection, investigation, notices and prosecution differ between: five industry groupings (agriculture, construction, manufacturing, energy and extractive industries, and the service sectors); different parts of the country; and in each of the last five years. Finally, the report examines the levels of fines imposed by the courts after conviction.

The most fundamental conclusions of this Report are twofold. First, it shows how health and safety is being enforced in a very haphazard way: despite there being detailed policies, the levels of inspections, investigations and prosecutions vary enormously by region and by sector. Second, it documents how, in recent years, there has been a significant decrease in inspections, whilst investigations have increased. In summary, the data analysis demonstrated that:

- The number of inspections of workplaces declined by 41% in the five years to 2001 – a decrease of 48,300.
- On average, a workplace registered with HSE will now receive an inspection once in every twenty years.
- There has been an increase in the investigation of reported incidents over the five years but, in 2000/01, 3% of deaths of workers, 10% of deaths of members of the public, 80% of major injuries to workers, 93% of major injuries to the public, 70% of dangerous occurrences, 95% of over-three day injuries and 55% of reported cases of industrial diseases were not investigated.
- Some very serious injuries are still *not* being investigated, including: 905 of the 1144 reported major injuries to trainees or 126 of the 164 injuries to those involved in 'work-experience' over the five year period; and, in 2000/01, 72 'asphyxiations' (44% of the total), 31 'electrical shocks' (35% of total), 333

'burns' (57% of the total) and 418 'amputations' (41% of the total).
- Prosecution rates have increased over a three-year period but, in relation to incidents investigated in 1998/9, 67% of deaths of workers, 90% of deaths of members of the public, 89% of major injury to workers, 94% of major injury to members of the public, 95% of dangerous occurrences, and 99% of industrial diseases did not result in a prosecution.
- These percentages of investigation and prosecution, whilst generally low, vary enormously by industry and, perhaps even more worryingly, by region.

With statistics like these, it is easy to see why the HSE has been reluctant either to publish them or, previously, make them available for analysis. Appearing on *Newsnight* to discuss the Report, Justin McCracken, Deputy Director-General of the HSE, was very defensive, while the feature reported that "the HSE disputes some of the figures in the CCA's report".(8) This was repeated in an HSE statement the following day, in an HSE press release that coincided with the Report's publication (Health and Safety Executive, 2002). Yet this questioning of the data rather obscures the fact that the source of the data was the HSE itself, and the fact that they had been sent a draft version of the data analysis three months prior to publication!

In the context of this paper, it is worth making three observations on how the data for this audit was used and presented.

First, securing the data that made the statistical audit was dependent upon not inconsiderable resources:
- purchase of the data cost in excess of £1,600
- analysis of the data cost over £11,000
- production of the text for the statistical report expended a great deal of (unquantifiable) person hours at the CCA
- publication of the report – to reach the widest possible audience – cost £10,000.(9)

In sum, though these costs are significant, they are not beyond the reach of academics to secure, even if access to funds from charitable organizations and research councils which might be willing to resource such work is highly, and increasingly, competitive.

Second, funding alone would not have secured the data. Nor is it clear that an individual academic would have secured the agreement of HSE to provide the data. In the case of the CCA, the fact that it had achieved some organizational visibility and power over a number of

years was vital in successfully negotiating the release of the data from HSE.

Third, finally, and relatedly, access to the data would not have been possible without some shifts in policy and practice on the part of HSE regarding the provision of information on enforcement activities. There are perhaps a number of reasons for this, and it is almost impossible to assess the extent to which the HSE jumped or were pushed. For example, the HSE has

- published on its website (since 2000) a Public Register of Convictions, giving details of all prosecution cases taken by HSE, since 1 April 1999 which resulted in a conviction
- established a Public Register of Enforcement Notices, giving details of all enforcement notices issued since 1 April 2001
- since 2001, began to publish an annual list of all health and safety offenders convicted (and a similar list for the Local-Authority enforced sectors).

Each of these developments is welcome, but has limits, and also only emerged after years of resistance to providing such data – but such unwillingness was made less tenable after, for example, the Environment Agency had begun to publish precisely such forms of data on their own website, and when the CCA stated its determination to make available on its own website a searchable database on health and safety offences.

Obstacles to Data Access

Having made these points regarding the significance of funding, the hard-won benefits of organizational clout in terms of gaining access to, and making publicly available, data on deaths and injuries at work, and the shifting nature of regulators' responses, there remain key legal obstacles that are indicative of the 'official' view of such work and the (still) relatively hostile climate in which it must proceed.

First, we should emphasise that, in policy terms, and despite its commitment to 'Open Government', the HSE continues to guard access to data quite jealously. For example, in 1998 it became known that the HSE were operating a 'greylist', containing names of people who made 'persistent' enquiries of HSE for information, and whose future requests for information were to be monitored (Monbiot, 2000: 347-8). More recently, when a local campaign group secured data that was not publicly available from HSE, and around which a highly critical report of safety practices within a chipboard plant was written, HSE's concern was not to investigate the practices thereby exposed

but to seek to determine the source of the leak; within weeks, an explosion and fire at the site led to HSE serving a prohibition notice on the company.

