

SAFETY

Safety Last?

The Under-Enforcement of Safety law

LAST?

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The Centre for Corporate Accountability aims to promote worker and public safety by providing advice, and undertaking research and advocacy, on matters relating to law enforcement and corporate accountability.

It runs a 'Work-related Death Advice Service' to assist bereaved families in ensuring that the death is adequately investigated and subjected to proper prosecution scrutiny.

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HSE Areas and Industry Categories



The Map shows 19 different HSE areas which make up seven regions.

Industry Categories	
Construction	includes all forms of construction, demolition and building installation
Manufacturing	includes all forms of manufacturing of products
Energy and Extractive Sector	comprises all kinds of mining and quarrying activities and the production/supply of electricity, gas, steam & water
Agriculture	comprises farming, hunting, forestry and Fishing
Service Sector	comprises wholesale/retail trade, hotels, restaurants, transport, storage, Post, communication etc

HSE Regions	HSE Areas
London and South East	Greater London South East
Home Counties	Northern Home Counties South East Anglia
Wales and West	South West Marches Wales
Midlands	North Midlands East Midlands West Midlands
North West	Greater Manchester North West Merseyside
York and North East	North East South Yorkshire North & West Yorkshire
Scotland	Scotland East Scotland West

Introduction

An Audit

The Health and Safety Executive (HSE) – established by the Health and Safety at Work Act 1974 – is the main Government body responsible for enforcing health and safety law in Britain.

This report is a statistical audit of the core activity of the HSE – the work undertaken by its '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. The HSE undertakes many other activities including research, policy development and standard setting, but this report does not evaluate these activities.

This report does not scrutinise the work of all of HSE's inspectors – only those that work in its Field Operations Directorate (known as 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 concerned with construction, agriculture, general manufacturing, quarries, entertainment, education, health services, local government, crown bodies, and the police.

This report considers the activities of these inspectors over a five year period – between 1 April 1996 and 31 March 2001. It looks at:

- the number of premises that they inspect;
- the number of reported incidents that they investigate;
- the numbers of enforcement notices that they impose;
- the numbers of organisations and individuals that they prosecute;

It looks at how the levels of inspection, investigation, notices and prosecution differ:

- between five industry groupings – Agriculture, Construction, Manufacturing, the Energy and Extractive industries, and the Service sector;
- between different parts of the country; and
- in each of the last five years;

The report will therefore allow answers to the following types of questions:

- which industry receives the most inspections?
- which part of the country investigates the most injuries?
- has the rate of prosecution changed between 1996/7 to 2000/01?

Note on Scotland

In Scotland, FOD is not responsible for taking prosecution decisions. This is the decision of the "Crown Office and Procurator Fiscal Service". FOD inspectors will pass details of their investigation (or inspection) to the Crown Office who, after looking at the evidence, will decide whether any prosecution action will be taken. The differences in the courts and procedures are discussed in subsequent chapters.

The report has three main purposes:

- *to make FOD's activities more transparent.* Although the HSE produces comprehensive data on the extent of work-related harm itself, it produces little data that allows its own activities to be scrutinised and assessed. It does not produce any information, for example, on comparative levels of inspection and investigation or on the number of deaths and major injuries that result in prosecution.
- *to make FOD (and HSE) more accountable.* This report raises a number of questions concerning the sufficiency of HSE resources, the adequacy of its enforcement policies and apparent inconsistencies in its enforcement record in different parts of the country and between different industries. It is hoped that this report will result in the HSE itself being more willing to publish similar information in the future and to explain apparent inconsistencies in its performance.
- *to assist in the process of policy reform.* Although it is not always practicable, it is important that arguments about reforms of the HSE should, as far as possible, be evidence-based. This report contains statistical information that should assist Government, (and those wishing to lobby Government), with information crucial to a number of current debates concerning HSE reform including, for example, those relating to the adequacy of HSE's investigation and prosecution policy and whether or not HSE is adequately resourced.

It is the first time that such an audit has been undertaken.

The Data

The tables in this report have been compiled after analysing raw HSE data. The data was extracted from FOD's 'Focus' database – created in 1996 – which contains details of all registered workplaces and reported incidents and into which inspectors input information on their contacts with workplaces and details of any enforcement action. The names of workplaces and the names of injured or deceased persons were not provided.

This report has six chapters. The first two concern the levels of inspection and investigation – the means by which inspectors can gain access to workplaces and assess whether organisations and individuals are complying with health and safety law. Whilst inspections (considered in **Chapter One**) are supposed to be unplanned visits to workplaces, investigations (considered in **Chapter Two**) are visits in response to a reported incident of one kind or another, such as an injury or a dangerous occurrence .

Chapters Three and Four consider the level of 'formal' enforcement action – legal notices or prosecutions - taken by inspectors when they discover, in the course of an inspection or investigation, that there is evidence of a breach of health and safety law. Chapter Three deals with the numbers of 'enforcement notices'. There are two main types – an 'improvement' and a 'prohibition' notice. In order to impose an improvement notice the inspector must be of the view that there has been a contravention of a provision of health and safety law. The notice will state that particular changes must be made within a particular time period. A prohibition notice – which stops an identified activity - can only be imposed when an inspector is of the view that there is or will be a risk of serious injury if this activity continued.

Chapter Four deals with levels of prosecutions. In order for a prosecution to take place an inspector must be able to collect evidence to prove that an organisation or individual has failed to comply with a provision of health and safety law. A prosecution can take place in either the magistrates court (where fines are either a maximum of £5000, for a breach of a regulation, or £20,000, for breach of a statute) or they can take place in the Crown court where fines are unlimited.

Chapter Five allows the reader to look at, and compare, the performance of each of the HSE Areas and industry groupings across a number of key indicators at a glance. It also groups together the HSE Areas into the seven geographical Regions which HSE has now organised itself.

Chapter six – the conclusion - provides an overview of the data, considers the policies developed by the HSE in relation to inspection, investigation and enforcement and what reforms are required.

It is important to note the limitations of this report.

- this is a quantitative rather than a qualitative analysis, that

is to say it only contains analysis of how much of a particular activity inspectors are undertaking; it does not look at how well the inspectors are doing it. It is important to keep this in mind since it could be argued, for example, in the context of limited resources, that 50 rigorous investigations are preferable to 100 cursory ones. The report does not contain any information on the quality of HSE inspections or investigations.

- the accuracy of the report depends upon the reliability of the data provided by the HSE. Inevitably, there will have been some errors when the data was initially entered into its database and also when the data was extracted for our use.
- the data is not absolutely comprehensive. The data was provided by the HSE on and this means that many prosecutions relating to inspections or investigations since 1999 will not have taken place. As a result we have limited our analysis of prosecution data to incidents prior to April 1999.

Despite those limitations, it is hoped that this report will facilitate a much greater understanding than ever before of the manner in which HSE conducts its core activities and will provide a real opportunity to initiate an informed debate about the enforcement policies and procedures of the HSE and the financial context in which they currently operate.

HSE Inspectors

In the HSE, there are two main types of inspectors: (a) 'Field inspectors' who are responsible for day to day inspections and investigations and (b) 'Specialist inspectors' who provide expert back up to the Field Inspectors.

However not all field inspectors actually do the day to day inspection and investigation. – it depends on their grade or 'band'.

- Band 4 is the grade at which inspectors are recruited. They will remain in this band whilst they are in training.
- Band 3 is the main grade for HSE inspectors. These are the inspectors who are primarily concerned with the HSE's day to day inspections and investigations.
- Band 2 is the grade for inspectors known as 'Principal Inspectors'. They manage the Band 3 inspectors.

The number of Grade 3 Field Inspectors determine the number of inspections and investigations.

FOD Inspector Numbers – by Grade					Total	
	0	1	2	3	4	
Field	5	26	124	419	145	719
Specialist	2	7	28	48	0	85
Total	7	33	152	467	145	804

Chapter 1

Inspections and other contacts with workplaces

Key Statistics

Over the five-year period, there has been a 13% decrease in the total number of contacts with premises.

- In South Yorkshire there has been 36% reduction in the total number of contacts whilst in the South there has been a 14% increase.
- In the Extractive Industries there has been a 34% decrease in the total number of contacts, whilst in Manufacturing the reduction has only been 1%.

In the five year period, the total number of contacts involving investigations has increased by 44%, whilst inspection contacts have decreased by 41%.

- In The Marches there has been a 52% reduction in the total number of contacts involving inspections whilst in the South the reduction has only been 18%.
- In Construction there has been a 52% decrease in the total number of contacts, involving inspections whilst in Manufacturing the reduction has only been 24%.

In 2000/01, one in nine registered workplaces had at least one contact, of some kind, with a FOD inspector. This ranged from:

- one in five in the Construction sector, to one in twelve in Agriculture; and
- one in six in Merseyside to one in ten in East Anglia.

In 2000/01, one in 20 premises had one contact (or more) with an inspector involving an inspection. This ranged from:

- one in ten in Construction to one in thirty six in the Service sector, and
- one in thirteen in the North West to one in thirty-three in the Northern Home Counties.

This chapter analyses the number of 'contacts' that FOD inspectors have with registered premises. In particular, it looks at level of 'inspections' and how these compare with the levels of other forms of contacts – in particular 'investigations'.

It is possible to compare the number of inspections, investigations and other forms of workplace contacts, as inspectors must enter details of every contact they have into the HSE Focus database. There are 14 different types of contact (see Box on page 16).

Analysis of total number of Contacts

Table 1

Total number of contacts (1996/7 – 2000/01)

	Total Contacts
1996/7	194,660
1997/8	178,267
1998/9	176,229
1999/00	169,969
2000/01	169,876

Table 1 shows that the total number of recorded contacts with premises has decreased between 1996/7 and 2000/01 by 24,774 – a decrease of 13%. There is no data available on the number of registered premises prior to 2002, so it has not been possible to determine if any of this decline can be explained by a decrease in the number of registered premises.

Table 2

Total number by HSE area (1996/7 – 2000/01)

	1996/97	2000/01	Nos Diff	% Diff
South Yorkshire	9,315	5,938	- 3,377	- 36.3%
Marches	13,106	8,954	- 4,152	- 31.7%
West Midlands	9,636	6,971	- 2,665	- 27.7%
East Midlands	9,429	7,042	- 2,387	- 25.3%
N/thn Home Counties	9,279	7,134	- 2,145	- 23.1%
North West	10,804	8,333	- 2,471	- 22.9%
N & W Yorkshire	11,506	9,224	- 2,282	- 19.8%
East Anglia	8,978	7,521	- 1,457	- 16.2%
North East	9,013	7,582	- 1,431	- 15.9%
Greater Manchester	10,294	8,885	- 1,409	- 13.7%
Scotland West	8,079	7,235	- 844	- 10.4%
South East	9,473	8,678	- 795	- 8.4%
North Midlands	9,028	8,509	- 519	- 5.7%
Wales	11,039	10,483	- 556	- 5.0%
Merseyside	9,422	9,086	- 336	- 3.6%
Greater London	12,971	12,880	- 91	- 0.7%
South West	10,449	10,525	+ 76	+ 0.7%
Scotland East	13,002	13,664	+ 662	+ 5.0%
South	9,827	11,232	+ 1,405	+ 14.3%

Table 2 looks at the number of contacts in different HSE areas and indicates how the levels of contacts have changed in each area over a five-year period. Three areas have increased their contacts: South, South West, and Scotland East. In all other areas, the numbers of contacts have decreased across the period. The level of decline ranges from a decrease of just 0.7% in Greater London (with 91 fewer contacts) to a decrease of 36% in South Yorkshire (3,377 fewer contacts).

Table 3

Total contacts by industry (1996/7 – 2000/01)

	1996/7	2000/01	Nos Diff	% Diff
Energy/Extractive	4,319	2,863	- 1,456	- 33.7%
Construction	57,205	41,729	- 15,476	- 27.0%
Agriculture	19,454	16,073	- 3,381	- 17.4%
Service Sector	53,396	49,766	- 3,630	- 6.8%
Manufacturing	60,276	59,445	- 831	- 1.3%

Table 3 examines the number of contacts in different industry groupings and how the levels of contact have changed over a five-year period. It shows that there have been decreases in all industrial sectors, with the greatest reduction of actual contacts being 15,476 in the Construction sector, compared to a reduction of only 831 in Manufacturing; the greatest percentage reduction was in Extractive industry sector, where there was a decline of 34%.

Analysis of Different Types of Contacts

Table 4
Numbers of different 'Types of Contacts' (1996/7 – 2000/01)

	1996/97	2000/01	Nos Diff	% Diff
Investigation	39,384	56,515	+ 17,131	+ 43.5%
Enforcement	12,835	18,702	+ 5,867	+ 45.7%
Education	2,826	6,870	+ 4,044	+ 143.0%
Advice	11,501	15,320	+ 3,819	+ 33.2%
Inspection	117,158	68,857	- 48,299	- 41.2%
Projects	3,878	0	- 3,878	- 100%
Product	2,761	1,333	- 1,428	- 51.7%
LHLR	1,197	0	- 1,197	- 100%
Hazards	716	381	- 335	- 46.8%
Standards	275	0	- 275	- 100%
NIG	503	707	+ 204	+ 40.6%
Asbestos	1,025	829	- 196	- 19.1%
Civil	494	356	- 138	- 27.9%
First Aid	99	6	- 93	- 94.0%

Table 4 looks at the numbers of each of the different types of contact over a five-year period. It shows that there have been considerable increases in the numbers of contacts relating to investigation (44%), enforcement (46%), education (143%) and advice (33%), whilst at the same time a very large decrease in the number of inspections (41%).

The four main contact types are 'inspection', 'enforcement', 'investigation' and 'advice', and Tables 5 and 6 address how these four particular types of contact have changed in different industries between 1996/7 and 2000/01. It is interesting to note that although in 1996/7 both the Construction and Manufacturing sectors have a similar number of inspections (around 35,000), by 2000/01 the number of inspections in Construction had decreased by over 50% (over 19,000 inspections) which was over twice the reduction in the number of inspection contacts in Manufacturing. One might expect that as a result there would be a corresponding difference in the

number of investigation contacts, but in fact there has been more of an increase in the number of investigations in Manufacturing (43%) compared to Construction (35%).

Of further note is that whilst the number of 'advice' contacts has decreased in Construction by 16%, they have increased in Manufacturing by 59%.

It is also notable that whilst there has been a similar percentage increase in the number of 'enforcement' contacts in Construction, Manufacturing, Energy/Extractive and Service sectors of around 50%, there has been an increase of just 0.2% (an increase of 4 contacts) in Agriculture.

Table 5
Numbers of 'Inspections' and 'advice' contacts by industry (1996/7 – 2000/01)

	Inspection			
	1996/97	2000/01	Nos Diff	% Diff
Construction	37,774	17,908	- 19,866	- 52.0%
Manufacturing	34,680	26,460	- 8,200	- 23.7%
Agriculture	13,484	6,542	- 6,942	- 51.5%
Energy/Extractive	2,996	1,397	- 1,199	- 46.2%
Service Sector	28,642	16,550	- 12,092	- 42.2%

	Advice			
	1996/97	2000/01	Nos Diff	% Diff
Construction	1,903	1,603	- 300	- 15.8%
Manufacturing	3,824	5,763	+ 2,139	+ 58.0%
Agriculture	732	911	+ 179	+ 24.5%
Energy/Extractive	277	203	- 73	- 26.3%
Service Sector	4,965	6,840	+ 1,875	+ 26.7%

Table 6
Number of 'Investigations' and 'enforcement' contacts by industry (1996/7 – 2000/01)

	Investigation			
	1996/97	2000/01	Nos Diff	% Diff
Construction	11,723	15,867	+ 4,144	35.3%
Manufacturing	12,434	17,770	+ 5,336	42.9%
Agriculture	2,233	2,826	+ 593	26.6%
Energy/Extractive	951	865	- 86	- 9.0%
Service Sector	12,043	19,187	+ 7,147	59.3%

	Enforcement			
	1996/97	2000/01	Nos Diff	% Diff
Construction	3,507	5,291	+ 1,784	+ 50.0%
Manufacturing	4,866	7,543	+ 2,677	+ 55%
Agriculture	1,561	1,565	+ 4	+ 0.2%
Energy/Extractive	179	265	+ 90	+ 50.3%
Service Sector	2,722	4,038	+ 1,316	+ 48.3%

Table 7
 Number of 'Inspection' and 'Advice' contacts by HSE Area, (1996/7 – 2000/01)

	Inspection				Advice			
	1996/97 Nos	2000/01 Nos	Nos Diff	% Diff	1996/97 Nos	2000/01 Nos	Nos Diff	% Diff
Marches	7,637	3,695	-3,942	-51.6%	640	703	+63	+9.8%
South Yorkshire	5,316	1,981	-3,335	-62.7%	441	702	+261	+59.2%
Scotland East	8,644	5,375	-3,269	-37.8%	504	1,299	+795	+157.7%
West Midlands	5,410	2,359	-3,051	-56.4%	593	653	+60	+10.1%
East Anglia	5,963	2,519	-2,844	-47.7%	626	769	+141	+22.5%
Greater Manchester	5,940	3,169	-2,771	-46.6%	600	895	+295	+49.2%
North West	6,368	3,831	-2,537	-40.0%	963	712	-251	-26.1%
Scotland West	5,547	3,036	-2,511	-45.3%	266	613	+345	+128.7%
Greater London	9,127	6,629	-2,498	-27.4%	471	777	+306	+65%
Wales	6,605	4,107	-2,498	-37.8%	486	805	+319	+65.6%
East Midlands	5,576	3,181	-2,395	-43.0%	603	788	+185	+30.7%
N & W Yorkshire	6,090	3,757	-2,333	-38.3%	726	846	+118	+16.2%
North East	5,420	3,090	-2,330	-43.0%	560	731	+171	+30.5%
South East	6,347	4,094	-2,253	-35.5%	330	751	+421	+127.6%
N/thn Home Counties	4,271	2,020	-2,251	-52.7%	1,304	890	-414	-31.7%
North Midlands	5,056	2,847	-2,209	-43.7%	740	948	+208	+28.1%
South West	6,832	4,635	-2,197	-32.2%	372	732	+360	+96.8%
Merseyside	5,471	3,486	-1,985	-36.3%	710	745	+35	+4.9%
South	6,116	5,046	-1,070	-17.5%	560	951	+401	+71.6%

Table 8
Number of 'Investigation' and 'Enforcement' contacts by HSE Area, (1996/7 - 2000/01)

	Investigation				Enforcement			
	1996/7 Nos	2000/01 Nos	Nos Diff	% Diff	1996/7 Nos	2000/01 Nos	Nos Diff	% Diff
Scotland East	2,453	4,535	+ 2,082	84.9%	698	1,669	+ 971	+ 139.1%
Greater London	2,054	3,752	+ 1,698	82.7%	871	1,486	+ 615	+ 70.6%
South West	1,885	3,421	+ 1,536	81.5%	668	1,095	+ 427	+ 63.4%
South	1,653	3,127	+ 1,474	89.2%	737	1,317	+ 580	+ 78.7%
Merseyside	1,594	2,924	+ 1,330	83.4%	578	1,135	+ 557	+ 96.4%
North Midlands	1,953	3,170	+ 1,217	82.3%	660	737	+ 77	+ 11.7%
Scotland West	1,638	2,722	+ 1,084	66.2%	259	535	+ 276	+ 105.8%
Greater Manchester	2,272	3,333	+ 1,061	46.7%	698	1,085	+ 387	+ 55.4%
East Anglia	1,919	2,892	+ 973	50.7%	393	863	+ 470	+ 119.6%
South East	1,617	2,469	+ 852	52.7%	638	760	+ 122	+ 19.1%
Wales	2,533	3,318	+ 785	31.0%	807	1,411	+ 604	+ 74.8%
West Midlands	2,154	2,844	+ 690	32.0%	919	808	- 111	- 12.1%
North East	1,810	2,482	+ 672	37.1%	554	945	+ 391	+ 70.8%
N/thn Home Counties	2,304	2,844	+ 540	23.4%	542	821	+ 279	+ 51.5%
Marches	2,863	3,158	+ 295	18.6%	1,433	1,072	- 361	- 25.2%
North West	1,822	2,296	+ 474	26.0%	537	864	+ 327	+ 60.9%
South Yorkshire	2,188	2,279	+ 91	5.1%	616	718	+ 102	+ 16.6%
East Midlands	2,004	2,053	+ 49	2.4%	518	621	+ 103	+ 19.9%
N & W Yorkshire	2,888	2,896	+ 8	0.3%	719	760	+ 41	+ 5.7%

Table 9
Changes in the levels of contacts over a five year period by HSE area (1996/7 - 2000/01)

	Comparative Differences		
	Nos Ins	Nos Inv	Nos Advice
Marches	- 3,942	+ 494	+ 63
South Yorkshire	- 3,335	+ 111	+ 261
Scotland East	- 3,269	+ 2,082	+ 795
West Midlands	- 3,051	+ 690	+ 60
East Anglia	- 2,844	+ 973	+ 141
Greater Manchester	- 2,771	+ 1,061	+ 295
North West	- 2,557	+ 474	- 251
Scotland West	- 2,511	+ 1,084	+ 345
Greater London	- 2,498	+ 1,698	+ 306
Wales	- 2,498	+ 785	+ 319
East Midlands	- 2,386	+ 49	+ 185
N & W Yorkshire	- 2,333	+ 8	+ 118
North East	- 2,330	+ 672	+ 171
South East	- 2,253	+ 852	+ 421
N/thn Home Counties	- 2,251	+ 852	- 414
North Midlands	- 2,209	+ 1,217	+ 208
South West	- 2,197	+ 1,536	+ 380
Merseyside	- 1,985	+ 1,330	+ 35
South	- 1,070	+ 1,474	+ 401

The data from Tables 7 and 8 is collapsed and presented in summary form in Table 9. Here it becomes clear that inspections have declined quite dramatically across areas, whilst there have been general increases in the numbers of investigations and 'advice' contacts. However, there is no clear relationship between these changes. For example, while Marches has seen the greatest decline in numbers of inspections (-3942), the simultaneous increase in investigation and advice are relatively small. North and West Yorkshire and North East both saw similar declines in the numbers of inspections (2,333 and 2,330 respectively) – yet there are significant differences between their increases in numbers of investigations and advice. Perhaps by contrast, in Scotland East there has been the highest increases in both investigation and advice and the third largest decline in inspections.

