Health and Safety Executive Board			HSE/10/54
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Review of Enforcement by FOD

Purpose of the paper

1. To provide information to the Board on the review of the level of formal enforcement (Notices and Prosecutions) by FOD. The Board is asked to note the current situation, the conclusions from the review, and the actions being taken by FOD.

Background and contextual information

2. The Board expressed concern at possible formal enforcement levels following the 2009/10 Q1 return, which suggested a potentially significant step change downwards in prosecutions approved in 2009/10. To establish why we are where we are in respect of formal enforcement, FOD has undertaken a comprehensive review to better understand what has been happening, so that we can take any necessary action to address any underlying issues. The review reports on the level of formal enforcement, and the factors that may have affected it, over the last 10 years, along with the actions that can and are being taken to address the situation.

3. Action by FOD in Q2-4 of 2009/10 to (i) improve timely recording of prosecution approvals and (ii) to conclude and bring forward prosecutions 'in the pipeline', has meant that the drop in prosecutions is not as great as was thought likely at Q1 – where a 40% reduction compared to the previous year's outturn was being predicted. However, there remains a continuing downward trend in prosecution approvals. Whilst there has also been a reduction in past years in the number of Notices issued, the trend has reversed and levels have increased in more recent years. Annex 1 gives the figures for prosecutions and notices from 1999/00 to 2009/10 and also shows the longer term trends in fatal and major injury rates as contextual background information.

4. Provisional data for 2009/10 for FOD indicate a c22% increase in notices, and c12% fewer prosecutions approved, when compared to 2008/09. It is worth emphasising that, partly in consequence of recent tougher sentencing guidelines we believe, HSE has recently delivered a run of high profile (and therefore high deterrence value) prosecutions across the spectrum of hazards, and against public and private, and large and small organisations, leading to high fines and in one egregious case to 30 months' imprisonment (reduced to 21 months following payment of £20 000 compensation to victim). These examples are show in Annex 2. This collective achievement is not conveyed by the bare number of prosecutions, but is of very high impact.

5. Annex 1 shows the long term trend in FOD's formal enforcement (for all activities) over the last 10 years. For prosecutions the trend is downward. The number of prosecutions approved in 2009/10 is 46% of the 1999/2000 level. For enforcement notices, there is a downward trend from 1999/2000 to 2007/08, with then an upward movement. The 2009/10 level is 87% of that of 1999/2000. It is important to note that the resources devoted to investigation and enforcement have not similarly fallen. Indeed in recent years the actual time spent on both investigations and enforcement has risen. This lends support to the view often expressed by staff that the processes they have to follow have become more demanding over time. In part this is inescapable; for instance the procedures for interviewing company directors under caution are now much more formal and subject to challenge than previously. However, FOD have issued guidance to staff on "common myths" that might cause unnecessary increases, such as the over-interpretation of what is meant by "all reasonable lines of enquiry."

6. To give context to the figures above, the worker fatality rate has reduced by 15.5% (2008/09p compared to 2000/01) and the employee major injury rate by 4.1% (2008/09p compared to 2000/01). Recent research attributes about 24% of the reduction in the rate of fatal injury in the last 10 years, and 50% of the non-fatal rate (since 1986), to a shift in employment towards (safer) service industries. By inference the rest reflects better standards, for which some (significant) credit might be claimed by the regulators, HSE and LAs. It is important to bear in mind that this achievement, which is reflected in health data as well as injuries, stems from the application of the full range of techniques as described, for instance, in the then HSC's 2005 publication, *Sensible health and safety: The regulatory methods used in Great Britain,* not simply from investigation and enforcement.

7. It is argued in paragraph 4 above that high impact prosecutions are of particular deterrent value. Part of the explanation for the different trends in the numbers of cases and the resources given to enforcement lies in an increase seen in such cases. Whilst the average fine per conviction secured by FOD only rose from around £5,700 in 2002/03 to around £11,000 in 2008/09, the number of fines exceeding £50,000 rose from 27 to 57 and of those the number over £100,000 rose from 5 to 25. In contrast, 602 of 815 convictions secured by FOD in 2008/09 secured fines of less than £10,000. Thus the term "prosecution" itself embraces a wide spectrum of outcomes of very different significance.

