

“Regulating health and safety risks - the implications for enforcement”

by: Tony Cox MA PhD (risk management consultant)

The field of health & safety, unwittingly notorious as the epitome of the “nanny state”, offers an instructive example of risk-based regulation in practice. Here, the concept of regulating to a non-zero risk level is not new, at least in the UK.

The principal legal duties (over which the UK has recently fought—and won—a battle with the European Commission) are to “...ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees”—the “SFAIRP” or “ALARP” principle. In case law, “health, safety and welfare” have been expressed in terms of risk, and “reasonable practicability” is a balance between risk reduction and the corresponding costs. This balance is heavily loaded in favour of safety, but nonetheless allows some residual risk. A corollary is that an accident may still occur in an organisation that has complied with the law.

This quintessentially British construction has been around from the days of the Factories Act, and in particular from a 1949 judgment, which has been repeatedly reaffirmed by the Courts. It is not a soft standard, as the EC seems to have believed, because the duty to control risk is continual, open-ended and pro-active. Moreover, it encourages the search for safeguards that are cheap to implement. Although comparisons are difficult, Britain seems to have the best workplace safety record in Europe.

In the period since the 1974 Health and Safety at Work Act, risk practitioners have taken the legal requirements and turned them into management processes that follow classical management models in controlling risks to health and safety. The input and output performance measures necessary to this approach include: frequency of injury or losses, near-misses, volume of preventative activities—all are indicators of risk. Because of the balance principle in ALARP (and because risk elimination is often impossible), the controlled level of risk is non-zero. This paradigm has been common ground between dutyholders and the HSE’s policy-makers for several decades.

As time goes by, however, improvements and efficiencies should be expected. The Health and Safety Commission has set up targets for reduction of UK accident and ill-health rates in the current decade—a good idea because improvement had ground to a halt. In my view, if those reductions in risk are to be achieved, it must be by further attention to the preventative duties that have to be carried out day after day, when no accidents are occurring or even appear likely. I believe that breaches of these duties should be the main focus of HSE’s enforcement efforts.

HSE’s enforcement work has to be prioritised and tends to focus on cases where a serious accident has actually occurred. In fatal accidents, they may not have a free hand because of the involvement of the police and public prosecutors, who tend (like the Courts) to have a “blame” mentality. Maximum penalties for health and safety breaches have been greatly increased and include heavy fines, “naming and shaming” and the imprisonment of individuals. Because the Courts will only hand down severe penalties when there are “aggravating circumstances”—which include

the harm done to victims—the effect has been that the crime is to have the accident, not so much to run the risk. That is retrograde.

More defendants are choosing to mount a defence rather than plead guilty, because they feel innocent and the penalties are high enough to be worth fighting over; this has absorbed more of HSE's limited prosecution resources. I have also encountered defendants pleading guilty while maintaining their innocence in private. Other dutyholders are motivated in unsatisfactory ways (for example, distancing themselves from safety issues, or behaving in a disproportionately risk-averse manner).

It is extremely difficult for Courts and regulators to set aside hindsight when a major and dramatic accident has taken place. There is also a tendency to leap from the proof of a breach of H&S law to the conclusion that such breach was actually causative of the accident. In reality, the network of causation is often complex and the contribution of any one person or organisation difficult to disentangle from that of others, and from the chance events that so often characterise reports of accidents and near-misses.

Although there are a few dutyholders whose behaviour is reckless and could cause an accident, in my experience the majority are “about average” in their control of H&S risks and it is difficult to equate this with the criminal standard of gross negligence. Besides the inequity of criminalising ordinary but unlucky managers, this policy does not communicate usefully to the others. The deterrence theory must apply to crimes of negligence in a different way from deliberate criminality.

All of the above pathology undermines the original concept of risk-based regulation and may cause society to lose the benefits that could derive from it. If we desire to improve safety performance in future, we have to motivate the vast majority of “average” managers who have not had their first accident - yet. I believe that this would happen if enforcement efforts were redirected to the preventive duties that are well covered by existing risk-based regulations, but frequently breached.

My general conclusion for the wider field of risk-based regulation is that the enforcement philosophy must be thought out at the same time that the regulatory regime is being designed, otherwise there is every chance that subsequent enforcement experience will undermine the original intention.