Ratios between numbers of registered premises and different types of Contact

The following Tables, 10 and 11, look at the year 2000/01 in further detail. They compare the number of contacts with the number of premises in each area and each industry. The information on the number of premises relates to the number of premises as of February 2002, and so does not relate exactly to the year 2000/01. It is, however, sufficiently accurate for the purposes of this brief analysis.

The Tables gives details of the number of total contacts/premises ratio in different industries and in different areas. Table 10 shows that whilst on average 1 in 3 Manufacturing premises had a contact with an inspector, in Agriculture this is about 1 in 10. Table 11 shows that the highest average level of contact was in Merseyside – with the lowest in Northern Home Counties

Table 10
Total number of premises and contacts by industry (2000/01)

	Nos Premises	Nos Contacts	Ratio
Manufacturing	179,901	59,445	33.0%
Construction	127,098	41,729	32.8%
Energy/Extractive	13,078	2,863	21.9%
Service Sector	277,729	49,766	18.0%
Agriculture	138,178	16,073	11.6%
TOTAL	735,984	169,876	23.1%

Table 11
Total number of premises and contacts by HSE area (2000/01)

	Nos Premises	Nos Contacts	Ratio
Merseyside	29,724	9,086	31.0%
Greater Manchester	30,358	8,885	29.2%
Scotland East	47,399	13,864	28.8%
North Midlands	32,086	8,509	26.5%
North East	28,584	7,582	26.5%
North West	32,074	8,333	26.0%
Scotland West	29,091	7,235	24.9%
South	47,047	11,232	23.9%
Marches	38,046	8,954	23.5%
West Midlands	30,199	6,971	23.1%
N & W Yorkshire	41,888	9,224	22.0%
Wales	48,475	10,483	21.6%
South East	40,434	8,678	21.5%
South Yorkshire	28,138	5,938	21.1%
Greater London	61,948	12,880	20.8%
South West	53,220	10,525	19.8%
East Midlands	36,562	7,042	19.3%
East Anglia	40,557	7,521	18.5%
N/thn Home Counties	40,196	7,134	18.0%

Whilst Tables 10 and 11 were concerned with the total number of premises and contacts, Tables 12 and 13 are concerned with the number of premises which have at least one contact (this is because some premises have more than one contact).

They show that, nationally, about one in nine registered premises has at least one contact with an FOD inspector each year. Table 12 shows that in Construction it is just over one in five whilst in Agriculture it is one in twelve. Table 13 shows that in Merseyside one in six registered premises had at least one contact, but in East Anglia it is one in ten.

It is worth emphasising that these statistics mean that in 2000/01, 90% of registered premises (including about a 100,000 construction sites) had no contact with a FOD inspector.

It is interesting to note that whilst the ratio of total contacts/premises for Construction and Manufacturing is about the same (Table 10), the number of premises in Manufacturing with at least one contact is significantly less than Construction. This shows that FOD inspectors made, on average, more contacts for each Manufacturing premises than for each Construction site.

Table 12
Number of different premises (by industry) with one inspector contact or more (2000/01)

	Nos Premises	Nos Premises with Contact	Ratio
Construction	127,098	28,706	22.6%
Manufacturing	179,901	26,819	14.9%
Service	277,729	25,264	9.0%
Energy/Extractive	13,078	1,159	8.9%
Agriculture	138,178	11,514	8.3%

Table 13

Number of different premises (by HSE area) with one inspector contact or more (2000/01)

	Nos Premises	Nos Premises with Contact	Ratio
Merseyside	29,724	4,600	16%
Scotland East	47,399	7,198	15.2%
Scotland West	29,091	4,439	15.2%
North West	32,074	4,816	15%
Greater Manchester	30,358	4,497	14.8%
North Midlands	32,086	4,571	14.2%
N & W Yorkshire	41,886	5,710	13.6%
North East	28,584	3,857	13.5%
South	47,047	6,268	13.3%
West Midlands	30,199	3,862	12.8%
South East	40,434	5,126	12.7%
Marches	38,046	4,867	12.8%
East Midlands	36,562	4,276	11.7%
Wales	48,475	5,687	11.7%
South West	53,220	6,029	11.3%
South Yorkshire	28,138	3,048	10.8%
Greater London	61,948	6,622	10.7%
N/thn Home Counties	40,196	4,150	10%
East Anglia	40,657	4,039	9.9%
TOTAL	735,984	93,462	12.7%

Tables 14 and 15 set out the total number of premises by industry and area, which have had at least one inspection. Nationally, one in 20 premises received at least one inspection during the course of the year, though this ranged from 1 in 10 in Construction to 1 in 36 in the Service sector, and between 1 in 13 in the North West to 1 in 33 in Northern Home Counties. Again, it needs to be emphasised that these are mostly very low levels of inspection.

Table 14

Number of different premises (by industry) with at least one inspection (2000/01)

	Nos Premises	Nos Premises with Inspection	Ratio
Construction	127,098	13,378	10.5%
Manufacturing	179,901	13,517	7.5%
Energy/Extractive	13,078	571	4.4%
Agriculture	138,178	5,051	3.6%
Service Sector	277,729	7,720	2.7%
TOTAL	735,984	40,237	5.5%

Table 15

Number of different premises (by HSE area) with at least one inspection (2000/01)

	Nos Premises	Nos Premises with Inspection	Ratio
North West	32,074	2,451	7.6%
Scotland East	47,399	3,413	7.2%
Scotland West	29,091	2,036	7.0%
South	47,047	2,986	6.3%
North East	28,584	1,800	6.3%
Merseyside	29,724	1,835	6.2%
South East	40,434	2,379	5.9%
Greater London	61,948	3,657	5.9%
N & W Yorkshire	41,886	2,376	5.7%
East Midlands	36,562	2,045	5.6%
Greater Manchester	30,358	1,683	5.5%
Marches	38,046	2,047	5.4%
South West	53,220	2,843	5.3%
Wales	48,475	2,329	4.8%
West Midlands	30,199	1,380	4.5%
North Midlands	32,086	1,456	4.5%
South Yorkshire	28,138	1,130	4.0%
East Anglia	40,657	1,204	3.0%
N/thn Home Counties	40,196	1,207	3.0%

Abbreviation	Description
Inspection	All planned
Enforcement	Any legal action taking state
Investigation	All investig
Advice	Giving adv

Chapter 2

Levels of Investigation into reported incidents

Key Statistics

Deaths

In the five year period, 75 deaths of workers - 15 in the construction industry - and 212 deaths of members of the public were not investigated.

In 2000/01 7 deaths of workers and 18 deaths of members of the public were not investigated.

In 1996/7 almost half of the reported deaths of members of the public were not investigated. In 2000/01, this figure reduced to 10%.

Major Injuries to Workers

Over the five year period, there has been an 8% increase in numbers of injuries investigated – from 11% to 19%.

81% of major injuries remained uninvestigated in 2000/01.

In 2000/01, investigation levels ranged from:

- 41% in the Agricultural Sector to 10% in the Service Sector; and
- 26% in the Marches to 11% in Greater London.

In the five year period, 935 of the 1144 reported major injuries to trainees were not investigated.

In 2000/01, only 13% of major injuries in the transport sector were investigated.

In 2000/01, 41% of amputations, 44% asphyxiations and 57% of burns were not investigated.

In 2000/01, whilst 69% of amputations in the Manufacturing sector were investigated, the level was only 33% in Construction industry.

In 2000/01, whilst in the North West, 73% of amputations were investigated, in Wales, the rate was only 36%.

In 2000/01, whilst 65% of burns in the Marches were investigated, in Northern Home Counties, the level was only 19%.

In 2000/01, the amputations of 3 arms, 7 hands, 2 legs, 1 ear and 400 fingers were not investigated.

In 2000/01, 210 burns to eyes, 14 burns to the arm and 8 burns to faces were not investigated.

In 2000/01, 40% of the 3,214 injuries which resulted from either 'contact with electricity', 'contact with moving machinery', 'high falls' or 'drowning/asphyxiations' were not investigated.

In 2000/01, whilst 44% of explosions in the Manufacturing industry were investigated, only 22% were investigated in the Construction sector.

In 2000/01, whilst 80% of high falls in the North East were investigated, only 36% were investigated in Greater London.

Major Injuries to Members of the Public

Investigation levels increased from 2% in 1996/7 to 7% in 2000/01.

93% of major injuries were not investigated in 2000/01.

In 2000/01, investigation levels ranged from:

- 36% in the Agricultural Sector to 6% in the Service Sector and
- 19% in Wales to 4% in North Midlands.

In 2000/01, 80 of the 116 of the amputations and 222 of the 297 burns were not investigated.

Over-three day injuries

Investigation rates increased from 3% in 1996/7 to 4.5% in 2000/01

95.5% of over-three day injuries were not investigated in 2000/01

In 2000/01, investigation levels ranged from:

- 12% in the Agricultural Sector to 2% in the Service Sector; and;
- 6% in the Marches to 4% in Greater Manchester.

In 2000/01, 71% of asphyxiations and 59% of electrical shocks were not investigated

Dangerous Occurrences (not resulting in injury)

Investigation levels increased from 26% in 1996/7 to 31% in 2000/01.

69% of dangerous occurrences were not investigated in 2000/01.

In 2000/01, investigation levels ranged from:

- 47% in the Agricultural Sector to 17% in the Energy/Extractive Sector; and
- 54% in the Marches to 18% in Scotland East.

In 2000/01, 73 out of 128 'building collapses', 146 out of 224 'plant fire and explosions' and 179 out of 230 'flammable liquid releases' were not investigated.

In 2000/01, in the Marches, whilst 11 out of 17 reports of 'machinery making contact with electricity' were investigated, in Scotland East only 3 out of 40 similar reports were investigated.

Ill Health

Investigation levels increased from 21% in 1996/7 to 45% in 2000/01

Whilst almost 69% of industrial diseases were investigated in the West Midlands in 2000/01, only 14% were investigated in the North East.

This chapter looks at levels of investigation into the main incidents reported to FOD.

These are:

- non-fatal major injuries (to workers and members of the public);
- over three day injuries to workers;
- dangerous occurrences;
- industrial disease.

The chapter does not contain information on of investigations into gas incidents or complaints.

Deaths

Tables 1 and 2 sets out how many reported deaths were investigated by FOD inspectors. Table 1 shows that a small percentage of deaths each year are not investigated, though this lack of investigation has reduced from 12.3% (40 deaths) to 2.5% (7 deaths) in the five year period. In the five year period a total of 75 deaths were not investigated – 15 in 'Construction'; 15 in 'Manufacturing'; 1 in 'Agriculture'; 1 in the 'Energy/Extractive' sector; and the remaining 43 in the 'Service' Sector.

Table 2 shows that a much larger number of deaths of members of the public were not investigated each year, ranging over the five year period from 48% (115 deaths) to 10% (18 deaths). Interestingly, all but 2 of the 212 uninvestigated deaths in the five year period were in the Service Sector (the remaining 2 being from Construction. Table 3 shows that the five year period has shown a sharp increase in the investigation of deaths in the Service Sector.

Table 1

Numbers of Reported and Investigated Deaths of Workers (1996/7 – 2000/01)

	Nos Rep	Nos Inv	% Inv
1996/7	325	285	87.7%
1997/8	270	254	94.1%
1998/9	259	250	96.5%
1999/00	221	218	98.6%
2000/01	279	272	97.5%

Table 2

Numbers of Reported and Investigated Deaths of Members of the public (1996/7 – 2000/01)

	Nos Rep	Nos Inv	% Inv
1996/7	240	125	52.0%
1997/8	183	138	75.4%
1998/9	151	134	88.7%
1999/00	170	153	90.0%
2000/01	191	173	90.6%

Table 3

Numbers of Reported and Investigated Deaths of Members of the Public in the Service Sector (1996/7 – 2000/01)

	Nos Rep	Nos Inv	% Inv
1996/7	219	104	47.4%
1997/8	160	116	72.5%
1998/9	135	118	87.4%
1999/00	148	131	88.5%
2000/01	165	148	89.7%

Table Abbreviations

Nos Rep = Numbers Reported

Nos Inv = Numbers Investigated

% Inv = Percentage Investigated

Major Injuries

Reportable injuries are divided into two categories: 'major' injuries and 'over-three day' injuries. For an injury to be 'Major', it must be one of a number of specified injuries set out in an annex to the Reporting of Injuries, Diseases and Dangerous Occurrences 1995 (see box on page 38).

Table 4
Numbers of Reported and Investigated Major Injuries to Workers, (1996/7 – 2000/01)

	Nos Rep	Nos Inv	% Inv
1996/97	23,356	2,532	10.8%
1997/98	24,095	2,710	11.2%
1998/99	23,323	2,740	11.7%
1999/00	23,365	3,336	14.3%
2000/01	22,438	4,335	19.3%

Table 4 shows that between 1996/7 and 2000/01, the percentage of reported major injuries to workers investigated by FOD has almost doubled from 10.8% to 19.3%. This percentage also represents an increase in the actual number of major injuries investigated from 2,532 to 4,335 – an increase of 71%.

Table 5
Numbers of Reported and Investigated Major Injuries to the Public, (1996/7 – 2000/01)

	Nos Rep	Nos Inv	% Inv
1996/97	32,813	576	1.8
2000/01	12,449	893	7.2

Table 5 shows that between 1996/7 and 2000/01 there has also been a rise in the percentage of major injuries to the public that have been investigated – from 1.8% to 7.2%. However, this increase can be explained by the decrease of almost a third in the number of injuries reported to FOD – from 32,813 to 12,449; the actual number of investigations has only increased by 317. It is notable that there is a 12% disparity between the investigation levels of worker and public injuries.

Consistency between industries

Table 6
Numbers of Reported and Investigated Major Injuries to Workers, by Industry, (1996/7 – 2000/01)

	1996/7			2000/01		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Agriculture	747	195	26.1%	647	262	40.5%
Manufacturing	8,316	1,270	15.3%	7,240	1,974	27.3%
Construction	3,978	559	14.1%	4,636	1,073	23.1%
Extractive/Energy	4,83	46	9.5%	297	66	21.9%
Service Sector	9,832	462	4.7%	9,618	958	10.0%

Table 6 illustrates how the percentage of investigated major injuries to workers differed between industries. In 2000/01, this ranged from 41% in Agriculture to 10% in the Service Sector: a major injury to an Agricultural worker was four times more likely to be investigated than an injury to a Service sector worker. However, the higher likelihood of an investigation in the Agricultural sector was a reflection of the much lower number of reported major injuries in this Sector (647) compared to the Service Sector (9,616) – and in fact more injuries in the Service Sector were investigated (958) compared to Agriculture (262).

Table 7

Numbers of Reported and Investigated Major Injuries to the Public by Industry, (1996/7 – 2000/01)

	1996/7			2000/01		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Agriculture	187	31	16.6%	143	52	36.4%
Manufacturing	433	70	16.2%	312	87	27.9%
Construction	125	19	15.2%	87	21	24.1%
Extractive/Energy	38	3	7.9%	28	7	27.0%
Service Sector	32,030	453	1.4%	11,881	726	6.1%

Table 7 shows that by far the majority of major injuries to members of the public were in the Service Sector - only 568 out of the 12,449 major injuries in 2000/1 were in the non-Service sector industries - and that the levels of investigation of injuries in this sector remained much lower than in the other sectors. However, 70% of the injuries to members of the public in 'traditional' industries were still not being investigated – a low level of investigation. It is interesting to note that whilst 10% of worker injuries in the Service sector were investigated, only 6% of injuries to members of the public were investigated. In the other industries, there is little difference between the percentage of investigation into injuries to workers or members of the public.

Table 8

Numbers of Reported and Investigated Major Injuries to Service Sector Workers, (2000/01)

	Nos Rep	Nos Inv	% Inv
Wholesale and Retail	663	155	23.4%
Community Activities	921	142	15.4%
Transport	2,005	267	13.3%
Real state/business activities	718	88	12.3%
Hotels/Restaurants	81	9	11.1%
Private households	11	1	9.1%
Health and Social work	1,639	93	5.7%
Education	1,455	92	6.3%
Public Administration	2,100	112	5.3%
Financial activities	22	0	0%

As the Service Sector is the sector with both the largest number of major injuries and the lowest investigation rate (for both workers and public), Table 8 breaks down the rates of investigation into worker injuries in this sector into ten categories.

It is clear from this Table there are significant disparities in the investigation rates between categories. In 'Wholesale and Retail' there is an investigation rate, which is over four times greater than is the case of injuries in 'Public administration'. It is interesting to note that the levels of investigation into major injuries in the transport sector was only 13%.

Consistency around the country?

Table 9

Numbers of Reported and Investigated Major Injuries to Workers by HSE Area, (2000/01)

	Nos Rep	Nos Inv	% Inv
Marches	979	257	26.3%
Scotland East	1,241	322	25.9%
East Anglia	1,148	283	24.7%
Scotland West	1,159	279	24.1%
Merseyside	802	176	21.9%
West Midlands	1,163	247	21.2%
North East	1,106	234	21.2%
South	1,363	271	19.9%
Greater Manchester	968	187	19.5%
North West	881	169	19.2%
South West	1,343	254	18.9%
North Midlands	1,226	223	18.2%
Wales	1,403	254	18.1%
South Yorkshire	1,076	194	18.0%
N & W Yorkshire	1,303	228	17.5%
South East	1,334	221	16.6%
N/thn Home Counties	1,024	166	16.2%
East Midlands	1,001	160	16.0%
Greater London	1,829	210	11.5%

The next couple of Tables look at the levels of investigation into injuries in different parts of the country. Table 9 shows a wide range of investigation rates, from 26% in the Marches to 11% in Greater London. The low level of investigations in Greater London can not simply be explained by the fact that it has the highest rate of reported injuries (1929), since Scotland East, for example investigated 322 major injuries (112 more than London) and East Anglia investigated 283 major injuries (73 more than London).

Table 10

Numbers of Reported and Investigated Major Injuries to Members of the Public by HSE Area, (1996/7 – 2000/01)

	Nos Rep	Nos Inv	% Inv
Wales	425	79	18.6%
Greater Manchester	222	40	18.0%
South West	676	95	14.1%
Scotland East	424	55	13.0%
Merseyside	307	37	12.1%
Scotland West	503	50	9.9%
Marches	488	48	9.8%
East Anglia	507	42	8.3%
West Midlands	409	33	8.1%
N/thn Home Counties	617	49	7.9%
North East	566	35	6.2%
North West	717	42	5.9%
South East	1,012	53	5.2%
South Yorkshire	324	17	5.2%
South	1,144	51	4.5%
N & W Yorkshire	874	38	4.3%
East Midlands	1,021	43	4.2%
Greater London	1,484	60	4.0%
North Midlands	729	26	3.6%

The same sorts of discrepancies exist in relation to injuries to members of the public (Table 10), where rates of investigation range from 19% in Wales (79 of 425) to 3.6% in North Midlands (26 of 729). It is interesting to note that Scotland East and Scotland West have relatively higher rates, and Greater London and East Midlands have relatively low rates of investigation, in relation to both injuries to workers and to members of the public

Table 11

Numbers of Reported and Investigated Major Injuries to workers, (1996/7 - 2000/01)

	1996/97			2000/01		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Marches	1,044	193	18.5%	979	257	26.3%
Scotland West	957	141	14.7%	1,159	279	24.0%
East Anglia	1,103	160	14.5%	1,148	283	24.7%
North East	1,207	174	14.4%	1,105	234	21.1%
N & W Yorkshire	1,505	201	13.4%	1,303	228	17.5%
South Yorkshire	1,085	137	12.6%	1,076	194	18.0%
Scotland East	1,163	141	12.1%	1,241	322	26.0%
North West	983	114	11.6%	881	169	19.2%
West Midlands	1,202	135	10.9%	1,163	247	21.2%
South West	1,337	134	10.0%	1,343	254	18.9%
Wales	1,457	146	10.0%	1,403	254	18.1%
N/thn Home Counties	1,006	100	9.9%	1,024	166	16.2%
North Midlands	1,326	131	9.9%	1,226	223	18.2%
Merseyside	955	88	9.2%	802	176	22.0%
South East	1,409	121	8.9%	1,334	221	16.6%
East Midlands	1,130	99	8.8%	1,001	160	16.0%
South	1,279	104	8.1%	1,363	271	19.9%
Greater Manchester	1,149	91	8.0%	958	187	19.5%
Greater London	1,979	122	6.1%	1,929	210	10.9%

Table 11 shows how investigation rates into major injuries sustained by workers changed in each HSE area over a five year. Rates of investigation have increased over this period in all areas. However, while in three areas – Scotland East, West Midlands, and South – they have more than doubled (from varying starting-points), in other areas, notably Greater London, the increase in the level of investigation has been much less marked.