Argument

8. The key finding of the enforcement review is that it is not possible to identify any single cause that answers the question "why are we where we are in respect of formal enforcement?", although there is a strong positive correlation between incidents investigated and prosecutions approved. Many activities and influences have been at play, preventing identification and proof of causal connection between any individual event and subsequent changes in formal enforcement levels. Some possible driving forces behind formal enforcement levels identified are:

    - Aggregation and accumulation of activities and initiatives,

    - Number of investigations – and managing and reviewing them, (90+% of prosecutions arise from investigations – which have also reduced significantly i.e. the 2009/10 investigation level is c37% of that of 1999/2000)

- Staff levels and trainees – time available, e.g. in 2009/10, 43% of FOD's front-line Inspectors (Band 3/4) are in training on the Warwick post-graduate diploma,

- Business plans and the way we work, (e.g. dedication of inspector resources to certain FIT3 topics which were not mature 'enforcement rich' areas),

- Messages and culture – including operational management action,

- Setting (or not) of targets for formal enforcement activities and numbers of investigations.

9. It is believed that all of these have an effect, although they cannot be quantified. The main aspects are:-

    - completing fewer investigations (but without a commensurate reduction in the resources required)

    - doing, for good reason, other things differently

    - a significant proportion of our staff in training

    - communication of expectations and targets.

10. One example of doing things differently is the successful construction priority programme, which was a programme of varied and targeted activities aimed at improving the management of health and safety across the construction industry. The programme, which has brought positive benefits in reducing risk and potential for harm across the industry, changed the way of working. Resources that might otherwise have been engaged in formal enforcement activity were put to very good effect in taking forward the programme. This was acknowledged in the Donaghy report.

11. The cumulative effect, at a given time and over time, of successfully completing all initiatives has resulted in less formal enforcement. Strategic priorities and decisions can have a significant impact on the levels of formal enforcement (either positively or negatively) and therefore managerial decisions need to be made against this context (of perhaps unintended consequences). But such strategic priorities and decisions also need to be judged alongside the wider outcomes they have (or may) achieve.

12. The data appear to show a step-down around 2004/05 in both prosecutions approved and notices issued. This coincides with a range of activities that may have affected formal enforcement, which include the impact of the previous HSE strategies and the removal of investigation and formal enforcement targets. However, the introduction of COIN and associated changes to work recording introduces a confounding factor, which means that such attribution cannot be made with full certainty.

13. Prosecutions have been produced almost exclusively from RIDDOR investigations. We recently have been concluding fewer investigations and therefore generating fewer prosecutions. We have also taken action to increase the time spent on preventive work which has improved our proactive:reactive

ratio – and taken steps to manage the time taken by investigation work. However, as the vast proportion of enforcement notices arise out of our inspection activity, the increase in the preventive work has resulted in a direct increase in the number of Notices issued.

14. Most prosecutions relate to safety matters, rather than health (a non-statistically significant sample indicates a safety:health ratio of around 7:1), which may be a reflection of the fact that most prosecutions come from RIDDOR investigations and most RIDDOR reports arise from safety issues. For some health matters, particularly chronic health ones, it may not be as easy to identify and obtain the evidence necessary for prosecution, as it is for safety matters. The role of formal enforcement in particular prosecution in improving health matters needs, therefore, to be considered further. But based on our long standing experience of evidential difficulties in health prosecutions, in particular chronic ill-health, will always be more difficult to take.

15. Flexibility in the selection of incidents, along with active monitoring of their progress, is vital to ensure appropriate and targeted investigations that are pursued in a timely manner.

16. To ensure that we properly target our field resources we should:

- Make sure that we select those 'serious' incidents where formal enforcement action is more likely to be appropriate and necessary;
- Finish all of our investigations as quickly as possible; and
- Ensure that we do not miss the opportunity to take prosecutions arising from our proactive work (e.g. inspections), when it is appropriate to do so.

17. Clear, unambiguous and effective communications in relation to formal enforcement via consistent and repeated messages are vital.

18. FOD's proposed actions address both shorter and longer term matters - covering 'what' we do, 'where' we do it and 'how'. All actions are directed at ensuring we continue to develop the most efficient and effective processes we can and have a culture fully embedded with all inspectors (and managers) of firm but fair and consistent application of HSE's Enforcement Policy Statement in all of our regulatory activities – and that our staff operate in a managed and quality assured environment.

Action

19. HSE Board is asked to note the following actions being taken by FOD:

20. FOD has already taken practical action to ensure that our internal processes and procedures are followed and that there is appropriate operational management oversight and monitoring. We have also set up a quality assurance section accountability team, to work with other FOD HQ sections and field operational management, to help deliver quality fieldwork.

21. FOD will ensure that investigations, and subsequent prosecutions, are done in an effective way with fit-for-purpose processes. This will include, in particular, that:

- investigation reviews by managers are effective;

- investigations are completed more quickly;
- investigations are closed-down early, where appropriate;
- we use the full range of our existing staff to carry out investigations and to take prosecutions forward to conclusion; and
- we consider the wider benefits of a different staffing model for certain elements of the process.