Thus there remain real limits to the levels of information available. Some of these are outside the HSE's control. Section 28 of the HASAW Act 1974 does restrict the release of a great deal of information that HSE inspectors obtain in the course of their activities, or that companies are required by law to provide to the HSE. Undoubtedly, there are occasions when the HSE's hands are tied, even when they want to make information public. However, section 28 appears sometimes to be used by the HSE as an excuse not to provide information. One example is its refusal to pass to the CCA details of all RIDDOR reports – the reports which employers are legally required to submit in the event of a reportable incident. The CCA intended to publish these reports upon its website, with two aims, which were communicated to the HSE: first, to allow individuals to check whether their own employer had met their legal duty to report an incident; and, second, to allow individuals to check the incident records of specific companies, sectors, and so on (which might, for example, be useful from the point of ethical investment). According to HSE's own interpretation of Section 28, this information could be made available if the provision of it served a 'positive health and safety purpose' – which the HSE decided it did not since it was of the opinion that to provide such information might further deter employers from meeting their legal duties to report! (10)

Second, then, we should always be aware also that the instinctive - almost *natural* - tendency of HSE as an organisation (and of other state bodies) is to give less rather than more information, though this should not obscure the fact that the HSE does have a positive open government policy and there are many individuals within the HSE (and other organisations), who are striving towards greater openness. It could also be argued that in assessing requests for information, HSE tend to make judgments about the *relative power* of those doing the asking, thus enjoying a degree of discretion which ought not to be available to a publicly funded body. Indeed, this is indicative of a general tendency of government departments and a civil service operating in what has generally been noted to be still a highly secretive state. And the Labour Governments, for all their early trumpeting of improving access to state information, have hardly tackled this tendency with vigour: for example, in 1999, 29% of requests for information under the Code of Practice on Access to Government Information were rejected, whilst it was found by the

ombudsman that Government had wrongly withheld information in 17 of 21 cases investigated (Barnett, 2000).

Conclusions and Discussion

With these words of caution in mind, what lessons can we draw from the substance of this article?

1. It demonstrates that it is possible to go beyond the limitations of the data offered most freely by HSE, namely that available in its annual publications. Thus, with persistence, time and money, much more utilizable data can be obtained.

2. It indicates that what data the state – here, via a regulatory agency – is either willing or can be pushed to make available clearly needs to be understood dynamically. That is, what is possible is crucially influenced by the socio-political climate and by the balances of relevant forces. Thus, for example, over a longer period, political space to be exploited by health and safety campaigners and researchers has been created by a series of one-off events, namely disasters (for example, the series of incidents on the railways) and high profile deaths, such as the death of Simon Jones and the (successful) campaign that followed this for a manslaughter prosecution to be launched. (11)

3. It contains lessons regarding the role of academics. As noted above, there have been no attempts hitherto to generate such a systematic audit of HSE activities. Yet this article has shown that the production of such an audit is possible, and possible in the context of a combination of factors and circumstances that are not *necessarily* denied to academics. Perhaps, then, those of us who have been concerned with safety crimes and their regulation have been 'guilty' of some element of self-censorship here, too readily accepting, rather than adequately challenging, the level of access to data that we have historically been granted. (12)

One final point needs to be made here. Namely, it should be emphasized that any statistical audit regarding inspection, investigation, prosecution and so on does not provide us with information of the *adequacy* of such activity. For this, more qualitative work is required. But the securing of the data under discussion in this article is at least the starting point of this exercise, an exercise which seeks to call to account the government body which itself exists to call

to account companies and individuals whose actions or omissions endanger, injure and kill on an almost routine basis.

Notes

1. HSE can impose legal notices upon employers compelling them to make improvements - Improvement Notices - or to stop work where there is a serious risk of injury - Prohibition Notices.

2. Since 1998, it has been HSE policy to investigate all deaths, in the presence of the police. In 2000/01, 97.5% of the 279 reportable deaths of workers, and 90.6% of the reportable deaths of members of the public, were investigated (Unison/CCA, 2000b: 19).

3. In its most recent Open Government statement, HSE sets out the kinds of information which they will make available on request (Health and Safety Commission, nd: 2-3), then adds, "Sometimes we will not be able to give you all the information you would like because this could harm the nation, individuals or companies" (ibid.: 3).

4. The database used prior to this is not strictly comparable with FOCUS, making longer-term longitudinal analysis virtually impossible.

5. Most importantly, the CCA runs a work-related death advice service that provides free, independent and confidential advice to families bereaved through work-related activities on how to ensure that the death is properly investigated and the evidence subjected to proper prosecution scrutiny. See the CCA's website at www.corporateaccountability.org

6. Published in the form of two Reports. Both are available at www.corporateaccountability.org/HSEReport/ index.htm.

7. At Spring 2001

8. Paul Mason, BBC's Business Correspondent, *Newsnight*, BBC2, 15 October 2002.

9. Provided by Unison.

10. Under-reporting remains a major issue: "Overall, employers report about 44% of the non-fatal injuries that they should report" (Health and Safety Commission, 2002: 1).

11. See http://www.simonjones.org.uk/

12. David Bergman, Executive Director of the CCA, and largely responsible for securing access to the HSE data discussed in this paper, is not a University academic. I am, and I do not exclude myself from these critical comments. Of course, there are exceptions to this criticism.

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