Employment Status of the worker

Table 12 compares the rates of investigation over a five year period by the employment status of the worker – whether the person was employed, self employed, a trainee or involved in work-experience. It shows that in each of the years, FOD was more likely to investigate an injury to a worker who was self-employed, a trainee or in work-experience compared to one who was employed (explained in part by the greater number of reports of major injuries to employees).

Further, although the rates of investigation increase over the years, it is notable that so many injuries to workers involved in ‘work-experience’ or ‘training’ remain uninvestigated, considering their particular vulnerability. Over the five years period there were 164 major injuries to people involved in ‘work-experience’ but 126 were not investigated; there was also 1,144 injuries to those involved in ‘training’ but 935 were not investigated.

Table 12

Numbers of Reported and Investigated Major Injuries to Workers by Employment Status, (2000/01)

	EMPLOYED			SELF EMPLOYED			WORK EXPERIENCE			TRAINEES		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
1996/97	21,872	2,239	10.3%	1,265	233	18.4%	48	13	27.0%	371	47	12.7%
1997/98	23,104	2,532	11.0%	725	128	17.0%	37	6	16.2%	229	44	19.2%
1998/99	22,499	2,567	11.4%	626	137	21.8%	26	6	23.0%	170	30	17.6%
1999/00	22,579	3,131	13.9%	576	162	28.1%	27	5	18.5%	183	38	20.8%
2000/01	21,633	4,101	19.0%	588	176	29.9%	26	8	30.8%	191	50	26.2%
	111,487	14,570	13.0%	3,782	836	22.0%	164	38	23.0%	1,144	209	18.3%

Nature of Injury

This section looks at the investigation rates by the 'nature of the injury' – an amputation, burn, loss of eyesight, and so on. This allows some sort of assessment to be made about the

seriousness of the injuries that have not been investigated. Abbreviations are used for each of the different types of injury, and these are set out in the box below.

Table 13
Numbers of Reported and Investigated Major Injuries to Workers by 'Nature of Injury', (2000/01)

	Nos Rep	Nos Inv	% Inv
Amputation	1,013	595	58.7%
Asphyxia/Poisoning	163	91	55.8%
Electrical Shock	90	49	54.4%
Burn	576	243	42.2%
Unknown	66	23	34.8%
Multiple	464	152	32.6%
Bruising	432	119	27.5%
Concussion	491	129	26.3%
Laceration	1,189	281	23.6%
Loss of eye-sight	99	21	21.2%
Other injury	163	34	20.9%
Fracture	16,284	2,496	15.3%
Superficial	278	35	12.6%
Strain	184	13	7.1%
Dislocation	939	51	5.4%
Natural	7	0	0%
	22,438	4,335	19.3%

Table 13 looks at the levels of investigation by the nature of the major injury to the worker in 2000/01. This shows, for example, that large numbers of what appear to be the most serious injuries remain uninvestigated, including 418 'amputations' (41%), 72 'asphyxiations' (44%), 31 'electrical shocks' (35%), and 333 'burns' (67%). It is also notable that 78 out of 99 reported 'loss of eyesight' were not investigated – though some of these may have been temporary.

Table 14
Numbers of Reported and Investigated Major Injuries to Members of the public by 'Nature of Injury', (2000/01)

	Nos Rep	Nos Inv	% Inv
Asphyxia/Poisoning	87	33	37.9%
Amputation	116	36	31.0%
Electrical Shock	20	6	30.0%
Burn	297	75	25.3%
Loss of eye-sight	31	7	22.6%
Natural	6	1	16.7%
Concussion	211	29	13.7%
Other injury	285	36	12.6%
Unknown	246	31	12.6%
Multiple	291	34	11.7%
Laceration	2,205	148	6.7%
Bruising	1,276	85	6.7%
Fracture	4,881	277	5.7%
Superficial	1,241	63	5.1%
Strain	957	27	2.8%
Dislocation	299	5	1.7%

Table 14 looks at the level of investigations by the nature of the major injury to a member of the public. It is notable that 80 of 116 amputations and 222 of the 297 burns were not investigated. The Table also shows that there was a far lower percentage of investigations into even the most serious injuries to members of the public compared to the levels of investigation into worker injuries.

Table 15

Numbers of Reported and Investigated Major Injuries to Workers by 'Nature of Injury', (1996/97 - 2000/01)

	1996/7			2000/1		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Asphyxia/Poisoning	219	88	40.2%	163	91	55.8%
Amputation	1,084	417	38.5%	1,013	585	58.7%
Electrical Shock	109	37	33.9%	90	49	54.4%
Burn	708	218	30.8%	576	243	42.2%
Unknown	121	31	25.6%	66	23	34.8%
Multiple	419	97	23.2%	454	152	32.8%
Other injury	270	54	20.0%	163	34	20.9%
Bruising	448	68	15.2%	432	119	27.5%
Laceration	1,074	154	14.3%	1,189	281	23.6%
Loss of eye-sight	82	10	12.2%	99	21	21.2%
Concussion	260	26	10.0%	491	129	26.3%
Fracture	17,026	1,278	7.5%	16,284	2,496	15.3%
Superficial	279	18	6.5%	278	36	12.9%
Natural	29	1	3.4%	7	0	0%
Strain	334	10	3.0%	184	13	7.1%
Dislocation	894	25	2.8%	939	51	5.4%

Table 15 compares how the levels of investigation of different injuries have changed from 1996/7 to 2000/01. Over the five-year period under examination, rates of investigation of injuries of all types have increased (with the exception of the category 'natural', in which there is an extremely small number).

Table 16 shows how the levels of investigation of different types of injuries differ across industries in the year 2000/01. So, whilst 69% of amputations in Manufacturing were investigated, this compared with only 42% in the Service Sector and just 33% in Construction; and whilst all burns in Agriculture were investigated, it was only 43% in Manufacturing.

If we look at what major injuries are most likely to be investigated across sectors, we see further evidence of seemingly inexplicable disparities. Therefore, we find that in Agriculture, 'asphyxia', 'burn' and 'eye-sight' injuries are most likely to be investigated, but in Manufacturing it is 'amputations' and in Construction it is 'electrical' injuries.

Table 16

Numbers of Reported and Investigated Major Injuries to Workers by 'Nature of Injury' and Industry, (2000/01)

	Agriculture			Manufacturing			Construction			Energy/ Extractive			Service Sector		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Amputation	48	31	64.6%	644	442	68.6%	131	43	32.8%	12	5	41.7%	177	74	41.8%
Asphyxia/Poisoning	3	3	100%	55	30	54.5%	22	10	45.5%	0	0	-	83	48	57.8%
Electrical Shock	0	-	-	28	18	64.3%	24	12	50.0%	3	1	33.3%	35	18	51.4%
Burn	11	11	100%	273	118	43.2%	123	58	47.2%	17	11	64.7%	152	45	29.6%
unknown	0	0	-	26	12	46.2%	14	4	28.6%	0	-	-	26	7	26.9%
Multiple	24	16	66.7%	125	45	36.0%	121	57	47.1%	8	4	50.0%	186	30	16.1%
Bruising	17	7	41.2%	177	66	37.3%	99	33	33.3%	5	1	20.0%	134	12	9.0%
Laceration	54	25	46.3%	562	173	30.8%	306	35	11.4%	12	1	8.3%	255	47	18.4%
Eye-sight	2	2	100%	25	9	36.0%	25	6	24.0%	1	0	0%	46	4	8.7%
Other injury	4	2	50.0%	40	12	30.0%	26	4	15.4%	2	1	50.0%	90	14	15.6%
Concussion	12	6	50.0%	135	46	34.1%	77	31	40.3%	7	3	42.9%	260	43	16.5%
Fracture	432	152	35.2%	4740	958	20.2%	3,427	759	22.1%	215	36	16.7%	7,461	591	7.9%
Superficial	11	3	27.3%	113	23	20.4%	49	4	8.2%	0	0	-	106	6	5.7%
Strain	6	1	16.7%	49	4	8.2%	34	4	11.8%	4	1	25.0%	90	3	3.3%
Dislocation	23	3	13.0%	247	18	7.3%	155	13	8.4%	11	1	9.1%	501	16	3.2%
Natural	0	-	-	1	0	0%	3	0	0%	0	0	-	3	0	0%

Focus on Amputations and Burns

This section looks in further detail at two types of particularly serious injury. Tables 17 and 18 set out how the level of investigations of amputations and burns suffered by workers differed from one part of the country to another in 2000/01.

In the case of amputations, there are clearly great differences in the rates of investigations from 73% in the North West to 36% in Wales. It is also notable, for example, that North East and Greater London have very similar numbers of reported amputations but very different rates of investigation – in North East 40 out of 63 amputations

(64%) were investigated but just 29 out of 62 amputations (42%) were investigated in Greater London.

In the case of burns, there are also great differences in the rates of investigations, ranging from 70% in the North West to just 19% in Northern Home Counties. Again taking two areas with roughly similar numbers of reported burns, we find that of the 43 reported burns in North and West Yorkshire, 22 (51%) were investigated, while only 7 (19%) of the 37 burns reported in Northern Home Counties were investigated.

Table 17

Numbers of Reported and Investigated Amputations to Workers by HSE Area, (2000/01)

	Nos Rep	Nos Inv	% Inv
North West	26	19	73%
Scotland East	55	39	71%
Greater Manchester	41	29	71%
East Anglia	46	31	67%
North East	63	40	64%
East Midlands	45	28	62%
South York	66	41	62%
South West	60	37	62%
Marches	33	20	61%
South	63	38	60%
West Midlands	62	49	60%
South East	54	31	57%
N & W Yorkshire	54	31	57%
North Midlands	56	32	57%
Scotland West	52	29	56%
N/thn Home Counties	43	23	54%
Merseyside	45	23	51%
Greater London	62	29	47%
Wales	67	26	39%

Table 18

Numbers of Reported and Investigated Burns to Workers by HSE Area, (2000/01)

	Nos Rep	Nos Inv	% Inv
North West	10	7	70%
Marches	23	15	65%
East Midlands	22	13	59%
Scotland West	14	8	57%
N & W Yorkshire	43	22	51%
South	30	15	50%
Wales	56	26	46%
West Midlands	44	20	46%
South Yorkshire	28	12	43%
Greater Manchester	21	9	43%
South East	20	8	40%
North Midland	26	10	39%
South West	42	16	38%
Merseyside	22	8	36%
Greater London	47	17	36%
North East	25	9	36%
East Anglia	34	11	32%
Scotland East	32	10	31%
N/thn Home Counties	37	7	19%

We can learn more about the types of amputations and burns not being investigated by looking at the level of investigations into amputations and burns of different parts of the body. This is set out in Tables 19 and 20 for the year 2000/1.

In relation to amputations, it is particularly notable that the amputation of 3 arms, 7 hands, 2 legs, and 1 ear, and 410 fingers were not investigated.

Table 20 sets out in more detail in which industries the failure to investigate amputations can be located. It is notable that in the Service Sector there were incidents involving the amputation of 2 legs, 2 hands, 2 arms and 1 ear which were not investigated.

Table 19
Numbers of Reported and Investigated Amputations Suffered by Workers, by 'Site' (2000/01)

	Nos Rep	Nos Inv
Ear	1	0
Face	3	1
Finger	942	542
Hand	19	12
Arm	15	12
Toe	12	9
Foot	7	7
Leg	14	12
Several Locations	2	1

Table 20
Numbers of Reported and Investigated Amputations suffered by workers by Industry, (2000/01)

	MANUFACTURING		CONSTRUCTION		AGRICULTURE		EXTRACTIVE/ENERGY		SERVICE	
	Nos Rep	Nos Inv	Nos Rep	Nos Inv	Nos Rep	Nos Inv	Nos Rep	Nos Inv	Nos Rep	Nos Inv
Ear	0	-	0	-	0	-	0	-	1	0
Face	1	0	0	-	0	-	0	-	0	-
Head	0	-	0	-	0	-	0	-	2	1
Finger(s)	609	412	117	34	41	24	12	5	162	67
Hand	13	10	3	1	1	1	0	-	2	0
Arm	8	7	2	1	1	1	0	-	4	3
Toe	4	4	4	2	1	1	0	-	3	2
Foot	3	3	2	2	2	2	0	-	0	-
Leg	5	5	3	3	3	2	0	-	4	2
Several Locations	1	1	0	-	0	-	0	-	1	0

Table 21 sets out in which industries the failure to investigate burns to certain parts of the body (not all) can be located. It is notable that whilst in the Agricultural sector every single burn was investigated, in the Construction

industry none of the burns to the eyes were investigated; and whilst most of the hand burns in the Manufacturing and Construction sectors were investigated, only 3 out of 12 were investigated in the Service sector.

Table 21
Numbers of Reported and Investigated Burns suffered by workers by Industry, (2000/01)

	MANUFACTURING		CONSTRUCTION		AGRICULTURE		EXTRACTIVE/ENERGY		SERVICE	
	Nos Rep	Nos Inv	Nos Rep	Nos Inv	Nos Rep	Nos Inv	Nos Rep	Nos Inv	Nos Rep	Nos Inv
Eye	158	48	23	0	4	4	2	0	77	12
Face	8	7	6	2	1	1	2	2	4	1
Fingers	2	1	1	1	1	1	0	-	2	1
Hand	13	8	10	6	0	-	1	1	12	3
Arm	7	2	8	4	1	1	1	0	3	-
Sev. Arm Locations	3	1	11	6	0	-	0	-	1	-
Foot	9	6	1	1	0	-	0	-	4	1
leg	4	2	5	3	0	-	1	0	4	1
Sev Body Locations	49	38	45	27	3	3	8	7	32	20

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Table 23

Numbers of Reported and Investigated Major Injuries by 'Kinds of Incidents' and industry, (2000/01)

	MANUFACTURING			CONSTRUCTION			AGRICULTURE			ENERGY/ EXTRACTIVE			SERVICE SECTOR		
	NOS REP	NOS INV	% INV	NOS REP	NOS INV	% INV	NOS REP	NOS INV	% INV	NOS REP	NOS INV	% INV	NOS REP	NOS INV	% INV
Contact with Electricity	44	30	68%	76	44	58%	1	1	100%	12	9	75%	45	25	56%
Contact with Moving Machinery	1152	738	64%	161	45	28%	87	65	75%	8	2	25%	170	93	55%
High Fall over 2 Meters	242	137	57%	770	492	63.9%	42	32	76%	19	11	58%	312	143	46%
Drowning, Suffocation or Asphyxiation	16	8	50%	11	6	55%	3	3	100%	0	0	-	45	27	60%
Exposure to Fire	16	11	69%	22	11	50%	1	1	100%	0	0	-	16	5	31%
Trapped by Collapse	35	18	51%	61	32	53%	9	7	78%	2	2	100%	34	12	35%
Exposure to an Explosion	27	12	44%	9	2	22%	2	2	100%	2	2	100%	15	9	60%
Struck by Moving Vehicle	245	123	50%	94	48	51%	22	16	73%	7	5	71%	265	104	39%
Contact - Hot Object/Subst	266	110	41%	67	23	34%	8	7	88%	7	2	29%	204	59	29%
Struck by Moving Object	1426	353	25%	850	161	19%	118	49	42%	53	12	23%	1113	149	13%
Injury by Animal	11	2	18%	3	0	0%	71	15	21%	0	0	-	85	16	19%
Not Known	17	3	18%	17	3	18%	0	0	-	0	0	-	25	4	16%
Fall - height unknown	98	20	20%	82	20	24%	14	6	43%	7	2	29%	208	17	8%
Low Fall	698	126	18%	874	112	13%	63	20	32%	51	5	10%	1161	95	8%
Other	73	14	19%	50	8	16%	9	4	44%	10	2	20%	236	10	4%
Lifting Incident	701	88	13%	374	29	8%	45	10	22%	25	2	8%	789	37	5%
Struck against Object	365	42	12%	143	9	6%	14	4	29%	12	3	25%	418	21	5%
Assault	13	1	8%	15	0	0%	3	1	33%	1	0	0%	626	35	6%
Trip	1795	138	8%	957	28	3%	135	19	14%	81	6	7%	3851	97	3%

Table 24

Numbers of Reported and Investigated Major Injuries resulting from 'Contact with moving machinery' by HSE Area, (2000/01)

	Contact with Moving Machinery		
	Nos Rep	Nos Inv	% Inv
South Yorkshire	86	63	73.3%
East Anglia	89	63	70.8%
North East	85	58	68.2%
Greater Manchester	72	49	68.1%
Marches	72	48	66.7%
South East	102	67	65.7%
Merseyside	48	31	64.6%
North West	53	34	64.2%
Scotland East	67	40	59.7%
North Midlands	104	60	57.7%
South	97	55	56.7%
Scotland West	64	36	56.3%
West Midlands	137	77	56.2%
East Midlands	76	42	55.3%
Wales	87	47	54.0%
South West	104	54	53.5%
N & W Yorkshire	100	53	53.0%
Greater London	72	38	52.8%
N/thn Home Counties	66	28	42.4%

Tables 24 and 25, look at two different types of incident - 'Contact with Moving Machinery' and 'High Falls' - reported in 2000/01 in an attempt to see how the investigation rates for each of these vary in different parts of the country.

Again, the picture is one of clear disparities across areas. Whilst in both Greater Manchester and in Greater London there were 72 reported incidents involving contact with moving machinery, the rates of investigation of these vary from 68% to 52% respectively; across the country, investigation rates vary from 73% (South Yorkshire) to 42% (Northern Home Counties). Similarly, in relation to high falls, investigation rates vary from 71% (North East) to 36% (Greater London).

Table 25

Numbers of Reported and Investigated Major Injuries resulting from 'High Falls' by HSE Area, (2000/01)

	High Fall over 2 Meters		
	Nos Rep	Nos Inv	% Inv
North East	71	57	80.3%
Marches	52	38	73.1%
N/thn Home Counties	51	37	72.5%
East Anglia	71	51	71.8%
South	90	61	67.8%
Merseyside	60	40	66.7%
Scotland West	80	53	66.3%
North West	49	32	65.3%
N & W Yorkshire	65	42	64.6%
Greater Manchester	56	36	64.3%
North Midlands	75	48	64%
West Midlands	74	43	58.1%
East Midlands	46	26	56.5%
Scotland East	117	64	54.7%
Wales	68	37	54.4%
South West	59	29	49.2%
South Yorkshire	56	27	48.2%
South East	87	38	43.7%
Greater London	158	57	36.1%

Investigation of 'Over-3 Day' Injuries

Table 26

Numbers of Reported and Investigated Over-3 Day Injuries to Workers, (1996/7-2000/01)

	Nos Rep	Nos Inv	% Inv
1996/97	106,609	2,803	2.6%
1997/98	107,878	2,906	2.7%
1998/99	104,567	3,112	3.0%
1999/00	106,671	3,714	3.5%
2000/01	104,623	4,378	4.5%

An over-three day injury is an injury (other than one defined as a 'major' injury) that results in a worker being off work for more than 3 consecutive working days.

Table 26 show that the rates of investigation into over-three day injuries are far lower than the level of investigation into major injuries – 4.5% compared to 19.3% in 2000/01. The numbers and percentages of over-three day injuries investigated did however increase by over 50% over the five year period.

Table 27

Number of Reported and Investigated over-3 day injuries by Industry, (1996/7- 2000/01)

	1996/1997			2000/2001		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Agriculture	1,428	138	9.7%	1,416	166	11.7%
Manufacturing	40,450	1,758	4.3%	37,127	2,604	7.1%
Construction	9,259	285	3.1%	9,753	478	4.9%
Extractive/Energy	2,200	32	1.6%	1304	49	3.8%
Service Sector	53,272	590	1.1%	55,023	1,061	1.9%

Table 27 shows the level of investigation into over-three day injuries across different industries. In 2000/01 these levels ranged from 11.7% in Agriculture to 1.9% in the Service sector. The disparity between the investigation of injuries in the Manufacturing (7.1%) and Service sector (1.9%) is particularly noteworthy, since they are dealing with a similar number of reported injuries. In fact although there were 18,000 less injuries in Manufacturing, FOD inspectors investigated over twice the number of injuries.

Table 28

Numbers of Reported and Investigated Over-3 day Injuries by HSE area, (1996/7 – 2000/01)

	1996/7			2000/01		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Marches	4,610	237	5.2%	4,434	270	6%
East Anglia	5,560	194	3.5%	5,342	222	4.2%
South West	5,973	215	3.4%	5,979	330	5.5%
Wales	5,752	193	3.4%	6,465	285	4.4%
North West	4,630	156	3.4%	4,228	156	3.7%
Scotland West	4,390	146	3.3%	4,807	227	4.7%
Scotland East	5,794	183	3.2%	5,002	246	4.9%
North East	6,177	183	3.0%	5,581	230	4.1%
N & W Yorkshire	6,605	189	2.9%	6,273	210	3.3%
South	5,772	135	2.7%	5,726	272	4.8%
South Yorkshire	4,897	129	2.6%	5,398	188	3.5%
N/thn Home Counties	4,530	107	2.4%	4,802	196	4.1%
West Midlands	6,319	144	2.3%	5,748	170	3.0%
Merseyside	5,286	109	2.0%	4,162	277	6.7%
South East	5,084	93	1.8%	5,169	224	4.3%
North Midlands	5,903	102	1.7%	5,741	204	3.6%
Greater London	9,149	120	1.3%	9,468	283	3.0%
East Midlands	4,963	95	1.9%	5,180	176	3.4%
Greater Manchester	5,215	87	1.7%	5,118	212	4.1%

Table 28 shows the wide variation in investigation rates in different parts of Britain, as well as changes in these rates over a five year period. In 1996/7, investigation rates ranged from 5.2% in Marches to 1.3% in Greater Manchester; and in 2000/01 from 6.7% in Merseyside to 3.0% in Greater London. It is notable that over the period, some HSE Areas have significantly increased their investigation levels. Merseyside, for example, increased its level of investigation from 2% in 1996/7 to 6.7% in 2000/01, and Greater Manchester from 1.3% to 4.1% in the same period. Others have made barely a change: North West, for example, investigated 3.4% over-three day injuries in 1996/7 and 3.7% in 2000/01.