22. Securing improvements in **health matters**. FOD's ability to target and improve standards in health matters in respect of serving improvement notices has improved over the last few years– for example in silica dust control and the provision of effective local exhaust ventilation. Additionally, identification of and securing evidence for acute health issues (eg asphyxiations in confined space working, domestic gas safety and carbon monoxide poisoning) is possible and prosecutions – either with or without actual harm - can be undertaken (in line with the EPS). However for chronic or longer latency health matters, evidence collection can be more problematic, particularly in establishing cause/effect relationships from exposure to the onset of ill-health. In such circumstances, prosecution activity needs to be centred on the deficiency in immediate risk control measures – clearly there are circumstances where prosecution is appropriate despite the absence of actual harm being demonstrated eg exposure to asbestos fibres or silica dust. Because of such evidential difficulties, careful consideration of the effort put into prosecution activity needs to be made as to what the return of our efforts will be. It is not, therefore, an 'open and shut' case that automatically we should put more effort into prosecution activity for health if it displaces other activity eg service of notices that may be a more efficient and effective way of improving standards.

23. But we recognise that a successful prosecution is the most powerful regulatory tool we have in our intervention toolkit. We intend to undertake further work (in conjunction with relevant policy colleagues) to identify the aggravating circumstances and health topics where, in a limited range, we would emphasise prosecution as being vital to improving health standards and we will then communicate clearly our expectations to our staff.

24. As is indicated at paragraph 6, 90+% of our prosecution arises from our investigative work which has declined over the last few years. We need, therefore, also to consider prosecutions that arise from our proactive work.

25. Consideration of prosecution in the absence of actual harm or injury is expected by our EPS which sets out the circumstances where this is appropriate – regardless as to whether immediate action has been taken to control the risk eg service of enforcement notice. This is analogous to chronic ill-health situations. The need for actual harm to have occurred should not prevent the ultimate regulatory sanction being taken where the circumstances warrant it.

26. To meet the requirements of our EPS, we will produce further and clearer practical guidance on where proactive prosecutions should be actively considered. This will include setting out, in simple terms, the aggravating features where, in the public interest, proactive prosecutions should take place.

27. There is a risk that courts may take a view - and reflect in their sentencing - that the absence of actual harm makes these mere 'technical' offences. But strong advocacy and explanation of the reasons at court could mitigate against this. We will also seek to assist inspectors to be able to prepare such prosecutions in efficient ways to minimise the resources needed – for example through 'templated' prosecution reports, guidance on the minimum evidence that is needed in such cases. We **ask the Board to endorse this approach.**

28. HSE will maintain the current position of having no targets for our prosecution numbers ensuring our actions are fully guided by the Enforcement Policy Statement and the Code for Crown Prosecutors. The Board will recall the improvement in the consistency of enforcement decisions taken during investigations, that was reported in paper HSE/09/33 in April 2009, following the second Regulatory Decision Making Audit in HSE. FOD is now rolling out this peer review technique across Divisions.

29. FOD will continue to make it clear to our inspectors that we would expect, across FOD generally, a certain level of formal enforcement action to flow from properly targeted and executed work as part of the 'Delivery of Quality Fieldwork' initiative; and that all of our inspectors' performance in this area is regularly reviewed – with unjustified inconsistencies and variation in the individual level of performance to be challenged by management and, over time, reduced.

30. Whilst the large proportion of prosecutions is currently generated from our investigation activity, we do not propose that we should currently set explicit targets for the numbers of RIDDORs to be investigated as this may lead to undesirable consequences. In addition, setting targets for the number of investigations would impede FOD's efforts to move to a sustainable long term proactive:reactive ratio of around 60:40 – as proved to be the case when, in response to a Select Committee report in 2000, we did introduce such targets.

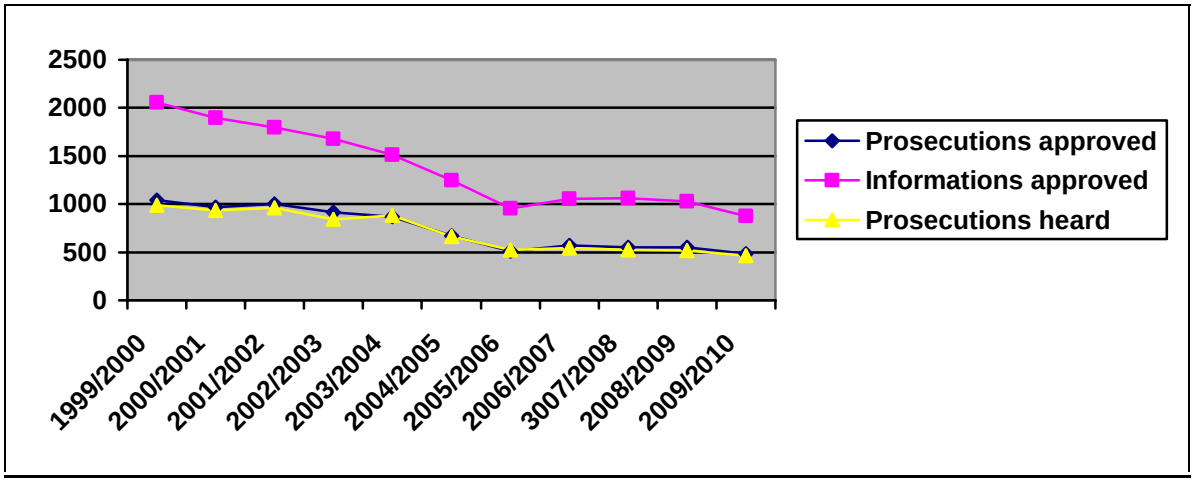
Paper clearance

31. Cleared by SMT on 2 June.

Annex 1 – FOD prosecutions and Notices (including public safety)

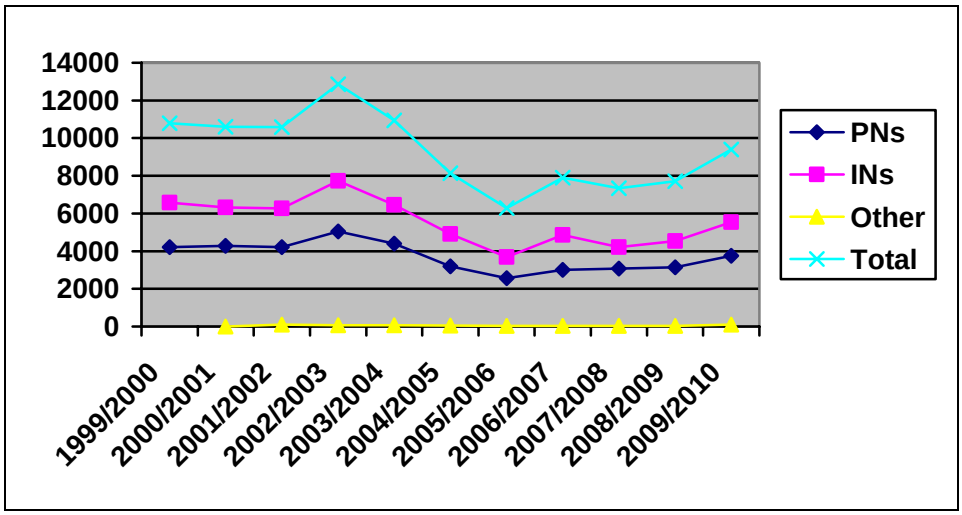
Prosecutions

	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10
Prosecutions approved	1040	967	1001	918	866	671	512	570	550	549	482
Informations approved	2053	1898	1794	1676	1512	1245	953	1054	1062	1027	877
Prosecutions heard	989	932	960	844	884	665	522	543	526	520	467