Table 29

Numbers of Reported and Investigated Over-3 day Injuries by 'Nature of Injury', (2000/01)

	Nos Rep	Nos Inv	% Inv
Electrical Shock	186	77	41.4%
Asphyxia/Poisoning	305	86	28.9%
Burn	2,783	420	19%
Loss of eye-sight	21	2	9.5%
Concussion	533	41	7.7%
Other injury	1,383	102	7.4%
Laceration	11,447	827	7.2%
Fracture	4,679	323	6.9%
Multiple	3,311	205	6.2%
Unknown	1,047	56	5.3%
Bruising	20,457	1,012	4.9%
Superficial	8,251	375	4.5%
Dislocation	371	12	3.2%
Strain	49,841	838	1.7%
Natural	8	0	0%
Amputation	0	0	-

Table 29 looks at the type of injuries that are not being investigated. Almost half of over-three day injuries concern "strains" – and only 1.7% of these are investigated. However, it is notable that 71% of asphyxias and 59% of electrical shocks are not investigated.

Investigations into Dangerous Occurrences

Table 30

Total numbers of Reported and Investigated Dangerous Occurrences to Workers (1996/7 – 2000/01)

	Nos Rep	Nos Inv	% Inv
1996/7	3,583	925	26%
1997/8	3098	973	24%
1998/9	4,051	927	23%
1999/00	4,194	1,077	26%
2000/01	3,778	1,185	31%

Certain sorts of incidents – whether they cause an injury or not – are defined as 'dangerous occurrences' (see Box). These dangerous occurrences fall into two different categories – those that result in death and injury and those that do not. In order to avoid 'double counting', this section only contains information on the latter category.

Table 30 shows that the level of investigation into dangerous occurrences is higher than investigation levels into major injuries – 31% compared to 19% in 2000/1. However, when one considers the relatively low numbers of reports of dangerous occurrences, and the fact that the reports must be a strong indication of unsafe workplaces, it is surprising that 70% of dangerous occurrences remain uninvestigated. Further, whilst at first glance it appears that there has been some – albeit relatively small – increase in investigation rates over the five year period, it is in fact clear that there was an increase only in the last year under examination, 1999/2000 to 2000/2001; upto to 1999/2000, the investigation rate had remained more or less constant.

Table 31 looks at the levels of investigation in different industries. Considering that these incidents are all 'dangerous', there is a surprising level of inconsistency: in 1996/7, from 40% in Agriculture to 20% in the Service Sector, and in 2000/01, from 47% in Agriculture to 17% in the Energy/Extractive industries. Two notable changes have taken place in the five years. The rate of investigation in the Service sector rose dramatically from 19.8% in 1996/7 to 35.4% in 2000/01 even though there were 99 more reported incidents in 2000/01 than five years earlier. At the same time, however, the number of dangerous occurrences investigated in the Energy/Extractive industries declined in this period by over 7% even though the same number of dangerous occurrences were reported.

Table 31
Numbers of Reported and Investigated Dangerous Occurrences by Industry, (1996/7 – 2000/01)

	1996/7			2000/01		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Agriculture	53	21	39.6%	60	28	46.7%
Manufacturing	1,419	430	30.3%	1,072	381	35.5%
Construction	778	192	24.7%	1,208	342	28.3%
Extractive/Energy	395	97	24.6%	394	67	17.0%
Service Sector	948	185	19.8%	1,035	366	35.4%

Table 32
Numbers of Reported and Investigated Dangerous Occurrences by Area (2000/01)

Table 32 considers the level of investigation in different HSE areas in 2000/01. This ranged from 54% in the Marches to 18% in Scotland East. Although Scotland East had the highest number of reports – almost double the number in the Marches – it still investigated fewer dangerous occurrences than the Marches. It is also notable that the South East had even fewer reports than the Marches and investigated 50 fewer dangerous occurrences.

	Nos Rep	Nos Inv	% Inv
Marches	157	84	53.5%
North East	170	88	51.8%
N & W Yorkshire	170	85	50.0%
South Yorkshire	169	78	46.2%
Merseyside	171	67	39.2%
West Midlands	131	49	37.4%
East Midlands	147	50	34.0%
Scotland West	221	73	33.0%
South	215	69	31.9%
Greater Manchester	152	49	32.2%
North West	131	40	30.5%
Wales	237	71	30.0%
South West	328	89	27.1%
East Anglia	175	43	24.6%
N/ithn Home Counties	170	43	25.3%
North Midlands	242	56	23.1%
South East	154	31	20.1%
Greater London	328	65	19.8%
Scotland East	309	55	17.8%

Table 33

Numbers of Reported and Investigated Dangerous Occurrences by 'Type' (2000/01)

	Nos Rep	Nos Inv	% Inv
Movement of Quarry tip	8	6	75%
Radiation Equipment Failure	14	7	50%
Diving Equipment Failure	2	1	50%
Quarry Misfire	33	16	49%
Building Collapse	128	55	43%
Diving Breathing Apparatus failure	115	48	42%
Failure on Fair Ride	8	3	38%
Failure of Lifting Machinery	944	352	37%
Failure of Closed Vessel	151	55	36%
Plant Explosion or fire	224	78	35%
Train Crash	6	2	33%
Movement of Excavated slope	15	5	33%
Scaffold Collapse	60	19	32%
Failure of Road Tanker with dangerous substances	25	8	32%
Fire or release of dangerous Substance from Vehicle	25	8	32%
Contact of Machine with Electricity	320	98	31%
Incident from use of Explosives	55	17	31%
Dangerous Substance	502	153	31%
Release of Biological Agent	126	38	30%
Failure of Freight Container	26	7	27%
Fire or Explosion from short circuit	328	85	26%
Explosive Blast resulting in injury	4	1	25%
Flammable Liquid Release	230	51	22%
Failure of Pipeline	422	72	17%
Failure of Well	2	0	0%
Storage Bunker	1	0	0%
Sinking of Waterborne Craft	3	0	0%
Quarry Blast	0	0	-
Explosion in Vehicle	1	0	0%

Table 33 looks at the level of investigation of different 'types' of dangerous occurrences in 2000/01. Apart from incidents involving the 'movement of quarry tips', only half or less of the reported injuries in all the other categories of dangerous incidents were investigated. It is particularly notable that 73 out of 128 'building collapses', 146 of 224 'plant fire and explosions', and 179 out of 230 'flammable liquid releases' were not investigated.

Table 34 compares 14 of the 29 types of dangerous occurrences in different industries in 2000/01. It is notable that there are some wide divergences. For example, both the Agricultural sector and the Extractive industry sector had 28 reports of 'Contact of Machine with electricity' and whilst 19 of the 28 were investigated in one sector (Agriculture), none were investigated in the other (Energy/Extractive sector).

Table 34
Numbers of Reported and Investigated Dangerous Industries by Industry, (2000/01)

	Agriculture			Construction			Manufacturing			Energy/ Extractive			Service Sector		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Failure of Lifting Machinery	14	3	21%	230	83	36%	454	170	37%	43	7	16%	203	89	44%
Failure of Closed Vessel	0	0	-	13	4	31%	80	28	35%	14	4	29%	44	19	43%
Failure of Freight Container	0	0	-	2	1	50%	12	4	33%	2	0	0%	10	2	20%
Contact of Machine with Electricity	28	19	68%	197	52	27%	20	8	40%	28	0	0%	46	21	46%
Fire from short circuit	3	1	33%	129	31	24%	72	22	30%	50	8	16%	74	23	31%
Incident from Explosives	0	0	-	2	0	0%	15	6	40%	28	9	32%	10	2	20%
Release of Biological Agent	0	0	-	14	7	50%	12	2	16%	5	0	0%	95	29	31%
Radiation Equipment Failure	0	0	-	2	0	0%	4	2	50%	10	0	0%	99	48	47%
Scaffold Collapse	0	0	-	48	19	40%	3	0	0%	0	0	-	9	0	0%
Failure of Pipeline	0	0	-	277	52	19%	26	8	31%	77	3	4%	39	8	21%
Building Collapse	0	0	-	62	33	53%	30	8	27%	3	0	0%	33	14	42%
Plant Explosion/fire	3	1	33%	16	3	19%	126	55	44%	17	4	24%	59	15	26%
Flammable Liquid Release	2	0	0%	97	21	22%	59	21	36%	39	2	5%	33	7	21%
Dangerous Substance	7	4	57%	103	32	31%	138	40	29%	25	6	24%	227	71	3%

Table 35

Numbers of Reported and Investigated Dangerous Occurrences in Marches and in Scotland East (2000/01)

	MARCHES			SCOTLAND EAST		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Failure of Lifting Machinery	41	27	66%	72	15	21%
Failure of Closed Vessel	5	3	60%	13	4	31%
Contact of Machine with Electricity	17	11	65%	40	3	8%
Fire or Explosion from short circuit	19	9	47%	23	5	22%
Incident from use of Explosives	1	1	100%	5	0	0%
Release of Biological Agent	1	1	100%	3	0	0%
Failure of Breathing Apparatus	5	4	80%	9	5	56%
Failure of Pipeline	12	6	50%	62	4	7%
Building Collapse	3	2	67%	7	2	29%
Explosion Blast resulting in injury	16	4	25%	18	4	22%
Flammable Liquid Release	5	1	20%	17	3	18%
Dangerous Substance	27	15	56%	33	9	27%

Table 32 above showed that whilst in the Marches, FOD inspectors investigated 84 out of 157 reports (54%), in Scotland East they inspected only 55 out of 309 (18%) reports. Table 35 examines these two areas in further detail to determine which types of dangerous occurrences in these two areas were not investigated. It is interesting that, for example, in Marches 11 out of 17 reports of 'Machinery making contact with electricity' were investigated, whilst in Scotland East only 3 out of 40 of these incidents were investigated. And whilst Marches investigated 9 out of 19 reports of 'fire or explosions from short circuit', Scotland East only investigated 5 out of 23. There was one report of a scaffold collapse in Scotland East but this was not investigated.

Industrial Disease

Certain forms of occupational diseases must be reported to the Health and Safety Executive. These are set out in the adjacent box.

Table 36

Numbers of Reported and Investigated Industrial Diseases by HSE Area (1996/7 – 2000/01)

	1996/97			2000/01		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
West Midlands	153	66	43.1%	194	133	68.6%
North West	82	41	50.0%	194	132	68.0%
North Midlands	112	7	6.25%	174	111	63.8%
N/thn Home Counties	50	13	26.0%	85	52	60.9%
N & W Yorkshire	100	34	34.0%	119	72	60.5%
East Midlands	66	13	19.7%	63	37	58.7%
Marches	90	10	11.1%	77	45	58.4%
South	92	8	8.7%	155	82	52.9%
East Anglia	112	4	3.6%	117	60	51.3%
Merseyside	120	7	5.8%	44	22	50.0%
South East	89	8	9.0%	94	45	47.9%
South West	182	50	27.5%	167	79	47.3%
Greater London	77	21	27.3%	92	32	34.8%
Scotland East	87	24	27.6%	118	34	28.8%
Wales	87	32	36.8%	119	34	28.6%
Greater Manchester	43	11	25.6%	144	29	20.1%
Scotland West	55	9	16.4%	87	16	18.4%
South Yorkshire	164	11	6.7%	116	20	17.2%
North East	162	28	17.3%	236	34	14.4%

Table 36 shows that the level of investigation throughout Britain has increased from 20.6% in 1996/7 to 44.6% in 2000/01 - even though the total number of reports increased from 1923 to 2396 in the same period. The actual numbers of investigations increased from 397 to 1069 - almost a 300% rise. However there are wide disparities in different areas from 68.6% in West Midlands to 14.4% in the North East.

Table 37 shows rates of investigation of reported cases of industrial diseases by industry over the five year period. It is clear from this that there have been increases in rates of investigation across all industries during this period – with the exception of the Extractive industries, where 16.5% of reported cases were investigated in 2000/01, compared to

20% five years earlier. The rate of investigation increased over four-fold in Manufacturing. The Table also indicates disparities in the levels of investigation between different industries. Investigation levels range from 62.5% in Agriculture to 16.5% in the Extractive industries.

Table 37
Numbers of Reported and Investigated Industrial Diseases by Industry (1996/7 – 2000/01)

	1996/97			2000/01		
	Nos Rep	Nos Inv	% Inv	Nos Rep	Nos Inv	% Inv
Agriculture	30	12	40%	16	10	62.5%
Manufacturing	681	95	14.2%	642	366	57.0%
Construction	121	41	33.9%	194	86	44.3%
Extractive/Energy	1,051	240	22.8%	1,289	555	43%
Service Sector	40	8	20%	255	42	16.5%
	1,923	397	20.7%	2,396	1,069	44.6%

Table 38:
Numbers of Reported and investigated Industrial Diseases by 'Type' (2000/01)

	Nos Rep	Nos Inv	% Inv
Hand Arm Vibration	889	299	33.6%
Occupational dermatitis	477	256	53.7%
Inflamed Hand Tendons	385	209	54.3%
Cramps	181	74	40.9%
Carpal tunnel syndrome	161	72	44.7%
Occupational asthma	93	52	55.9%
Infection	53	29	54.7%
Beat Elbow	33	15	45.5%
Beat Knee	19	6	31.6%
Tuberculosis	16	9	56.3%
Legionellosis	14	10	71.4%
Leptospirosis	12	7	58.3%
Poisoning	10	5	50.0%
Chrome ulceration	10	4	40.0%
Mesothelioma	8	3	37.5%
Hepatitis	7	3	42.9%
Pneumoconiosis	6	1	16.7%
Occupational Dermatitis	5	2	40%
Decompression illness	4	4	100%
Asbestosis	4	3	75.0%
Lyme disease	3	1	33.3%
Beat Hand	1	1	100%
Anthrax	1	1	100%
Chlamydiosis	1	1	100%
Q fever	1	1	100%
Folliculitis	1	0	0%
Extrinsic alveolitis	1	1	100%

Table 38 looks at the level of investigation of different types of industrial disease in 2000/01. It shows that significant numbers of the most common industrial diseases were not investigated including 590 of 889 'Hand arm vibrations', 221 of the 477 cases of 'occupational dermatitis', and 89 of the 161 cases of 'carpel tunnel syndrome'. It is also notable that 24 cases of 'infection', 7 cases of 'tuberculosis', 4 cases of 'hepatitis' and 6 cases of 'chrome ulceration' were not investigated.

Table 39
 Numbers of Reported and Investigated Industrial Diseases by 'Type', (2000/01)

	SOUTH YORKSHIRE		NORTH EAST	
	Nos Rep	Nos Inv	Nos Rep	Nos Inv
Cramp	6	0	14	4
Beat Knee	0	0	2	1
Beat Elbow	1	1	6	2
Inflamed Hand Tendons	10	7	30	7
Carpal tunnel syndrome	5	7	12	2
Hand Arm Vibration	59	8	146	6
Legionellosis	1	1	0	0
Leptospirosis	1	0	2	2
Infection	2	0	1	0
Chrome ulceration	2	0	0	0
Asbestosis	1	1	0	0
Occupational Dermatitis	27	7	19	6
Extrinsic Alveolitis	0	0	1	1
Occupational asthma	1	0	3	2

Table 39 looks in further detail at the levels of investigation into industrial diseases in South Yorkshire and North East, which were the two HSE areas with the lowest investigation rates. This shows that in both areas, large numbers of 'Hand Arm Vibrations' and cases of 'Occupational Dermatitis' were not investigated.

Sight	Loss of sight (when
Strain	Strains and sprains
Burn	Burns from electrical requiring resuscitat
Electrical	Any injury resulting admittance to hosp
Asphyxia/Poison	Loss of consciousness

Chapter 3

Use of Notices

This chapter looks at the use of improvement and prohibition notices by FOD inspectors

In order to impose an Improvement Notice the inspector must be of the view that there has been a contravention of a provision of health and safety law. The notice will state that particular changes must be made within a particular time period. A prohibition notice can be imposed when an inspector is of the view that there is or will be a risk of serious injury. Technically, a Prohibition Notice does not require a breach of health and safety law, though, in practice, this will usually be the case. It is of course possible that an improvement and a prohibition notice can be imposed in relation to the same incident.

Table 1
Numbers of notices between 1996/7 and 2000/01

	Nos Imp Notices	Nos Pro notices	Nos Crown Imp notices	Nos Crown Pro notices
1996/7	3,721	3,805	6	1
1997/8	4,332	4,438	9	3
1998/9	6,240	4,468	14	3
1999/00	6,849	4,320	24	4
2000/01	6,462	4,315	12	2

Table 1 shows that the levels of improvement notices has increased by 73% - from 3721 to 6462. The number of prohibition notices has also increased – but only by 20%. It is interesting to note that whilst in 1996/7 the number of improvement and prohibition notices was almost identical, in 2000/01 over 2000 more improvement than prohibition notices were used. The number of Crown notices is small and shows no particular trend– although there was a quadrupling of crown improvement notices between 1996/7 to 1999/00 (6 to 24), which however reduced again the following year (to 12).

Table 2
Numbers of notices by Industry 1996/7 and 2000/01

	Improvement Notices				Prohibition Notices			
	1996/7	2000/01	Nos Diff	% Diff	1996/7	2000/01	Nos Diff	% Diff
Agriculture	592	693	+ 101	+17%	434	610	176	+40%
Manufacturing	2121	3778	+ 1657	+78%	923	1226	383	+ 33%
Construction	187	546	+ 359	+192%	1807	2084	277	+ 15%
Energy/Extractive	23	135	+ 112	+487%	82	36	46	- 56%
Service Sector	798	1310	+ 512	+ 64%	359	359	0	-

Table 2 looks at the number of notices used in different industries and how that differed over a five year period. It shows that the biggest percentage increases in the use of improvement notices over the period was in Construction (an increase of 359 notices - 192%) and the Energy/Extractive Sector (an increase of 112 notices - 487%) though both sectors started from particularly low levels of notices in 1996/7.

It is notable that in only the Energy/Extractive and Construction sectors was the number of prohibition notices imposed higher than the number of improvement notices – in fact, in 1996/7 the number of prohibition notices was almost ten times that of improvement notices (1807 compared to 187) and in 2000/01 it was four times (2084 compared to 546).

Table 3

Numbers of Improvement Notices, by HSE Area (1996/7 and 2000/01)

	Imp Notices 1996/7	Imp Notices 2000/01	Nos Difference	% Difference
North West	98	257	+159	+162%
Scotland West	80	204	+124	+155%
North East	133	330	+197	+148%
South	188	453	+265	+141%
Wales	241	571	+330	+137%
Merseyside	150	345	+195	+130%
East Anglia	188	409	+221	+118%
Scotland East	211	458	+247	+117%
Greater Manchester	184	392	+208	+113%
North Midlands	158	294	+136	+86%
N/thn Home Counties	150	267	+117	+78%
South West	284	459	+175	+62%
East Midlands	167	251	+84	+50%
South East	184	252	+68	+37%
N & W Yorkshire	165	225	+60	+36%
South Yorkshire	192	258	+66	+34%
Greater London	289	328	+59	+22%
Marches	436	456	+20	+5%
West Midlands	243	253	+10	+4%

Table 3 and 4 looks at the number of improvement and prohibition notices used in different HSE areas and how the levels changed over a five year period. In relation to improvement notices (Table 3), it shows that there was an increase in all HSE areas – though this ranged from 162% in North West (an increase of 159) to 4% in the West Midlands (an increase of just 10).

Table 4

Number of Prohibition Notices, by HSE Area (1996/7 and 2000/01)

	Pro Notices 1996/7	Pro Notices 2000/01	Difference	% Difference
South West	150	274	+124	+83%
Scotland East	236	402	+166	+70%
South	158	241	+83	+53%
North East	222	315	+93	+43%
Wales	178	245	+67	+38%
North West	193	257	+64	+33%
East Anglia	144	190	+46	+32%
East Midlands	172	219	+47	+28%
South East	173	218	+45	+26%
Merseyside	189	193	+24	+14%
Scotland West	177	200	+23	+13%
N & W Yorkshire	228	248	+20	+9%
South Yorkshire	153	164	+11	+7%
Marches	171	173	+2	+1%
Greater Manchester	203	205	+2	+1%
N/thn Home Counties	156	154	-2	-1%
Greater London	363	329	-34	-9%
North Midlands	180	141	-19	-12%
West Midlands	199	147	-52	-26%

In relation to prohibition notices, there were four HSE areas where there was a decrease in the use of notices - Northern Home Counties (-1%), Greater London (-9%), North Midlands (-12%) and West Midlands (-26%). These decreases compared to an increase of 83% in the South West.

Chapter 4

Prosecutions

Key Statistics

Prosecutions following Investigated Deaths

33% of investigated worker deaths in 1998/9 - 83 out of 250 – resulted in a prosecution and all but one resulted in a conviction. This was an increase of 9% in prosecution rates compared to the rate following deaths in 1996/7.

The rate of prosecution following deaths in 1998/9 ranged from:

- 50% of deaths in Manufacturing to 11% in Agriculture;
- 60% in the West Midlands to 10% in the South West;

10% of deaths of Members of Public in 1998/9 resulted in a prosecution, all of which resulted in a conviction.

In 1998/9, none of the 23 deaths of Members of the Public in North and West Yorkshire and only 1 of the 27 deaths in the South West resulted in a prosecution.

Only 9 out of 854 deaths that took place between 1996/7 to 1998/9 resulted in the prosecution of a company director or senior manager. One employee was prosecuted.

Prosecutions Following Major Injuries

11% of the investigated major injuries to workers in 1998/9 resulted in a prosecution. This was an increase of 3% in prosecution rates compared to the rate following major injuries in 1996/7.

The rate of prosecution following major injuries in 1998/9 ranged from:

- 12% in Manufacturing to 3% in the /Extractive sector;
- 20% in Wales to 6% in the North Midlands;

6% of investigated major injuries to members of the public in 1998/9 resulted in a prosecution. This was an increase of 4% compared to the rate following major injuries in 1996/7.

Only 4 out of 7982 major injuries that took place between 1996/7 to 1998/9 resulted in the prosecution of a company director or senior manager. 13 employees were prosecuted.

Prosecutions Following Dangerous Occurrences

4% of the investigated dangerous occurrences in 1998/9 resulted in a prosecution. This was just an increase of 1% compared to the rate following dangerous occurrences in 1996/7.

The rate of prosecution following dangerous occurrences in 1998/9 ranged from:

- 14% in the North West to none of the 79 reported incidents in the South West and none of the 45 reported incidents in Northern Home Counties

Prosecutions following Industrial Disease

Only 1% of investigated ill health events in the three years between 1996/7 to 1998/9 resulted in a prosecution.

This section looks at FOD's prosecution record – and in particular the level and rate of prosecutions following investigations into reported incidents.

An investigation into a reported incident (death, injury, dangerous occurrence and so on) can result in more than one company, organisation or individual being prosecuted. In addition each of those prosecutions (or 'cases') may allege that more than one offence (or 'breach') has been committed.

A single death or injury can therefore result in one or more prosecutions. However, we are not concerned with

the total number of cases or breaches alleged after investigations, but with the total number of incidents that have resulted in at least one organisation or individual being prosecuted. This analysis considers a prosecution following a reported incident to have resulted in a conviction, if at least one offence alleged following the investigation resulted in a conviction

Data in this section covers reported incidents that took place between 1996/7 to 1998/9. We do not cover incidents beyond this period due to the time lag between date of death and completion of prosecution which would make any analysis of the data incomplete.

Prosecutions following Deaths

Tables 1 and 2 sets out the percentage of reported work-related deaths that have resulted in a prosecution.

Table 1

Numbers of investigated deaths of workers between 1996/7 – 1998/9 that resulted in prosecutions

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	285	70	24.6%	68
1997/8	254	78	30.7%	75
1998/99	250	83	33.2%	82

Table 1 show that the number of worker deaths investigated in 1998/9 that resulted in a prosecution was 33% - a rise of 8% from 1996/7. This percentage increase also reflects an increase in the total number of deaths resulting in a prosecution – from 70 to 83.

Table 2

Numbers of investigated deaths of members of the public between 1996/7 – 1998/9 that resulted in prosecutions

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	125	12	9.6%	11
1997/8	138	13	9.4%	12
1998/9	134	14	10.4%	14

Table 2 shows that the number and percentage of investigated deaths of members of the public that resulted in prosecution remained stable in this period. It is notable that in 1998/9, the level of prosecution following deaths of members of the public was almost six times lower than the number of prosecutions following worker deaths.

Table 3

Numbers of investigated deaths in 1998/9 that resulted in a prosecution, by Industry

	Nos Inv	Nos Pros	% Pros	Nos Conv
Manufacturing	70	35	50%	35
Construction	71	28	39%	28
Agriculture	46	5	11%	5
Service Sector	61	12	20%	11
Energy/Extractive	6	3	50%	3

Table 3 compares the rate of prosecution following deaths of workers in different industries in 1998/9. It shows that whilst the percentage of manufacturing deaths in 1998/9 that resulted in prosecution was 50%, prosecutions followed only 39% of construction deaths, 20% of service industry deaths and 11% of Agriculture deaths.

Table 4

Numbers of investigated deaths of workers in 1996/7 and 1998/9, that resulted in prosecution, by HSE Area

	1996/7			1998/9		
	Nos Inv	Nos Pros	% Pros	Nos Inv	Nos Pros	% Pros
West Midlands	7	3	43%	15	9	60%
South Yorkshire	13	5	39%	8	4	50%
East Midlands	11	2	18%	13	6	46%
N/thn Home Counties	14	7	51%	5	2	40%
N & W Yorkshire	13	4	31%	15	6	40%
Merseyside	10	1	10%	15	6	40%
East Anglia	12	4	33%	11	4	36%
South East	18	5	28%	17	6	35%
Greater London	22	5	23%	18	7	39%
Wales	31	9	29%	23	8	35%
North East	12	2	17%	13	4	30%
Scotland East	23	5	2%	24	7	29%
North West	6	2	33%	7	2	29%
Greater Manchester	6	1	17%	5	2	40%
Marches	17	5	29%	12	3	25%
Scotland West	21	3	14%	13	3	23%
North Midlands	15	3	20%	6	1	17%
South	15	1	7%	10	1	10%
South West	19	3	16%	20	2	10%

Table 4 shows that there is also considerable divergence in rates of prosecution following deaths of workers in different HSE Areas. In 1998/9, 60% of deaths in the West Midlands (9 out of 15) resulted in a prosecution compared to 10% (2 out of 20) in the South West. There were increases in the prosecution levels in most areas between 1996/7 and 1998/9, particularly in Merseyside with an increase from 10% to 40%.

Table 5

Numbers of investigated deaths of members of the public in 1998/9 that resulted in prosecution, by HSE Area

	Nos Inv	Nos Pros
South West	27	1
South	3	0
South East	3	1
Greater London	4	1
East Anglia	12	0
N/thn Home Counties	4	1
East Midlands	4	1
West Midlands	1	0
Wales	6	1
Marches	8	1
North Midlands	4	1
South Yorkshire	3	0
N & W Yorkshire	23	0
Greater Manchester	3	2
Merseyside	4	0
North West	10	2
North East	4	0
Scotland East	7	1
Scotland West	4	1

Table 5 sets out the levels of prosecution in different HSE areas following investigated deaths of members of the public in 1998/9. It shows that the very low level of prosecutions following these deaths occurred equally in all HSE Areas – though it is notable that in the South West, only 1 out of investigated 27 deaths, and in North and West Yorkshire, none of 23 deaths resulted in prosecution. It is interesting that 2 out of the 4 deaths in Greater Manchester did result in a prosecution.

Prosecutions Following Major Injuries

Tables 6 and 7 sets out percentages of investigated major injuries, over a three year period, that have resulted in a prosecution and conviction. Table 6 shows that only a small percentage (11% in 1998/9) of major injuries to workers resulted in prosecution and that the percentage had hardly changed in the three year period. This is a much lower rate of prosecution than after deaths - over a third less when

Table 6

Numbers of investigated major injuries to workers in 1996/97 – 1998/9 that resulted in prosecution

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	2,532	204	8%	201
1997/8	2,710	296	11%	291
1998/9	2,740	297	11%	294

comparing major injuries and deaths that took place in 1998/9.

Table 7 shows that – as with deaths - the level of prosecution after major injuries to the public is far less that worker injuries – though there has been a three fold increase in the percentage of prosecutions in the three year period from 2% to 6%.

Table 7

Numbers of investigated major injuries to members of the public in 1996/97 – 1998/9 that resulted in prosecution

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	576	14	2%	13
1997/8	507	24	5%	24
1998/9	549	34	6%	33

Table 8 to 12 set out prosecution and conviction data in relation to major injuries of workers in different industries over a three year period. It is notable that the Energy and Extractive sector was the only industry where the level of prosecution decreased over the three-year period (7% to 3%).

The levels of prosecution are still divergent, however. In

1998/9, whilst in manufacturing, 12% of investigated major injuries resulted in prosecution, in agriculture the level was only 7% - even though there were far fewer injuries investigated. In the Service Sector the increase in prosecution rates was particularly notable – from 17 major injuries to 36.

Table 8

Numbers of investigated major injuries to workers in the Construction sector in 1996/7 – 1998/9 that resulted in prosecution

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	599	46	8%	45
1997/8	581	78	13%	76
1998/9	658	80	12%	79

Table 10

Numbers of investigated major injuries to workers in Agriculture in 1996/7 – 1998/9 that resulted in prosecution

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	195	12	6%	12
1997/8	180	17	9%	17
1998/9	199	13	7%	13

Table 9

Numbers of investigated major injuries to workers in Manufacturing in 1996/7 – 1998/9 that resulted in prosecution

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	1270	126	10%	124
1997/8	1422	178	13%	177
1998/9	1372	167	12%	165

Table 11

Numbers of investigated major injuries to workers in the Energy/Extractive sector in 1996/7 – 1998/9 that resulted in prosecution

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	46	3	7%	3
1997/8	56	3	5%	3
1998/9	32	1	3%	1

Table 12

Numbers of investigated major injuries to workers in 1996/7 and 1998/9 that resulted in prosecution, by HSE Area

	1996/7			1998/9		
	Nos Inv	Nos Pros	% Pros	Nos Inv	Nos Pros	% Pros
Wales	146	15	10%	169	34	20%
Greater Manchester	91	7	8%	129	23	18%
East Midlands	99	11	11%	94	14	15%
South Yorkshire	137	3	2%	145	18	12%
West Midlands	135	9	6%	136	16	12%
South	104	5	5%	158	18	12%
South East	121	15	12%	124	14	11%
North West	114	6	5%	124	13	11%
N/thn Home Counties	100	17	17%	118	12	10%
Merseyside	88	4	5%	129	13	10%
Scotland East	141	5	4%	190	19	10%
Marches	193	18	9%	178	17	10%
South West	174	8	5%	129	12	9%
North East	141	9	6%	133	12	9%
Scotland West	134	23	17%	148	13	9%
East Anglia	160	7	4%	174	15	9%
Greater London	122	9	7%	134	11	8%
N & W Yorkshire	201	24	12%	173	14	8%
North Midlands	131	9	7%	155	9	6%

Table 12 sets out the levels of prosecution in different HSE areas following major injuries to workers. As in Tables 4 and 5 above dealing with deaths, this Table shows that there is considerable (though not so wide) divergence between different HSE areas. In 1998/9, 20% of major injuries in Wales (34 out of 169) resulted in a prosecution compared to 6% in North Midlands (9 out of 155). In most HSE areas, there were increases in the prosecution levels between 1996/7 and 1998/9. In South Yorkshire there was an increase from 2% of those investigated (3 out of 137) to 12% (18 out of 145). However, it is notable that in some areas there were considerable decreases in prosecution rates: in Northern Home Counties there was a reduction in prosecution levels from 17% of those injuries investigated (17 out of 100) to 10% of those investigated (12 out of 118), and in the Scotland West from 17% of those investigated (23 out of 134) to 9% (13 out of 148).

Table 13

Numbers of investigated major injuries to members of the public in 1998/9 that resulted in prosecution, by HSE Area

	Nos Inv	Nos Pros	% Pros	Nos Conv
Wales	43	7	16%	7
N/thn Home Counties	20	3	15%	3
Greater Manchester	30	4	13%	3
East Midlands	19	2	11%	2
Scotland East	39	4	10%	4
West Midlands	23	2	9%	2
South East	42	3	7%	3
South	34	2	6%	1
N & W Yorkshire	22	1	5%	1
East Anglia	46	2	4%	2
Greater London	47	2	4%	2
North West	28	1	4%	1
Marches	34	1	3%	1
South West	16	0	-	-
North Midlands	7	0	-	-
South Yorkshire	16	0	-	-
Merseyside	21	0	-	-
North East	29	0	-	-
Scotland West	33	0	-	-

Table 13 sets out the levels of prosecution in different HSE areas following Major injuries to members of the public in 1998/9. This Table shows a considerable divergence between different HSE areas. Whilst, in Wales, 16% of all major injuries investigated resulted in a prosecution (7 out of 43), there were five HSE areas where no prosecutions followed investigations into major injuries: South West, North Midlands, South Yorkshire, Merseyside, North East, and Scotland West

Prosecutions following Dangerous Occurrences

Table 14

Numbers of investigated dangerous occurrences between 1996/97 – 1998/9 that resulted in prosecution

	Nos Inv	Nos Pros	% Pros	Nos Conv
1996/7	925	27	3%	27
1997/8	973	46	5%	45
1998/9	927	39	4%	38

Table 14 shows that the number of dangerous occurrences that result in prosecution are very small – 5% at its highest. It also shows that although the percentage of dangerous occurrences resulting in prosecution has increased over the three year period, this was only by 1.3% .

Table 15

Numbers of investigated dangerous occurrences in 1998/9 that resulted in prosecution, by industry

	Nos Inv	Nos Pros	% Pros	Nos Conv
Construction	239	19	8%	19
Agriculture	15	1	7%	1
Manufacturing	305	12	4%	12
Service Sector	250	6	2%	5
Energy/Extractive	116	1	1%	1

Table 15 shows that the level of prosecution following investigated dangerous occurrences is low in every industry, but there are still some big differences between them - from 8% (19 out of 239) in Construction to 1% (1 out of 116) in the Energy/Extractive sector.

Table 16

Numbers of investigated dangerous occurrences in 1998/9 that resulted in prosecution by HSE area

	Nos Inv	Nos Pros	% Prose
North West	42	6	14%
Greater Manchester	29	3	10%
West Midlands	26	2	8%
North Midlands	60	4	7%
Merseyside	47	3	6%
Greater London	42	2	5%
East Midlands	39	2	5%
Wales	42	2	5%
North East	44	2	5%
Scotland East	55	3	6%
South East	45	2	4%
South	60	2	3%
South Yorkshire	38	1	3%
N & W Yorkshire	69	2	3%
East Anglia	60	1	2%
Marches	60	1	2%
Scotland West	45	1	2%
South West	79	0	-
N/thn Home Counties	45	0	-

Table 16 concerns the level of prosecutions following dangerous occurrences in 1998/9 by HSE area. It shows that there are still some significant differences between the HSE Areas. Whilst in the North West, 14% of investigated dangerous occurrences (6 out of 42) resulted in prosecution, none of the 79 investigated dangerous occurrences in the South West and none of the 45 in the Northern Home Counties resulted in a prosecution.

Prosecutions following Industrial Disease

Table 17

Numbers of investigated industrial diseases between 1996/97 – 1998/9 that resulted in prosecution

	Nos Inv	Nos Pros	% Pros
1996/7	397	4	1.0%
1997/8	486	2	0.4%
1998/9	521	7	1.3%

Less than 1% of investigated reports of industrial diseases resulted in prosecutions. Table 17 shows that over the three year period only 13 of the 1404 investigated ill health incidents investigated resulted in prosecution.

Prosecutions against Individuals

Individuals can be prosecuted in three main ways

- if the employer is a partnership or a sole trader: since the employer is an individual, when the employer is prosecuted, the individual partners or sole trader will be prosecuted.
- if the employer is a company: Section 37 of the Health and Safety at Work Act allows company directors or senior managers of a company to be prosecuted if it can

be shown that an offence committed by the company, was committed with their consent or connivance or was attributable to their neglect.

- employees: any employee can be prosecuted for breach of section 7 of the HASAW. This can include a shop floor worker or a manager.

The tables below only concern breaches of section 37 and 7.

Table 18

Numbers of Prosecutions involving Section 37 of the Health and Safety at Work Act 1974

	Nos Pros	Nos Conv	Pros from Deaths	Pros from Major injuries
1996/7	11	10	4	2
1997/8	11	11	2	2
1998/9	12	12	3	0

Table 18 shows that prosecutions relating to section 37 of the Health and Safety at Work Act 1974 are few and far between (34 in three years) and that there has only been a very minor increase over the three year period. It also shows that very few directors/senior managers are prosecuted following deaths and major injuries.

Table 19

Numbers of Prosecutions involving Section 7 of the Health and Safety at Work Act, 1974

	Nos Pros	Nos Conv	Pros from Deaths	Pros from Major injuries
1996/7	14	14	0	5
1997/8	10	10	0	2
1998/9	14	14	1	6

Table 19 concerns prosecutions for breaches of section 7 of the Health and Safety at Work Act 1974. It is not known how many of these prosecutions concern 'shop floor workers' or 'managers' so it is difficult to come to any particular conclusion about the level of prosecutions below. The table shows that section 7 prosecutions are just slightly more frequent than section 37 prosecutions – though only 1 in the three year period concerned a death.

Chapter 5

Courts and Sentencing

Key Statistics

Between 1996/7 and 1998/9, the average fine following a death has more than doubled from £29,000 to almost £67,000

- The number of cases sentenced in the Crown court has reduced from 61% to 40%
- Whilst the average level of fine after a Manufacturing death is £108,000, in the service sector it is only £16,000

The average fine following a death of a member of the public in 1998/9 is £33,000, which has not increased over the three year period

The average fine following a major injury to a worker in 1998/9 was £10,000

- only 20% of cases are sentenced in the Crown Court.

Between 1996/7 and 1998/9, the average fine following a dangerous occurrence has more than doubled from £13,000 to £28,000.

The average fine following an industrial disease in 1998/9 was £6,000

Health Warning

It is difficult to interpret sentencing data since the average level of fines can be easily distorted by one or two large fines. Also certain fines that may appear to be large could well be small when compared to the profits or turnover of the company/organisation sentenced; and, conversely, a fine that may appear to be small could well be large compared to the wealth of the company.

This section provides information on:

- the levels of fines imposed by the courts subsequent to convictions following reported incidents and;
- in what courts sentencing takes place.

The prosecution process is different in England/Wales compared to Scotland.

In England and Wales, prosecutions and sentencing takes place in either the Magistrates Court or the Crown court. A Magistrate Court only has the power to impose a maximum sentence of £20,000 for a breach of the Health and Safety at Work Act 1974 or £5,000 for a breach of a Regulation. A Crown Court has the power to impose unlimited fines in relation to breaches of both the 1974 Act and Regulations.

Unless the defendant pleads 'non-guilty' and chooses a trial before a jury in the Crown Court, the decision about the court in which a case is heard (and sentenced) is made by a Magistrate. This decision, however, can be influenced by submissions of the prosecutor – FOD inspector or a lawyer representing FOD.

In Scotland, there are two types of court – the Sheriff Court and the High Court. The Sheriff’s court has similar sentencing powers to a magistrates and a High Court to a Crown Court. The decision as to whether a case should be heard in the Sheriff or High Court is one that is made by the Procurator Fiscal, not the court itself.

Understanding the Tables

In most prosecutions, a single incident will result in one defendant being prosecuted in one court. However, in a small number of incidents, a prosecution may result in either:
 (a) one defendant being sentenced for two different offences -one taking place in the magistrates court and the other in the Crown Court or;
 (b) two separate defendants being sentenced - one in the magistrates court and the other in the Crown Court.

When this happens we have counted it as those the incident resulted in a conviction in the Crown Court.

Since some deaths or injuries may result in more than one defendant being prosecuted the tables tell you what is the average total fine that resulted from a single death or injury – not what is the average fine for each defendant convicted following these incidents.

The tables set out the average fines in the Magistrate and Crown Court. There however are not exact – they have been rounded up to the nearest thousand pounds. They continue to give a good indication of the different levels of fines in the two courts.

Sentencing Following Deaths

Table 1 sets out sentencing details relating to convictions following deaths of workers. It shows that in the three years between 1996/7 and 1998/9, the average fine following a death has more than doubled to almost £67,000. The Table shows that this is the result of two factors. First, there has been an increase in the number of cases that have resulted in sentencing in the Crown court – an increase from 40% to 60%; and secondly, the average fine imposed by the Crown Court for each death has nearly doubled from £55,000 to £100,000.

Table 1
Sentences following deaths of workers (1996/7 – 1998/9)

	Nos Conv	Average Fine	Nos Mag	% Mag	Average Mag Fine	Average Crown Fine
1996/7	70	£28,908	43	61%	£12,000	£55,000
1997/8	75	£42,813	42	56%	£11,000	£82,000
1998/9	82	£66,911	33	40%	£15,000	£100,000

Table 2 concerns convictions following deaths of members of the public. It is notable that the levels of fines imposed by the courts are much lower than those following worker deaths. Moreover, unlike the position with worker deaths, the level of the average fine does not show any consistent increase over the years. It is also notable that, in contrast to worker deaths, the number of cases that were sentenced in the Crown Court has decreased during the three-year period.