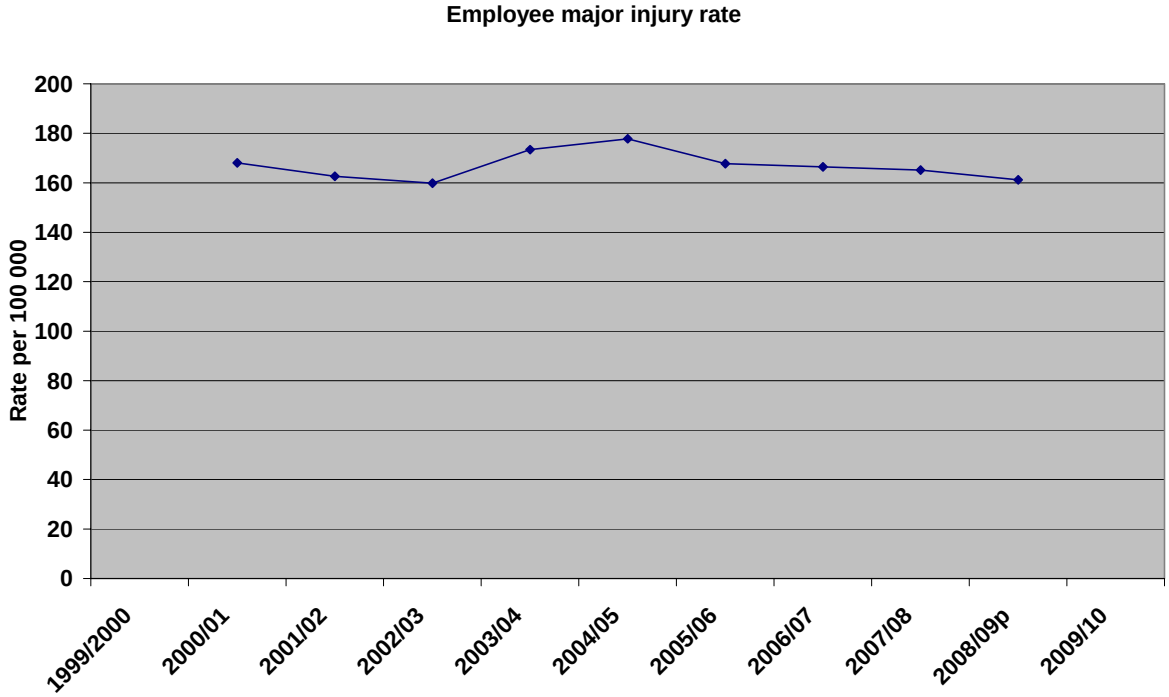
Notices

Notices	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10
PNs	4214	4285	4215	5046	4407	3188	2567	3006	3077	3136	3756
INs	6571	6322	6267	7736	6460	4902	3682	4859	4214	4533	5546
Other		3	98	74	69	50	40	28	42	39	101
Total	10785	10610	10580	12856	10936	8140	6289	7893	7333	7708	9403



Annex 1 (cont) Injury Rates

Rate per 100000	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09p
Fatality (workers)	1.29	1.57	1.39	1.36	1.37	1.31	1.51	1.43	1.09
Major injuries (employees)	168.0	162.6	159.8	173.4	177.8	167.7	166.4	165.2	161.2



Annex 2 – examples of more recent 'high profile' prosecutions

1. Landlord jailed for 21 months (originally 30 months but reduced after defendant paid £20 000 compensation to victim) following fire in rented property leaving teenager with 80% deep burn tissues. Joint prosecution between HSE and Norfolk Fire and Rescue Service.

2. Two companies and a managing director fined total of £170 000 after 23 year old worker fell over nine metres on a construction site, leaving him paralysed from the chest down. The director was also disqualified from being a director for four years.

3. NHS Trust fined £75 000 and ordered to pay costs of £25 000 after a mother died immediately after giving birth following administration of the wrong drug. There was no proper management system for the storage of drugs and warnings from earlier incidents had not been properly actioned.

4. Confectionery company fined £75 000 and ordered to pay costs of £37 500 after employee suffered serious head injury during cleaning of machinery on a production line. The accident resulted in individual spending two weeks in a coma and he now has significant level of blindness and deafness, loss of taste and smell as well as suffering personality changes as a result of the accident.

5. Company fined £140,000 with £20,500 in costs following fatal accident to an employee at a food factory. Employee had gained access to a dangerous part of a machine at the bottom of a silo. The company could have prevented the fatal accident if a simple padlock had been fitted to the silo access door.

6. HSE and police jointly investigated the tragic death of a severely disabled teenager who suffered 25% burns after being lowered into a bath. The complex investigation involved several dutyholders. One was prosecuted by HSE, found guilty and fined £100,000. Employees of the company were unaware of the bathing policy as no training had been provided. The suppliers of the bath have since agreed to HSE's recommendation to factory set temperatures for baths they supply in future.

7. Two waste recycling companies and a director were prosecuted following an investigation for exposing 20 employees, one of whom was pregnant at the time, to mercury and lead during the processing of electrical waste. Fines of £140,000 were imposed on the companies by the court, and a fine of £5,000 on the director.

8. Two men were jailed for three years for gross negligence manslaughter following the death of a 15yr old labourer, crushed to death during the demolition of a wall. Inexperienced workers were working at a wall already deemed to be dangerous, without supervision or proper instructions on how the work should be carried out.

9. Two construction firms fined £126,000 following major scaffolding collapse that left one man dead and two others seriously injured. The scaffolding was not strong or stable enough for the work being carried out and inspection of the scaffold was inadequate, despite instructions from HSE and the firm's health and safety manager.