Table 2

Sentences following deaths of members of the public,
(1996/7 – 1998/9)

	Nos Conv	Average Fine	Nos Mag	% Mag	Average Mag Fine	Average Crown Fine
1996/7	11	£31,364	4	36%	£9,900	£43,600
1997/8	12	£22,708	7	58%	£13,600	£35,400
1998/99	14	£33,179	9	64%	£22,000	£54,000

Table 3

Sentences following deaths of workers by Industry,
(1996/7 – 1998/9)

	Nos Conv	Average Fine	Nos Mag	% Mag	Average Mag Fine	Average Crown Fine
Manufacturing	35	£108,039	16	46%	£15,000	£153,000
Construction	28	£55,666	9	32%	£9,500	£79,000
Agriculture	5	£16,750	3	60%	£23,000	£8,000
Service Sector	11	£16,125	5	45%	£16,000	£22,000
Energy/Extractive	3	£23,666	0	-	-	£24,000

Table 3 concerns convictions following deaths of workers in 1998/9 and breaks down the sentencing data by industry. It shows that there are significant differences in the average fines imposed by the courts – from £108,00 per death in the manufacturing sector to £16,000 in the Service Sector.

Table 4

Sentences following deaths of workers by HSE Area (1996/7 – 1998/9)

	Nos Conv	Nos Mag	Average Fine
North West	2	0	£343,500
East Anglia	4	0	£305,000
East Midlands	6	4	£132,458
Greater London	7	1	£76,857
West Midlands	8	3	£52,188
Merseyside	6	4	£51,500
Wales	8	1	£51,375
South Yorkshire	4	1	£45,000
North East	4	2	£40,500
Marches	3	2	£39,667
South	1	1	£36,000
North Midlands	1	0	£30,000
N/thn Home Counties	2	1	£24,500
Scotland East	7	2	£23,607
South East	6	3	£23,417
Greater Manchester	2	2	£22,500
South West	2	1	£16,500
N and W Yorkshire	6	5	£13,250
Scotland West	3	0	£7,083

Table 4 concerns convictions following deaths of workers in 1998/9 and breaks down the sentencing data by HSE Area. Because of the small numbers involved, one should be wary of making too much of the average fines since one large fine can have a distorting effect. The huge disparity between the average level of fines – from £343,500 in the North West to £7,083 in Scotland West – is, however notable.

Sentencing following Major Injuries

Table 5

Sentences following major injuries to workers (1996/7 – 1998/9)

	Nos Conv	Average Fine	Nos Mag	% Mag	Average Mag Fine	Average Crown Fine
1996/7	201	£9,382	176	88%	£6,300	£26,900
1997/8	291	£7,587	253	87%	£6,900	£12,000
1998/9	294	£10,236	239	81%	£9,000	£14,800

Table 6

Sentences following major injuries to Members of the Public (1996/7 – 1998/9)

	Nos Conv	Average Fine	Nos Mag	% Mag	Average Mag Fine	Average Crown Fine
1996/7	13	£3,798	11	85%	£3,579	£5,000
1997/8	24	£5,863	21	88%	£6,319	£2,700
1998/9	33	£11,643	27	82%	£9,083	£23,000

Tables 5 and 6 sets out the levels of fines which followed major injuries to workers and members of the public. In relation to injuries to workers, it is notable how low the average fines are when compared to those imposed following deaths of workers - in 1998/9, six times less – and how the average level of fines have not increased over the three year period. The relatively low level of fines is linked to the high percentage – 80% of the prosecutions in all three years – that resulted in sentencing in the magistrates Court.

Table 7

Sentences following major injuries to workers by Industry, (1996/7 – 1998/9)

	Nos Conv	Average Fine	Nos Mag	% Mag	Average Mag Fine	Average Crown Fine
Manufacturing	165	£9,978	140	85%	£9,200	£14,600
Agricultural	13	£3,576	8	62%	£4,300	£1,900
Energy/Extractive	1	£150,000	0	0%	-	£150,000
Service Sector	36	316,097	32	89%	15,800	£10,900
Construction	79	£7,469	59	75%	£5,800	£12,500

Table 7 concerns convictions following major injuries to workers in 1998/9 and breaks down the sentencing data by industry. It is notable that the level of fines in Agriculture is particularly low.

Table 8

Sentences following major injuries to workers by HSE Area, (1996/7 – 1998/9)

	Nos Conv	Nos Mag	Average Fine
N/thn Home Counties	11	9	£20,823
Greater London	11	8	£18,127
Wales	34	30	£15,701
North Midlands	9	8	£14,778
North East	12	11	£13,700
Greater Manchester	23	23	£13,076
South	18	16	£12,111
South Yorkshire	18	15	£11,408
East Anglia	15	11	£10,407
South East	14	12	£10,079
East Midlands	13	13	£8,731
West Midlands	16	16	£6,594
South West	13	13	£6,277
Marches	17	15	£5,765
N & W Yorkshire	14	14	£5,514
North West	13	13	£5,212
Scotland East	19	0	£4,908
Merseyside	13	12	£4,800
Scotland West	11	0	£2,655

Table 8 concerns convictions following major injuries to workers in 1998/9 and breaks down the sentencing data by HSE Area. As with the situation set out in table 4 concerning deaths of workers, there is a wide, though not as great, divergence between the average level of fines – from £20,823 in the Northern Home Counties to £2,655 in Scotland West.

Sentencing following Dangerous Occurrences

Table 9

Sentencing following Dangerous Occurrences, (1996/7 – 1998/9)

	Nos Conv	Average Fine	Nos Mag	% Mag
1996/7	27	£12,859	19	70%
1997/8	45	£18,230	35	78%
1998/9	38	£28,292	25	58%

Average Mag Fine	Average Crown Fine
£9,600	£20,600
£6,800	£64,900
£26,900	£31,000

Tables 9 to 11 concern sentences following dangerous occurrences. It is interesting to note that the average fine following a dangerous occurrence has more than doubled over the three years and is almost double the levels imposed following a major injury. It is also notable that more dangerous occurrence prosecutions take place in the Crown Court compared to those following major injuries.

Table 10

Sentencing following Dangerous Occurrences by Industry (1998/9)

	Nos Conv	Average Fine	Nos Mag	% Mag
Construction	19	£18,703	12	63%
Agriculture	1	£500	1	100%
Service Sector	5	£30,000	3	60%
Manufacturing	12	£27,438	8	67%
Energy/Extractive	1	£240,000	1	100%

Average Mag Fine	Average Crown Fine
£12,029	30,143
500	-
25,000	£37,500
£23,528	£29,375
£240,000	-

Table 11

Sentences following dangerous occurrences by HSE area (1998/9)

	Nos Conv	Nos Mag	Average Fine
North West	6	4	£70,750
East Midlands	2	2	£87,675
West Midlands	2	0	£57,500
South East	2	2	£52,500
Greater London	2	1	£23,750
North Midlands	4	2	£21,250
North East	2	1	£17,250
Merseyside	3	3	£15,167
Wales	2	2	£11,000
Scotland West	1	0	£10,000
East Anglia	1	1	£9,500
Scotland East	3	0	£6,167
Marches	1	1	£5,000
Greater Manchester	3	2	£4,167
N & W Yorkshire	2	2	£1,750
South Yorkshire	1	1	£1,250
South	1	1	£500
South West	0	-	-
N/thn Home Counties	0	-	-

Table 11 breaks down the sentencing data for 1998/98 by HSE Area and shows the great disparity in fines between different parts of the country – from an average of £71,000 in the North West to barely a £1000 in a number of HSE Areas,

Sentences following Industrial Diseases

Table 12 concern sentences following industrial diseases. It is intriguing that the level of fines has decreased by over a fifth over the three year period – however because of the small number of cases involved it is difficult to know whether there is any significance in this decrease.

Table 12

Sentences following Industrial Diseases (1996/7 - 1998/9)

	Nos Conv	Average Fine
1996/7	4	£24,125
1997/8	2	£11,500
1998/9	7	£5,642

Chapter 6: Best and the Worst

This short chapter contains three tables that allow the performance of FOD to be observed and assessed across a range of indicators, and to rank

- each of the 19 HSE Areas;
- each of 7 HSE regions;
- each of the 5 Industry groups;

The tables below contain information on

- the % of major injuries suffered by workers in

- 2000/01 which were investigated;
- the % of major injuries suffered by members of the public in 2000/01 which were investigated;
- the % of investigated dangerous occurrences in 2000/01 which were investigated
- the % of industrial diseases in 2000/01 which were investigated;
- the % of investigated deaths in 1998/9 which resulted in prosecution;
- the % of investigated major injuries to workers in 1998/9 which resulted in a prosecution;
- the % of investigated major injuries to the public in 1998/9 which resulted in a prosecution;

- the % of investigated dangerous occurrences in 1998/9 which resulted in a prosecution;
- the % of premises which received at least one inspection in 2000/01

Along side the percentage is the ranking of either the HSE Area, HSE Region or Industry.

The overall ranking has been obtained by adding up all the percentages and ordering them – with the HSE area, Region or Industry with the highest level of investigation/prosecution at the top.

	Deaths		Major Injuries to Workers			Major Injuries to Public			Over-3 Day Injury			Dangerous Occurrences			Disease		Inspections		OVERALL RANKING	
	% Pros	Rank	% Inv	Rank	% Pros	Rank	% Inv	Rank	% Inv	Rank	% Inv	Rank	% pros	Rank	% Inv	Rank	% Premises inspected	Rank		
West Midlands	60	7	21	6	11.8	5	8.1	9	6	3	18	37	6	7.7	3	68.6	1	4.5	15	1
Marches	25	15	26	1	9.6	12	9.8	7	13	6	2	54	1	1.7	16	58.4	7	5.4	12	2 _a
East Midlands	46	3	16	18	14.9	3	4.2	17	4	3.4	16	34	7	5.1	7	58.7	6	5.6	10	2 _a
N & W Yorkshire	40	4 _a	17	15	8.1	18	4.3	16	5	3.3	17	50	3	2.9	14	60.5	5	5.7	9	4
Merseyside	40	4 _a	22	5	10.1	10	12.1	5	0	14 _a	1	39	5	6.4	5	50	10	6.2	6	5
North West	28.6	14	18	12	10.5	8	3.6	19	4	3.6	14	31	11	14.3	1	68	2	7.6	1	6
N/ithn Home Counties	40	4 _a	19	10	10.2	9	5.9	12	15	2	3.7	25	15	0	18 _a	60.5	4	3	18 _a	7
Grter Manchester	40	4 _a	20	9	17.8	2	18	2	13	3	4.1	32	10	10.3	2	20.1	16	5.5	11	8
Wales	34.6	11	18	13	20.1	1	18.6	1	16	1	4.4	7	30	12	4.8	28.6	15	4.8	14	9
East Anglia	36.4	8	25	3	8.6	16	8.3	8	4	10	4.2	9	25	14	1.7	51.3	9	3	18 _a	10
South Yorkshire	50	2	18	14	12.4	4	5.2	14	0	14 _a	3.5	46	4	2.6	13	17.2	18	4	17	11
South East	35.3	9	16	16	11.3	7	5.2	13	7	7	4.3	8	20	17	4.4	47.9	11	5.9	7	12
Scotland East	29.2	13	26	2	10	11	13	4	10	5	4.9	4	18	19	5.5	28.8	14	7.2	2	13
North Midlands	16.7	17	21	7	5.8	19	6.2	11	0	14 _a	4.1	23	16	6.7	4	63.8	3	4.5	16	14
South	10	18	20	8	11.4	6	4.5	15	6	8	4.8	5	32	9	3.3	52.9	8	6.3	4	15
North East	30	12	16	17	9	14	7.9	10	0	14 _a	4.1	11	52	2	4.5	14.4	19	6.3	5	16
South West	9.5	19	19	11	9.3	13	14.1	3	0	14 _a	5.5	3	27	13	0	47.3	12	5.3	13	17
Scotland West	23	16	24	4	8.8	15	9.9	6	0	14 _a	4.7	6	33	8	2.2	18.4	17	7	3	18
Greater London	35	10	11	19	8.2	17	4	18	4	11	3	19	20	18	4.8	34.8	13	5.9	8	19

HSE Regions

	Deaths		Major Workers			Major Public			Over-3 Day Inj		Dangerous Occurrences			Disease		Inspection		Overall Rank			
	% Pros	Rank	% Inv	Rank	% Pros	Rank	% Inv	Rank	% Inv	Rank	% Inv	Rank	% Pros	Rank	% Inv	Rank	% Premises inspected		Rank		
Midlands	45.7	1	18.6	6	10.1	3	4.7	7	8.2	2	3.3	7	30	4	6.4	2	66.2	1	4.9	6	1
North West	37.0	3	20.1	4	12.8	2	10	3	6.3	4	4.8	2	34.4	2	10.2	1	47.9	3	6.5	2	2
Wales and W	22.8	7	20.5	2	13.2	1	14	1	8.6	1	5.2	1	33.8	3	1.70	7.00	45.5	4	5.2	5	3
Home Counties	26.9	5	20.4	3	10	4	6.3	4	7	3	4.3	4	27.6	5	1.8	6	54.2	2	4.2	7	4
York and NE	38.9	2	18.8	5	9.6	5	5.1	5	1.5	7	3.6	5	49.3	1	3.3	5	26.8	6	5.4	4	5
London and SE	35.1	4	13.2	7	9.7	6	4.5	6	5.6	5	3.5	6	19.9	7	4.6	3	41.4	5	5.9	3	6
Scotland	26.3	6	25	1	9.5	7	11.3	2	5.6	5	4.8	2	24.2	6	4	4	24.4	7	7.1	7	7

Industrial sectors

	Deaths		Major Workers			Major Public			Over-3 Day Inj		Dang Occs			Disease			Inspection		Overall Rank		
	% Pros	Rank	% Inv	Rank	% Pros	Rank	% Inv	Rank	% Inv	Rank	% Pros	Rank	% Inv	Rank	% P premises inspected	Rank	% Premises inspected	Rank			
Manufacturing	50	1=	27.3	2	12	1=	27.9	2	7.1	2	36.5	2	4	3	57.8	2	7.5	2	7.5	2	1
Agriculture	11	3	40.5	1	7	4	36.4	1	11.7	1	46.7	1	7	2	62.5	1	3.6	4	3.6	4	2
Construction	39	2	23.1	3	12	1=	24.1	4	4.9	3	28.3	4	8	1	49.5	3	10.5	1	10.5	1	3
Energy/Extractive	50	1=	21.9	4	3	5	27	3	3.8	4	17	5	1	6	43	4	4.4	4	4.4	4	4
Service Sector	20	4	10	5	9	3	6.1	5	1.9	5	35.4	3	2	4	16.5	5	2.7	5	2.7	5	5

Chapter 7

Conclusion

This chapter looks at some of the main points that emerge from the tables set out in the previous chapters and considers some of the reforms that the HSE (and FOD in particular) have made, or are planning to make, that will affect enforcement issues in the future.

Inspections

At the end of 2001, there were 419 FOD field inspectors and 736,000 registered premises: one inspector to 1700 premises. Even if inspectors did nothing other than undertaking preventative inspections, most workplaces would not receive an annual visit from an inspector. However, the reality is that, in addition to undertaking inspections, inspectors have to conduct investigations – which may comprise many visits to a particular workplace – as well as prepare cases for prosecutions. It is therefore hardly surprising that each year, FOD inspectors can only undertake a relatively small number of inspections.

Chapter one shows that in the last five years there has been a 41% decline in the number of ‘contacts’ involving inspections – a reduction from 117,156 in 1996/7 to 68,857 in 2000/01. The audit also shows that in 2000/01, only 40,237 out of the 736,000 total registered premises received an inspection – one premises in 20. On average a construction site can expect one visit every ten years.

The decline is particularly significant since a recent independent research report funded by the HSE concluded that:

"Inspection is an effective means of securing employer compliance. If targeted at key groups, it can bring about significant improvements in health and safety performance, both in terms of ensuring control measures are effective and, at least according to the general literature (rather than specific HSE literature), securing improvements in employees' health and safety."

Why has there been such a decline in the number of inspections? The immediate cause – as shown in chapter one – is an increase in the number of inspector contacts involving investigations into reported incidents (an increase in the same time period of 43.5% from 39,384 to 56,515). However, such a reduction would not be necessary if the HSE was adequately resourced: during the years under consideration, the HSE simply did not have the money to employ a sufficient number of inspectors to ensure that, as levels of investigations increased, there was no decline in the levels of inspections.

The decline in inspector contacts indicates how finely balanced are HSE resources. An increase in one core activity of inspectors has to result in a reduction of another core activity.

Balancing Inspections with Investigations

However putting the question of resources to one side, the decline in inspector numbers raises an important question which goes to the heart of HSE's operational activities. Was FOD right to have prioritised investigations over inspections?

This is a very difficult question to answer. Undoubtedly, both inspections and investigations are important, but no research has been undertaken which assesses the relative effectiveness of one compared to the other.

The HSE has historically prioritised inspections. The reason for this is linked to its perception of itself as organisation concerned principally with ‘preventing death and injury’

rather than one concerned with 'accountability'. It is better to prevent a death or injury rather than simply responding to these incidents when they happen. This has resulted in an emphasis on inspections rather than investigations as the latter – in contrast to the former – are seen as principally concerned with 'accountability', not 'prevention'.

The only rationale that the HSE has given for the increase in the number of investigations is contained in the evidence it gave in 1999 to a Parliamentary Select Committee. It stated: "There is some public expectation that HSE should investigate more accidents, because accidents which are not investigated may result in potential offenders escaping punishment."

In saying this, the HSE was aware that this would impact upon its inspection programme:

"At present HSE plans to increase the number of investigations from 1999-2000 to 2001-02 by about 3 per cent. But any major increase beyond that would seriously reduce the number of preventative inspections and detract from the primary objective of ensuring that risks are properly controlled and that incidents do not occur. HSE believes that a balanced programme ... is needed to secure improvements in health and safety on a continuing basis. The balance of inspection and investigation work has to be kept under continuing review."

In its final report, the Select Committee concluded:

"We agree that the HSE's focus should remain largely preventative. However, we are disappointed by the low levels of investigation We therefore support the proposed target of a three per cent increase in investigation of reported injuries over the next three years. However, this target must be taken seriously: it should not be viewed as merely 'aspirational'. If resources are not currently available to allow the HSE to make this improvement, they must be provided."

Although it is not clear whether the Select Committee was aware of the consequences of an increase in HSE's investigation levels, it is interesting that both the HSE and the Select Committee have only one reason for increasing investigations – that is to increase accountability.

It is certainly correct to say that an important element of investigations is 'criminal accountability' – something which is generally absent in relation to inspections. Whilst inspections can reveal circumstances that justify a prosecution, the absence of harm usually make it inappropriate for prosecutions to take place unless the risk of endangerment or failure is very high. This is because the criminal justice system generally deals with offences involving harm, and experience has shown that courts take prosecutions less seriously where no harm has been caused. As a result inspections have a primarily preventative function. However, since most investigations concern 'harm', or circumstances where a high risk of harm is reported to have existed, an important purpose of investigations – over and above their preventative function – is to ensure that consideration is given to criminal accountability issues. Unless investigations take place, organisations and individuals escape the possibility of prosecution.

However, it is wrong to suggest – which both the HSE and the Select Committee appear to do – that investigations do not have a strong preventative function. 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.

In addition, it is also the case that investigations can fulfill a preventative role in a more targeted fashion than inspections. The identity of the premises that will be inspected is determined by a 'hazard rating' that is given to it at a previous inspection (see below). This prior inspection may have taken place quite some time earlier and may not be an accurate reflection of the company's level of safety at the time of the subsequent visit. Time spent on some inspections may as a result not be that useful.

In contrast, investigations take place in relation to a particular incident that has just

occurred. A report of such an injury indicates that unsafe or illegal practices may exist in relation to a particular workplace. Of course this is not necessarily the case. A death or injury may have occurred where the premises were faultless and conversely a dangerous premises may never have a reportable incident or injury. Yet since it must be the case that deaths or injuries are more likely to occur in unsafe workplaces (for if this wasn't so, there would be no point in trying to improve workplace safety conditions) the very fact of a reported incident is important up-to-date intelligence that there are issues of safety that need to be considered.

This point is even stronger in relation to reported 'dangerous occurrences'. Unlike a report of an injury (which may well not, as suggested above, be the result of unsafe or illegal conditions) a report of a 'dangerous occurrence' – like the collapse of a scaffold or contact with overhead power lines – indicates that a situation has in fact arisen which is unsafe and dangerous and most probably a breach of health and safety law. The situation needs immediate rectification.

It is often argued that an inspection that results in changes in working practices that prevents a major injury or death must be far more important than any investigation into a death or injury that has already taken place. Put like that, and if there is simply a choice between the two, this is an unarguable point. Why wait to investigate deaths or injuries when you can prevent them?

However, in practice this is not the choice that inspectors have to make. Even when an inspection does result in identified dangerous practices being halted, it is never known whether those dangerous practices would – had they continued to have existed - actually have caused a death or injury. It is only possible to say that had these practices not been stopped, there would continue to have been a significant risk of harm. What the inspection did was to reduce the risk of harm existing but not necessarily preventing any death or injury actually taking place.

Inspections, as with investigations reduce future risks of death and injury – not stop them happening. What investigations can do in addition is to ensure that those organisations and individuals that have committed criminal offences that deserve prosecution be held accountable.

The purpose of the above discussion is not intended to argue that the number of

Importance of Inspections

Inspections do provide an opportunity for the HSE to monitor workplaces in a way that investigations cannot.

- investigations will usually be very narrowly construed – only looking at one type of work activity and the particular circumstances associated with the event in question. Inspections, however, provide an opportunity to compile much more of an overview of the management of safety at a workplace.
- Inspections take place with little or no warning and so provide the advantage of the 'element of surprise' which investigations do not since the company or organisation may well be preparing itself for a visit from an inspector because it has reported an injury or dangerous occurrence.
- inspections provide an important opportunity for HSE inspectors to make contact not only with management, but with the workforce, and in particular with trade union safety representatives. The development of such contact may encourage employees and their representatives not only to keep in contact with HSE, but to inform HSE if any serious problems arise at the site.

inspections should be reduced even more to allow for more investigations or indeed that the HSE have got the balance right. This report is in no position to suggest what – in the context of HSE's current financial circumstances – should be the appropriate balance between inspections and investigations. It is our contention that the HSE should simply not have to be in a position to choose between one of its two core activities in the way that it

has been forced to so.

It is important, however, that the HSE recognises the value of investigations over and above that of ensuring 'accountability' and that any decision about redrawing the balance should not be based on an inaccurate view that an increase in investigations will only result in increased accountability and not prevention. Also, for the sake of transparency, the HSE should spell out more clearly to the public:

- its rationale for any decision to increase the level of investigations;
- the effect that this will have on its other activities;
- if lack of resources is the reason for a reduction in a core activity.

A particular problem faced by the HSE in making choices about priorities is that it has not commissioned any research – or at least published it - into the effectiveness of its inspection and investigation regimes. It is therefore difficult for the HSE to know what are the positive benefits of an increase in investigations, on the one hand, or an increase in inspections, on the other, and what will be the effects of reducing one at the expense of the other.

Who is inspected?

Whilst the level of inspection is important – it is also important to consider which premises have been subjected to inspection. FOD inspectors could, for example, have a high level of inspection, but fail to inspect the most hazardous premises: alternatively, inspectors could have a low level of inspection, but visit all the most hazardous plants.

During the whole of the five year period under analysis, FOD has run an 'inspection rating procedure' in which all premises, when inspected, are rated from 1 to 6 or 1 to 4, according to a number of criteria: "competence and attitude of management", "welfare compliance gap", "safety Rating" and 'health rating'. These numbers are then added up and a final 'hazard rating' number is obtained.

In April of each year, the identity of those premises which have the highest 'hazard rating' (falling into what is known as 'category A' – high Hazard) are made known to the principal inspectors around the country who give them priority in the following year's inspection plan. Inspectors will then decide what additional premises should be inspected by considering a number of factors including, the hazard ratings of premises, the particular priorities of FOD at that time, and other local factors.

The data we have obtained from the HSE does not allow any proper assessment of this rating system – but our analysis does raise some questions about its effectiveness. This is because, for example, out of all the industry groups, the one with the biggest decrease, in the level of inspections is in construction – a reduction of 52% from 37,774 in 1996/7 to 17,908 in 2000/01. One would imagine that the hazard rating system would ensure that any necessary reduction in inspection numbers would impact less on the construction industry than other industries since it has a historically high level of death and injury and is well known to be particularly hazardous.

The problem with the current rating system is that:

- it is based on historical data – so that the hazards of premises might have changed significantly between the time of the last inspection and the date any new inspection may take place. As a result a premises which should be inspected (because it is in fact hazardous) will not be inspected for some time simply because at the last time it was inspected it was given a low hazard rating;
- it is possible for the HSE to change the criteria which determines whether a workplace falls into the 'high hazard' category – depending on the pressure of inspector time.

In relation to the first point, it is difficult to see how the HSE can come up with a better system, other than to ensure that inspections of all premises are more frequent – again a resources issue.

Resource questions

The extent to which any organisation, empowered to enforce the law, can actually undertake inspections and investigations and use its powers to obtain compliance and accountability is highly dependent upon the financial resources available to it. This is as true of the Health and Safety Executive as of any other policing body.

The level of resources available to the HSE determines how many inspectors it can employ which in turn affects how many inspections and investigations the organisation can undertake. Resources will also have an inevitable impact upon the quality and the rigor of an inspection or investigation and, may also influence the decisions by inspectors about the way they use their powers since some decisions, particularly those involving prosecution, have significant time and resource implications.

This audit raises important questions about whether FOD has adequate resources in relation to undertaking an appropriate number of inspections and investigations and to ensuring that appropriate cases result in a prosecution.

In 2000/01, the HSE spent £133 million on enforcing health and safety law - £103 million of which was given by the Government. The Government contribution is barely a quarter of the grant it gave in the same period to the West Midlands police – just one of 43 police forces in England and Wales,

Consistency

One issue that cuts across all the chapters is the issue of consistency. There are wide inconsistencies in levels of inspection, investigations, notices and prosecutions between different parts of the country and between different industries. For example:

- In the five year period, whilst the number of inspection contacts had decreased by 17.5% in the South it had decreased by 51.6% in the Marches.
- In 2000/01, investigation levels into major injuries to workers ranged from 41% in the Agricultural Sector to 10% in the Service Sector and from 26% in the Marches to 11% in Greater London;
- in the five year period, the number of improvement notices increased by 192% in the construction sector but only 17% in Agriculture.
- In 2000/01, the number of deaths that resulted in prosecution was 51% in manufacturing, 41% in construction, 22% in the Service sector, and 10% in Agriculture

Such differences inevitably raise questions about whether or not there are inconsistent practices within FOD. HSC's new Enforcement Policy Statement states, 'consistency of approach does not mean uniformity. It means taking a similar approach in similar circumstances to achieve similar ends.' This is indeed the case. The fact that 73% of amputations in North West are investigated but only 36% amputations in Wales does not necessarily mean that the inspectors are using their discretion in an inconsistent manner – since there could be good reasons for the difference. However such glaring differences do raise serious questions about why there is such inconsistency and it is necessary for FOD to be able to justify the differences, or alternatively work to eradicate them.

One of the reasons for the inconsistencies in investigation levels is the differing number of reported injuries. So, for example, one of the reasons why 26% of major worker injuries were investigated in the Marches whilst only 11% were investigated in Greater London is because there were 950 more major injuries reported in Greater London than the Marches. This would appear to indicate that HSE areas only have enough inspectors to investigate a certain number of major injuries and reports of injuries beyond a certain number will simply not get investigated.

The new Investigation criteria (operational in April 2001) and the Enforcement Management Model (operational since May 2002) are supposed to assist in ensuring greater consistency in the future and they are discussed below.

Investigations

As noted above, this audit shows that the reduction in the levels of inspection has gone hand in hand with an increase in the number of investigation contacts. Although the number of investigation contacts by inspectors has risen by 43.5%, Chapter Two shows that the numbers of actual incidents investigated has not risen by anything near that number.

The percentages of investigations into:

- deaths of workers has risen from 88% to 98%.
- deaths of members of the public has risen from 52% to 92%.
- major injuries to workers has risen from 10.8% to 19.3%.
- major injuries to the members of the public has risen from 2% to 7.2%
- dangerous occurrences has risen from 26% to 31%
- over-three day injuries has risen from 2.6% to 4.5%

Although the increase in investigation levels since 1996/7 is certainly notable, very large numbers of major injuries and dangerous occurrences – 80% and 69% respectively - remain uninvestigated. Since the purpose of investigations – as set out above - is to stop any recurrence and to obtain criminal accountability, this failure to investigate such a high number of investigations must be of concern.

Investigation Criteria

This level of lack of investigation, however, may not be so serious if it can be shown that those injuries that are not investigated are neither very serious (even though they are formally called 'major') nor took place in circumstances where an investigation would be possible or very helpful.

This raises the question of what systems the HSE has to determine which of the thousands of reported incidents should be investigated.

In the first four years of our audit, between 1996/7 - 1999/2000, FOD inspectors were supposed to follow a document called "Selection of Accidents for Investigation" (See Appendix 1). This stated that the following incidents should always be investigated:

- all "fatalities";
- all incidents which "would give rise, or already have given rise to serious public concern"; and
- "very serious injuries".

The document went on to state that "exceptionally serious injuries" should generally be investigated – though it does not say how these injuries differ from the "very serious injuries" that should always be investigated.

The document stated that a principal inspector had discretion to investigate "other accidents" such as those which "appear to indicate a serious breach of the law, accidents to young persons or children, or those which recur at a particular premises or in a particular industry". In deciding which of these to investigate the inspector should take into account a number of factors including "the severity or potential severity of the injury" and "the gravity of any apparent breach of legislation".

This policy had the following problems:

- it gave the Principal Inspector a great deal of discretion in deciding which injuries or incidents to investigate;
- it did not define the difference between a "very serious injury" and an "exceptionally serious injury" and indeed whether particular forms of injury – like amputations or burns - did or did not fall into those categories;
- it did not mention 'dangerous occurrences' or 'industrial diseases' and therefore did not clarify how a principal inspector should treat them in contrast to a major injury;
- it did not give weight to any of the factors that inspectors should consider when deciding which of the "other accidents" it should investigate.

The defects in this policy are reflected in the statistics. For example, in the four years between 1996/7 to 1999/00, for example, only 41% of the 4533 amputations and 43% of the 817

poisonings/asphyxias were investigated.

In its 1999 report, the Parliamentary Select Committee criticised HSE's injury selection policy. It stated:

"we continue to have some concerns about how the criteria which determine which injuries will be investigated, are applied by HSE inspectors. Decisions in the past appear to have been unduly dictated by availability of resources. While the HSE needs to operate within its resource limitations, we believe that it should develop more detailed guidance for inspectors. In particular, more thought should be given to a) how to 'weight' the criteria, since some should surely have more influence than others and b) whether some categories of very serious injuries should automatically trigger an investigation in the same way that fatalities do. Such a system would mean that decisions on whether to investigate would be more rigorously based and more transparent which would ultimately lead to a greater consistency in application between inspectors. We urge the HSE to use its review to address these issues."

Following this criticism, in April 2000, FOD piloted a new investigation criteria policy – which has now been formally approved throughout the HSE (see Appendix 2). In summary, this states that inspectors should investigate the following incidents:

- all deaths 'arising out of or in connection with work activities' unless they involve suicides or deaths from natural causes;
- all reports of cases of industrial disease;
- certain specified 'major injuries' relating to either the injury caused (e.g. amputations) or the kind of incident which resulted in the injury (e.g. resulting from transport incidents)
- incidents that are "likely to give rise to serious public concern";
- incidents where there is "likely to have been a serious breach of health and safety law";

The policy states that when an investigation is not possible because of "inadequate resources" or "policy development", the incident "must be referred to the Head of Operations". The policy also allows an investigation not to go ahead due to investigations when it is "impracticable" or where there is "no reasonable practicable precautions available for risk reduction".

This new policy is an improvement on the previous one. It sets out much more clearly the criteria by which incidents should be investigated. However, a number of points should be made about it:

- the HSE has not provided any rationale as to why injuries resulting from certain types of incidents (like transport) must be investigated whilst others (like the "collapse of a scaffold" or an "explosion") should not be required to be investigated.
- the injuries mentioned do not directly match the way injuries are categorised on the form (the 'RIDDOR' form) on which employers report an injury. This will make it difficult for a Principal Inspector to determine whether a particular injury recorded on the form is in fact an injury that should be investigated or not. For example, it is unlikely that an inspector will know from reading the form whether a person has suffered 'scalping' or burn injuries covering "10% of the body";
- it makes no explicit reference to 'dangerous occurrences'.

FOD has in fact employed this policy in 2000/01 - the final year of our data analysis. Has this policy been implemented? Since, the categories in the new policy do not entirely reflect the RIDDOR form, the data provided to us by the HSE only allows a partial assessment. However, the box on the right does indicate that FOD is a long way from implementing the policy. For example, although the new policy requires them to have done so, FOD did not investigate:

- 12 out of 55 amputations of either hand, arm, foot or leg;
- 337 out of 633 injuries resulting from contact with moving vehicles ;
- 69 out of 178 injuries involving electricity;
- 569 out of 1384 falls from a height of over 2 metres;
- 1327 out of 2396 industrial diseases;

The Following injuries in the new investigation criteria should all have been investigated in 2000/01	Level of implementation by FOD of its selection criteria in relation to 'worker' injuries
All amputations of digit(s) past the first joint	400 of 942 amputations to fingers were not investigated but a number of these amputations may have been before the first joint and therefore did not require investigation
Amputation of hand/arm or foot/leg	12 out of the 55 amputations in this category were not investigated
Serious multiple fractures (more than one bone) not including wrist or ankle	Cannot be assessed
Crush injuries leading to internal organ damage eg ruptured spleen	363 of the 491 'concussions' were not investigated
Head injuries involving loss of consciousness	Cannot be assessed
Burns and scalds covering more than 10% of the surface area of the body	333 out of the 576 burns were not investigated but a number of these may have covered less than 10% of the body and therefore did not require investigation
Blow to the eye resulting in loss of sight	78 out of 99 loss of sight were not investigated but some of these may have been temporary and therefore did not require investigation
Any degree of scalping	Cannot be assessed
Asphyxiations	72 out of the 163 asphyxiations and poisoning were not investigated, but it is not known how many of these involved poisonings (rather than asphyxiations) and therefore did not require investigation
All Workplace transport Incidents	337 out of 633 injuries resulting from contact with moving vehicles were not investigated
All Electrical Incidents	69 out of 178 injuries resulting from contact with electricity were not investigated
All falls from a height of greater than two metres	569 out of 1384 falls from this height were not investigated
Any incident which arose out of working in a confined space	Cannot be assessed
All Industrial Diseases	1327 out of 2396 industrial diseases were not investigated

Quality of Investigations

It is important to note that this audit does not consider the quality or rigor of investigations that are undertaken by the inspectors. It is interesting to note, however, that between 1996/7 and 2000/01 the increase in the number of investigation contacts (43.5%) is much greater than the increases in the number of actual incidents investigated. This would indicate that each investigation in 2000/01 comprises more investigation contacts and is therefore more rigorous than those that took place in 1996/7. However our analysis does not look at increases in the number of complaints investigated which may at least in part explain this increase.

It is also important to note that the HSE has recently published new investigation procedures that are intended to improve the quality of investigations and have started a new training programme for inspectors (see Appendix 3).

Enforcement action

Chapters three and four looked at the extent to which inspectors use notices and prosecutions following inspections and investigations.

Notices and prosecutions serve different functions. The primary purpose of notices (and the provision of oral/written advice) is 'preventative' - that is, to ensure that changes are made that will reduce the risk of death, injury or disease in the future. The primary purpose of prosecution, however, is to ensure that an organisation or individual is held 'to account' for a criminal offence that has been committed – though, of course, the threat of a prosecution can, theoretically, have an important deterrent impact upon other organisations and individuals. It is therefore perfectly reasonable for an inspection or investigation to result in the imposition of both a notice and a prosecution.

Notices

In order to impose an Improvement Notice the inspector must be of the view that there has been a contravention of a provision of health and safety law. The notice will state that particular changes must be made within a particular time period. A prohibition notice can be imposed when an inspector is of the view that there is or will be a risk of serious injury. Technically, a Prohibition Notice does not require a breach of health and safety law, though, in practice, this will usually be the case. It is of course possible that an improvement and a prohibition notice can be imposed in relation to the same incident.

However, the fact there has been a breach of the law, or indeed a risk of serious injury, does not mean that an inspector must impose a notice; an inspector has discretion to simply provide oral or written advice.

Chapter three shows that in the five year period, the number of notices has increased by 42.4% from 3,721 to 6462. The number of prohibition notices has also increased, but by much less – an increase of 16% from 3,605 to 4,315. It is not clear what this increase represents – whether an increased willingness by inspectors to impose notices rather than simply provide oral/written advice or an increase in the number of investigations. In its evidence to the Select Committee, the HSE said in late 1999 that "we do not set targets for issuing notices but we expect the upward trend to continue" .

In the five years covered by this audit, FOD inspectors have had no formal guidance about how to use this discretion. This is now changing with the publication of the Enforcement Management Model.

Prosecutions

The other response to a breach of health and safety law is a prosecution. Companies, organisations and individuals can be prosecuted for failing to comply with safety duties imposed upon them either by statutes (for example, Health and Safety at Work Act 1974) or by regulations (for example, the Management of Health and Safety at Work Regulations 1992). Most prosecutions concern breaches of section 2 or 3 of the 1974 Act which impose general duties upon employers (in relation to the provision of training, instruction, equipment and so on) to take "all reasonable and practicable care" in relation to the safety of their employees or others affected by their activities.

Over the years, the HSE has been subject to criticism about its prosecution record in relation to three main issues:

- failures to prosecute a company, organisation and in particular individuals in circumstances where prosecution appears to be justified – particularly in relation to a death or injury;
- failing to make appropriate attempts to ensure that a magistrate refers a case to a crown court for sentencing;

It should be noted of course that in Scotland, it is the Procurator Fiscal (not the HSE) which decides whether or not to prosecute.

Prosecution Levels

In relation to the levels of prosecution, the HSE has never asserted that its inspectors would prosecute whenever an offence had been uncovered and when there is sufficient evidence to prosecute. In its view, the conduct in question or the circumstances surrounding the conduct had to be serious enough to justify prosecution. There is some sense to this policy: it could well be untenable if inspectors had to prosecute whenever an offence was identified and would mean, for example, that they would have to prosecute in most cases where an improvement notice was imposed. However, this obviously does raise the question of what conduct and what circumstances do, as far as the HSE is concerned, justify prosecution?

In 1995, the Health and Safety Commission published an Enforcement Policy Statement – which amongst other things, set out the circumstances when HSE inspectors should "consider" prosecution (see box below). This statement applied during the whole five year period for which this audit is concerned.

Prosecution Criteria from Enforcement Policy Statement (1995-2001)

18. Enforcing authorities must use discretion in deciding whether to initiate a prosecution. Other approaches to enforcement can often promote health and safety more effectively, but where the circumstances warrant it, prosecution without prior warning and recourse to alternative sanctions may be appropriate.

19. The Commission expects that enforcing authorities will consider prosecution when

- it is appropriate in the circumstances as a way to draw general attention to the need for compliance with the law and the maintenance of standards required by law, where there would be a normal expectation that a prosecution would be taken or whether, through the conviction of offenders, others may be deterred from similar failures to comply with the law;
- or there is judged to have been potential for considerable harm arising from breach;
- or the gravity of the offence, taken together with the general record and approach of the offender warrants it, for example apparent reckless disregard for standards, repeated breaches persistent poor standards.

These 'circumstances' have been criticised for being unduly vague and difficult to apply to individual cases. It is easy to argue, for example, that in relation to almost every breach either (i) "[prosecution] is appropriate in the circumstances as a way to draw general attention to the need for compliance with the law and maintenance of standards required by law", or (ii) that "there would be a normal expectation that a prosecution would be taken" or (iii) "through the conviction of offenders, others may be deterred from similar failures to comply with the law". This paragraph is also circular: it states that prosecution should be considered "where there would be a normal expectation that a prosecution would be taken", but does not state what factors should exist for there to be a "normal expectation" of a prosecution.

The lack of director allowed inspectors great latitude about when, and when not, to prosecute. It provided an opportunity for extraneous issues – like the level of available resources and inspector time - to dictate when prosecutions did and did not take place.

Chapter Four shows that the levels of prosecution after reported incidents is low. Over the whole three year period under consideration – 1996/7 to 1998/9 – prosecution took place after only:

- 231 of the 789 investigated worker deaths (29%);
- 797 of the 7982 investigated major injuries to workers (10%);
- 112 of the 2825 investigated dangerous occurrences (4%).

The question is to what extent the reason for the low level of prosecution is due to (a) there being insufficient evidence to justify prosecution; or (b) due to the fact, that even though there is sufficient evidence, the cases fall outside the "circumstances" set out in the Enforcement Policy Statement that justify prosecution; or (c) other extraneous factors.

Can low levels of prosecution be justified?

Since it is FOD inspectors who undertake the investigations and keep the evidence, it is difficult to assess in how many cases of deaths, major injuries or dangerous occurrences, there is sufficient evidence to prosecute. The lack of judicial reviews (yet alone successful ones) concerning HSE failures to prosecute can not be taken as an indication of the correctness of HSE decisions since there is no tradition of compensation lawyers considering whether judicial reviews of prosecution decisions are appropriate.

However it is interesting to note that in the three years of prosecution data analysed in this audit the numbers of incidents that have resulted in prosecution has increased:

- deaths to workers: 23% to 34%
- deaths to members of the public: 5% to 9.3%
- major injuries to workers: 8% to 11%
- major injuries to public: 2% to 6%
- dangerous occurrences: 3% to 4.2%

It is unlikely that there has, within this period, been a sudden increase in the number of incidents where sufficient evidence exists; the rise is much more likely to be explained by the fact that inspectors are now prosecuting in circumstances where in the past they did not. In effect that the reason for the low level of prosecution (at least in 1996/7) was not due to insufficient evidence but other non-evidential factors.

It also worthwhile pointing out the differences in prosecution rate subsequent to investigation into reported incidents – deaths (33%), major injuries (11%) and dangerous occurrences (4%). Why should it be the case that the level of worker deaths resulting in prosecution is three times the number of prosecutions following major injury investigations and almost eight times the number after investigations into dangerous occurrences? This disparity could of course be explained if the average levels of organisational culpability depended on the type of incident – whether it be a death, major injury or dangerous occurrence. However there is no reason why this should be the case. It would be much more likely to expect that the level of prosecutions following major injuries and dangerous

occurrences to be similar to that following deaths – that is close to 30% in 2000/01 - and the fact that this is not the case must be an indication that factors other than lack of evidence are intruding.

Although there is very little independent evidence to indicate what, on average, should be the approximate level of prosecutions following reported incidents, the evidence that does exist does support the contention that at least, as far as deaths are concerned, the percentage should be higher than at present. HSE's research in the late 1980's indicated that 70% of deaths in agriculture and construction were the result of 'management failure'. This does not necessarily mean that 70% of the deaths should result in prosecution since it is not clear what the HSE meant by 'management failure'. However it certainly does indicate that a figure closer to 70% would be appropriate for prosecution. In addition, research by the West Midlands Health and Safety Advice Centre also indicated that there was sufficient evidence in 70% of West Midlands deaths (between 1988 and 1992) for a health and safety prosecution to have taken place.

One must assume, therefore, that either the incidents are not being adequately investigated or that FOD inspectors must have considered the cases to have fallen outside the criteria of the Enforcement Policy Statement, or there are other reasons for the low level of prosecution. In relation to the first argument, it is simply not possible for us to know how adequate the investigations were into these incidents. In relation to the second, it is difficult to see how FOD could justify non-prosecution – assuming sufficient evidence existed - in relation to any case involving death or major injury, since the Statement says prosecution should be considered when "there is judged to have been potential for considerable harm arising from breach." It is therefore far more likely that extraneous issues like financial factors have determined levels of prosecution in the years under analysis.

HSE's Response on Prosecution Levels

In a letter to us, the HSE stated the following

"We prosecute about one third of cases following a fatality. Decisions not to prosecute following a fatality are now reviewed by our Heads of Operations to ensure inspectors are adhering to the Enforcement Policy Statement. There are a number of factors that influence our prosecutions rates. ... [A] few examples may help illustrate the points:

Incident attributed to action of the deceased:

- worker fell in the grain pit under the influence of alcohol.
- self employed window roofing contractors fell off unsecured ladder.

Not in public interest

Farmer ran over own child on farm

Lack of Evidence

Elderly patient fell down stairs after moving wheel chair forward. No witnesses. Unable to identify any evidence, which indicated that the carer has failed to provide adequate supervision of hadn't applied brakes.

No Breach identified

Motorway worker struck by a private car whilst working in a coned off area on motorway carriage. Driver prosecuted by police for road traffic offences. No HSE case as no weakness with traffic management or other health and safety issues."

HSE's New Prosecution Policies

In January 2002, the HSC published a new Enforcement Policy Statement. This includes a much clearer set of criteria for when prosecution – assuming sufficient evidence exist – should take place (see box below). It states, for example, that whenever there is sufficient evidence to prosecute in relation to a death, a prosecution should take place. However the Statement does not have a similar position in relation to major injuries, industrial diseases or dangerous occurrences.

Prosecution Criteria and the New Enforcement Policy Statement

Para. 39 sets out when, assuming there is sufficient evidence, it would be 'expected' in the public interest for prosecution to 'normally' take place. These are where:

- 'death was a result of a breach of the legislation;
- the gravity of an alleged offence, taken together with the seriousness of any actual or potential harm, or the general record and approach of the offender warrants it;
- there has been reckless disregard of health and safety requirements;
- there have been repeated breaches which give rise to significant risk, or persistent and significant poor compliance;
- work has been carried out without or in serious non-compliance with an appropriate licence or safety case;
- a duty holder's standard of managing health and safety is found to be far below what is required by health and safety law and to be giving rise to significant risk;
- there has been a failure to comply with an improvement or prohibition notice; or there has been a repetition of a breach that was subject to a formal cautions;
- case information has been supplied willfully, or there has been an omission to supply, in relation to a matter which gives risk to significant risk;
- inspectors have been intentionally obstructed in the lawful course of their duties.'

The EPS also states at para 40 that, it would also be in the public interest to prosecute if one or more of the following circumstances apply:

- 'it is appropriate in the circumstances as a way to draw general attention to the need for compliance with the law and the maintenance of standards required by law, and convictions may deter others from similar failures to comply with the law;
- a breach which gives rise to significant risk has continued despite relevant warnings from employees or their representatives, or from others affected by a work activity.'

However, prosecutions will not "normally" take place in the above two circumstances; the enforcing authorities only have to "consider prosecution".

In addition to the new Enforcement Statement, London and South East Region are piloting a new way of dealing with prosecutions. Currently, FOD inspectors (other than those in London and South East) decide themselves whether or not to lay criminal charges against an organisation or individual – without necessarily gaining any assistance from HSE lawyers. Inspectors are also responsible for conducting the case in court – unless it is likely to go to the Crown Court. This practice has been criticised for three main reasons:

- since inspectors are responsible for the investigation they should not – for reasons of public policy – be involved in making decisions about prosecution;
- inspectors are not necessarily in the best position to evaluate the evidence and determine whether or not a prosecution should take place;
- it is very time consuming for inspectors to be involved in the whole process of prosecution – time that could otherwise be use for inspections and investigations.

In 1999, the Select Committee looked into the involvement of lawyers in the prosecution

process and concluded that it would not be "in the public interest to replace inspectors with lawyers to prosecute cases in the lower courts, primarily due to the significant resource implications" (see Appendix 4). Instead, they welcomed "HSE proposals to have fewer, better qualified specialist prosecuting inspectors in the lower courts."

Prosecutions and Prevention

Prosecutions are not just concerned about accountability, as is shown by a recent research report published by the HSE. This made the following conclusion:

"A number of studies shed light on issues surrounding how the HSE achieves maximum impact. Although this was not directly part of our remit it seems sensible to report the main findings, if only in passing, in so doing we look at issues related to the role of regulation and enforcement as a factor motivating employers to take action on health and safety. The evaluations of specific legislation generally concluded that compliance with the law was the most important reason that employers took actions to improve their health and safety practices and procedures (eg Honey et al., 1996b, Lancaster et al. 2001). Hillage et al. (1997) found that among SMEs the threat of prosecution can raise awareness and understanding of workplace risks and can lead to the adoption of better health and safety practices. The two most influential factors identified by Lancaster et al. in their examination of the factors motivating health and safety management were the fear of loss of credibility and the belief that it is morally necessary and correct to comply with health and safety regulations. Ashby and Diacon (1996) found that the most influential factors motivating companies to take action to limit the risk of occupational harm were compliance with government health and safety regulations and limiting possible legal liabilities. These were found to be far more influential than business factors such as reducing wage costs or improving productivity. The evidence therefore seems to suggest that there are at least two related factors at work here:

- the fear of being taken to court and/or receiving claims for compensation if found to be in breach of the law;
- the acceptance that the law is an expression of what should be done and that there is a moral duty to meet it."

However the new Pilot "Prosecution Branch" goes further than the HSE had initially intended to do. In London and the South East, whenever a Principal Inspector has approved of an inspector's decision that a prosecution should take place, the case must be referred to the Prosecution Branch, comprised of lawyers. These lawyers will check the evidence and advise the inspector if further enquiries are necessary. The Branch will also, in most cases, take over the prosecution of the case.

This pilot project however does not go far enough. If HSE inspectors do not think a prosecution should take place, there is no independent oversight to check whether this is a correct decision. It is not clear why the Pilot has been limited in this manner.

Prosecutions against Directors and Managers

Another concern about HSE's prosecution policy relates to the low number of prosecutions against a director or manager.

Individuals can be prosecuted in three main ways

- if the individual is a sole trader or part of a partnership, the person can be prosecuted as the 'employer';
- if the individual is a director or senior manager of a company, they can be prosecuted if it can be shown that an offence by the company was the result of that individual person's neglect or was committed with their consent or connivance or was attributable to their neglect.

- if the individual is an employee, that person can be prosecuted for failing to take reasonable care in complying with a duty. This can include a shop floor worker, a manager or indeed a director who is employed by the company.

Paragraph 20 of the 1995 Enforcement Policy Statement stated that:

"enforcing authorities should identify and prosecute or recommend prosecution of individuals, including company directors and managers, if they consider that a conviction is warranted and can be secured."

However, the audit shows how rarely prosecutions under section 37 took place – only 34 prosecutions in 3 years.

The new Enforcement Policy Statement indicates that there might be a real change in the emphasis that FOD inspectors give to this issue. Paragraph 41 states that

'... enforcing authorities should identify and prosecute or recommend prosecution of individuals if they consider that a prosecution is warranted. In particular, they should consider the management chain and the role played by individual directors and managers, and should take action against them where the inspection or investigation reveals that the offence was committed with their consent or connivance or to have been attributable to neglect on their part and where it would be appropriate to do so in accordance with this policy. Where appropriate, enforcing authorities should seek disqualification of directors under the Company Directors Disqualification Act 1986.'

We will have to wait and see whether this section results in more prosecutions under section 37.

HSE's New Enforcement Management Model

In May 2002 – a year after the end of this audit - the HSE launched its 'Enforcement Management Model' which is supposed to help guide inspectors in deciding what is the appropriate enforcement action in individual cases and ensure that there is greater consistency in the enforcement action that inspectors take (see appendix 5).

The EMM takes inspectors through a series of risk tables and flow charts which requires the inspector to input the following information:

- the seriousness of any risk identified – in terms of the nature of the harm that could be reasonably expected to occur (serious personal injury, significant injury, minor injury) and the probability of it happening (probable, possible, remote, negligible);
- the level of risk that the law allows and the gap between this and the actual level of risk identified by the inspector;
- the reason for non-compliance with the law;
- whether harm has actually been caused by the non-compliance;
- current levels of compliance over a range of health and safety issues;
- attitude of the duty holder;
- previous enforcement action taken against the duty holder;

Dependent on what information is entered, the EMM will then suggest to the inspector that one of the following enforcement actions is appropriate to the circumstances:

- give a verbal warning;
- provide advice in a written form;
- impose a notice;
- prosecute as well as imposing a notice;

FOD requires its inspectors to use the EMM in relation to all decisions involving deaths, major injuries, and prior to making any decision to prosecute (for example in relation to an inspection or other injuries). Line managers will in addition be able to require their inspectors to use the EMM in other circumstances.

It will be interesting to see how this new policy will impact upon enforcement decisions,

Referral to the Crown Court

A further issue concerning HSE's prosecuting policy relates to the extent to which FOD inspectors have attempted to persuade magistrates that they should refer cases to the Crown court.

Our analysis in Chapter Five showed that whilst in relation to deaths of workers, there has been an increase in the number of cases that were sentenced in the Crown Court over the three year period (from 40% to 60%), in relation to major injuries the level remained at a low 20%.

It is difficult to know whether the increase in the number of worker deaths sentenced in the Crown Court is due to FOD inspectors making increased submissions to the magistrates, or due to a changed attitude of the magistrates themselves, or indeed a combination. During the period under examination, HSE inspectors had not received any guidance as to when they should recommend to the court that, following a guilty plea, whether a case should be sentenced in the Crown court. The new Enforcement Policy Statement however states the following:

"In case of sufficient seriousness, and when given the opportunity, the enforcing authorities in England and Wales should consider indicating to the magistrates that the offence is so serious that they may send it to be heard or sentence in the higher court higher penalties can be imposed."

It does not however state what is a case of "sufficient seriousness".

It is likely that even more cases will result in sentencing in the Crown court. In the 1999 case of *R v Howe and Son (Engineer) Ltd*, the Court of Appeal stated:

"In our judgment magistrates should always think carefully before accepting jurisdiction in health and safety at work cases, where it is arguable that the fine may exceed the limit of their jurisdiction where death or serious injury has resulted from the offence".

In addition in September 2000 – subsequent to the period under examination - the Magistrates Association published sentencing guidelines for magistrates that stated that "it is important to be careful when accepting jurisdiction as to whether the cases ought properly to be heard in the Crown court. This is especially so when dealing with large companies. ... Simple cases can, of course, be dealt with."

Sentencing

Our analysis on sentencing shows that whilst the level of fines after worker deaths and dangerous occurrences have doubled to an average of £66,000 and £30,000 respectively, other fines have remained static or declined. So the average level of fines after the death of a member of the public remained static at around £30,000 and after a worker major injury at £10,000. Our analysis does show that the level of fines does depend on whether cases are referred to the Crown court or not.

It is likely that analysis of subsequent years could show even higher levels of fines. This is both because (a) more cases will be referred to the Crown Court and (b) a recent Court of Appeal decision which provides greater guidance to courts on sentencing levels (see box on page 72).

Summary of the Howe case

A recent Court of Appeal case of Howe sets out the factors that a sentencing court should take into account when considering the level of fine.

- how far short of the appropriate standard required by law;
- whether a death has taken place;
- whether there was a deliberate breach of legislation with a view to profit;
- the degree of risk and the extent of danger created by the offence;
- whether the breach was isolated or continued over a period of time
- the defendant's resources and the effect of the fine on the business

The ruling stated that particular aggravating factors are:

- failure to heed warnings
- deliberately profiting from failing to take the necessary health and safety steps, or specifically running a risk to save money

and that particular mitigating features are:

- prompt admission of responsibility;
- steps taken to remedy deficiencies after they are drawn to the defendant's attention;
- a good safety record

In addition the Judges made the following comments:

- "Any fine should reflect not only the gravity of the offence but also the means of the offender."
- "The objective of prosecutions for health and safety offences in the workplace is to achieve a safe environment for those who work there and for other members of the public who may be affected. A fine needs to be large enough to bring that message home where the defendant company is a company not only to those who manage it but also to its shareholders."
- Although in general "we accept that [the fine should not be so large enough to imperil the earnings of employees or create a risk of bankruptcy] there may be cases where the offences are so serious that the defendant ought not to be in business."

Appendix 1:

FOD's policy on the "Selection of Accidents for Investigation" operative until April 2000

The following accidents should always be investigated:

- fatalities, irrespective of cause;
- those which are likely to give rise to, or have already given rise to, serious public concern, e.g., where there are multiple casualties and there has been considerable publicity in the media;
- very serious injuries or multiple casualties, e.g. explosions, cranes collapsing, major escapes of vapour; and
- those covered by special national and locally agreed initiatives.

Accidents that should generally be investigated:

- exceptionally serious injuries, irrespective of cause; and
- those which have given rise to a complaint.

Other accidents

Principal Inspectors (PIs) have discretion to select other accidents for investigation such as those which appear to indicate a serious breach of the law, accidents to young persons or children, or those which recur at a particular premises or in a particular industry.

In making a decision PIs should consider:

- the severity or potential severity of the injury;
- the gravity of any apparent breach of legislation;
- the need for factual information to support an approach to management or workers in relation to a particular firm or industry;
- the availability of Field Management Unit (FMU) inspectors and in particular the effect of the work involved on the preventive inspection programme; and
- allocating sufficient accidents for investigation by Band 4 trainee inspectors to satisfy their training needs, and to qualified inspectors joining a new FMU who require training on a particular industry sector.

Appendix 2:

HSE's New Incident Selection Procedure

(A) Defined Circumstances

1. All Fatalities as a result of an accident arising out of or in connection with work activities.
This specifically excludes suicides and deaths from natural causes. See OM 2000/124 for consideration of investigation of work-related road traffic incidents
2. The Following RIDDOR-defined major injuries to all persons, including non-employees, irrespective of cause:
 - all amputations of digit(s) past the first joint
 - amputation of hand/arm or foot/leg
 - serious multiple fractures (more than one bone, not including wrist or ankle);
 - crush injuries leading to internal organ damage eg ruptured spleen;
 - head injuries involving loss of consciousness;
 - burns and scalds covering more than 10% of the surface area of the body;
 - permanent blinding of one or both eyes;
 - any degree of scalping; and
 - asphyxiations.

3. Incidents which result in a RIDDOR-defined major injury in the following categories;
 - workplace transport incidents;
 - electrical incidents;
 - falls from a height of greater than 2 metres; and
 - any incident which arose out of working in a confined space
 see OM 2000/124 for consideration of investigation of work-related road traffic incidents.
4. Occupational Diseases: All reports of cases of occupational disease which meets the criteria of reportability under RIDDOR, except those arising from circumstances which have already been investigated.

(B) Circumstances requiring judgement as to seriousness

1. Public Concern

All incidents likely to give rise to serious public concern. This reflects the views of the public at large not just those of an individual. Give particular consideration to incidents involving children, vulnerable adults, and multiple casualties where the outcome of potential outcome of breach is serious.
2. Breach of health and safety law

Any incident where there is likely to have been a serious breach of health and safety law

Note: A serious breach of the law is one where, in accordance with the Enforcement Management Model, the national enforcement expectation would determine a notice or a prosecution.

(C) Circumstances allowing discretionary selection

- Any Incident which contributes through the FMU workplace to an HSC/E priority programme eg manual handling.
- Any incident which involves new process or plant which could enhance HSE's knowledge
- Training of Band 4s or B3s new to a Field Management Unit

Appendix 3:

Excerpt from FOD's New Investigation Policy

It is FOD policy that investigations will be conducted in accordance with the principles of proportionality, consistency, targeting, transparency and accountability. In particular, investigations will be:

- Continued so far as they are proportionate to the achievement of the objectives set for them (see below);
- Conducted and/or supervised by staff with suitable and relevant experience, training and expertise;
- Provided with adequate resources and support, including information, equipment and staffing;
- Conducted so that efficient and effective use is made of the resources committed to them;
- Timely, so far as this is within the control of the investigating inspector(s);
- Subject to suitable management procedures for monitoring the conduct and outcome of investigations;
- Conducted in accordance with FOD's obligations under Service First; and
- Conducted in conformity with the FOD Quality System procedure.

The following factors will be relevant in determining whether an investigation continues to be proportionate:

1. Public expectation, for example, where there has been a fatality or fatalities, serious ill health, or an incident involving multiple serious injuries;
2. The potential (taking account of reasonable foreseeability) for a repetition of the circumstances to result in fatality or fatalities, serious ill health, or serious injuries, either in the activities of a specific dutyholder or within industry generally;
3. The extent to which the available evidence allows conclusions as to causation to be drawn and supported with sufficient certainty, including conclusions as to responsibility for alleged breaches of relevant legislation;
4. The value to HSE of the information to be gathered by the investigation, for example where new technology is involved;
5. The extent to which the resources needed for the investigation are disproportionate to the hazard(s) or risk(s);
6. The extent to which the continuation of any investigation conflicts with the developing priorities within a FOD division; and;
7. The prevalence of the event, either in the activities under the control of a specific dutyholder, or in an industry sector generally.

Appendix 4:

Select Committee on HSE's Prosecution Policy

37. Concerns were also voiced in relation to a number of aspects of the HSE's policy on prosecuting employers. These focussed on the low levels of companies prosecuted; [and] the approach to the prosecution process
38. We received evidence to show that prosecutions are brought in only 10 per cent of major injury cases and 20 per cent of cases where a death has occurred. In relation to fatalities, the Centre for Corporate Accountability compared the number of companies prosecuted (five manslaughter prosecutions) to the numbers killed at work (25,000) since 1965 and commented that this is "an infinitesimal follow-through". The prosecution rate was also criticised by the London Hazards Centre and Mr Dalton who described the HSE's record in regard to prosecutions as "dismally inadequate".
39. However, increasing the number of companies prosecuted for health and safety offences will not be easy. Bringing a prosecution is a time consuming activity and it is, according to the HSE, "becoming increasingly difficult to win cases". Some witnesses questioned whether in fact this represented an efficient use of resources or inspectors' time. For example, Mr Alesbury of the CBI said: "I am aware that taking someone to court does involve them in a great deal of time and effort, and with their limited resources that will detract from other activities to promote and improve health and safety". Instead, one proposal we received was that the HSE should consider using lawyers, rather than HSE inspectors, to prosecute cases in magistrates courts. We considered this proposition, but do not believe that it would be in the public interest to replace inspectors with lawyers to prosecute cases in the lower courts, primarily due to the significant resource implications. Instead, we welcome the HSE proposals to have fewer, better qualified specialist prosecuting inspectors in the lower courts.
40. However, in addition, we believe that there may be some merit in enhancing the legal support currently available to HSE inspectors when prosecuting cases. We therefore recommend that the HSE provide better access for inspectors to legal expertise, whether this be in-house or external, to assist in the preparation of cases for magistrates courts. This may increase the chances of a successful prosecution and should allow inspectors to spend more time in the field.

41. Another aspect relevant to this discussion, is the success rate in prosecutions. Clearly there is little point in urging the HSE to prosecute more companies if these prosecutions fail. The Director General told us that the HSE prosecutes in cases where they think there is at least a 50 per cent chance of success. In 1998-99, it secured successful convictions in 83 per cent of the cases it prosecuted. Overall we accept that this is a strong performance and the Director General told us the HSE's record compared well with success rates in criminal courts. However, the record for defended cases, ie where the defendant pleads not guilty, is much poorer, with the HSE winning only 38 per cent of such cases. The Director General told us that this was because cases were being defended by "more competent lawyers" due to an increased stigma attached to health and safety offences. However since the HSE only proceeds in strong cases, we feel this is a very poor rate and expect to see an

Appendix 5:

Extract from 'The Enforcement Management Model'

"The Enforcement Management Model (EMM) is a framework which helps inspectors made enforcement decision in line with the Health and Safety Commission's (HSC) Enforcement Policy Statement. The EPS sets out the principles inspectors should apply when determining what enforcement action to take in response to breaches of health and safety legislation. Fundamental to this is the principle that enforcement action should be proportional to the health and safety risks and the seriousness of the breach. ...

The EMM .. is not intended to fetter inspectors discretion when making enforcement decisions, and it does not direct enforcement in any particular case. It is intended to:

- promote enforcement consistency by confirming the parameters, and the relationships between the many variables, in the enforcement decision making process;
- promote proportionality and targeting by confirming the risk based criteria against which decisions are made;
- be a framework for making enforcement decisions transparent, and for ensuring that those who make decision are accountable for them and
- help inexperienced inspectors assess their decision in complex cases, allow peer review of enforcement action, and be used to guide less experienced and trainee inspector in making enforcement decisions."

