

### ***'Parting Shot'***

When DWP minister Chris Grayling launched the statement '*Good health and safety, good for everyone*' on 21<sup>st</sup> March (<http://www.dwp.gov.uk/docs/good-health-and-safety.pdf>) he said that the Government wanted to explore what opportunities there might be to simplify health and safety legislation and, in doing so, '*...further ease the burden on business*'. Following on from the review of health and safety by Lord Young he has commissioned another review, this time to be chaired by Professor Ragnar Löfstedt, Director of the King's Centre for Risk Management at King's College London. The draft terms of reference were announced on 19<sup>th</sup> April (see <http://www.dwp.gov.uk/docs/lofstedt-tor.pdf>) together with the names of six people, including politicians, business people and employee representatives, to advise him and provide constructive challenge to the review.

Prof Löfstedt has been asked to consider the opportunities '*..for reducing the burden of health and safety legislation on UK businesses while maintaining the progress made in improving health and safety outcomes*'. According to the draft Terms of Reference, the review will call for evidence from a range of stakeholders in order to determine: the scope for consolidating, simplifying or abolishing regulations; whether the requirements of EU Directives are being unnecessarily enhanced ('gold-plated') on translation into UK law; if lessons can be learned from comparison with health and safety regimes in other countries; whether there is a clear link between regulation and positive health and safety outcomes; if there is evidence of inappropriate litigation and compensation arising from health and safety legislation; and whether changes to legislation are needed to clarify the legal position of employers in cases where employees act in an irresponsible manner.

The review will focus primarily on the approximately 200 statutory instruments and associated approved codes of practice rather than the Health and Safety at Work Act itself or other primary legislation enforced by HSE. It will be supported by a small team of DWP officials. Professor Löfstedt has been asked to report by this autumn and the Government will then decide what actions to take in the light of his recommendations.

Readers will understand that RoSPA is very keen to feed into the review but we feel strongly that the professor and his colleagues will need to commit to doing a lot of homework if they are to understand fully the background to what they have been asked to review.

In April 2008 I wrote a '*Parting Shot*' (accessible via <http://www.rosipa.com/occupationsafety/resources/partingshots/default.aspx>) on the case for the Health and Safety Executive (HSE) to adopt a 'doctrine management' approach to help them to reorganise their useful but somewhat inconsistent canon of guidance on health safety management issues. This project, which is to refresh HSE's 'capstone doctrine, HSG65 (*'Successful health and safety management'*), is actually progressing very well. And a wider project for HSE to look at how it brigades its overall range of guidance is also now underway - although logically any attempt to revise and restructure the HSE guidance lexicon should perhaps await the outcome of the Löfstedt review.

The core ideas in HSG65, which is essentially about aligning health and safety with the management of Quality, go back a long way. Many had their origins in guidance from HSE's one time Accident Prevention Advisory Unit which in its turn drew on ideas that went as far back as the old HM Factory Inspectorate and the report of the Joint Industrial Council on Accident Prevention of 1956! Ideas about how to manage health and safety have an enduring DNA!

One of the challenges which Professor Löfstedt and his panel will have I believe is to go back and understand the history and evolution of our system of health and safety law and guidance, since both are intimately connected. HSE and its stakeholders are currently wrestling with how to make established doctrines about managing (or more correctly, 'managing for') health and safety relevant and 'scaleable' to modern business. But one of the bigger questions this raises is how well rooted and reflected these are in contemporary health and safety law.

In theory there is supposed to be a logical flow of general considerations here, flowing from the general duties of care in the Health and Safety at Work (HSW) Act (establishing key objectives), through the Management of Health and Safety at Work Regulations (MHSWR) (setting out essential management ingredients) to other specific hazard and sector related regulations (specifying essential controls and processes). Guidance documents (which are what people actually read) then support all this. But as everyone now admits, the elegance and logic of this flow that were envisioned by Robens have been corrupted over time by adaptations to implement EC directives and so on. From the standpoint of proportionality both health and safety law and supporting guidance need to be focused on the big issues. In some hazard areas like chemicals and physical hazards the law is well developed but in others like psychosocial risks (ergonomics, stress, violence etc which affect millions of workers) it is still quite vague. Huge areas of hazard like work-related road safety, for example, (more people are killed while at work on the road than in all other workplace accidents) are addressed only by the most generic guidance. Arguably the balance between what is covered in regulation and what is addressed in guidance could be readjusted. On the other hand options here have been limited. Much of the problem, in my view, has been due to our inability in the UK to use Approved Codes of Practice (ACoPs) to transpose EC directives. Robens had high hopes for ACoPs since they were intended to provide both authoritative advice and flexibility. But this vision was not shared. On one side the TUC always thought ACoPs were too weak. The CBI on the other has always tended to view them as prescriptive regulation by the back door. And the European Commission refused to accept them as a vehicle for transposition of directives into national law anyway. This whole debate ought to be revisited.

What made the HSW Act and the post Robens architecture different from earlier Factories Act law was not just its goal setting nature, bounded by reasonable practicability but its attempt to describe the essential ingredients for arriving at and sustaining safe systems of work in an organisational setting. In other words, it was not just a long list of do's and don'ts related to hazards but in a suitably general way, it set out the people/policy/procedures needed to ensure that hazards were routinely identified, risks assessed, appropriate controls applied and refined, taking into account advances in knowledge and lessons from operational experience. Thus, whereas earlier law had sought only to prescribe measures to be taken in various

(actually quite limited) settings, the 1974 Act (later augmented by the MHSW Regulations) tried to indicate what employers needed to do to be able to work this out for themselves, using risk assessment and supported by competent people/advice, consultation with workers and so on. In theory regulations and guidance introduced subsequently to regulate specific risks and activities were designed to support this underlying core. In reality what we have however is actually quite untidy, incomplete and it is not easy to understand in the detail without going on a training course and/or reading quite a lot of guidance!

And of course law and guidance on their own provide only part of the answer since by themselves statutorily required systems and processes – even when supported by detailed requirements - are not enough to guarantee desired outcomes. Latterly, for example, we have come to realise again the fundamental importance of ‘health and safety culture’, founded on effective management leadership and workforce involvement; things which cannot really be legislated for but which are key nonetheless to delivery of safe and healthy working everyday - as well continuous improvement in performance. ‘Culture’ ensures the ‘fine fit’ between systems/standards and operational reality.

The challenge I believe Löfstedt faces in conducting his review is not only to show how we can return to the essence of the Robens vision, stripping out a lot of the confusing duplication and overlap of duties in the different sets of regulations (without reducing essential protections) but how we can ensure the architecture of the law really reflects the principles which underlie effective risk management in all undertakings regardless of their size or hazard burden.

The Government will insist, with justification, that any changes pass what is called ‘the small firms test’. There is continuing debate about whether in reality there is some sort of size threshold in today’s businesses below which ideas about formal risk management have no meaning in practice. It is often said that small firms ‘run’ their businesses, whereas large firms ‘manage’ them. And small firms of course are not just large ones that haven’t got big yet!

What we and most other stakeholders in the health and safety system continue to argue is it is the level of risk to workers and others and not size of the organisation that must be the guiding principle. So Prof. Löfstedt and his advisers need to begin at the beginning and consider if we do indeed have a clear set of goal setting risk duties in law which reflect the different elements in the risk management challenge, applicable to all organisations. At present these are scattered across the top of the legal structure and do not flow logically downwards and outwards in other subsidiary law and guidance. Some, like risk assessment, are repeated at several levels. Other really important ones like investigation and organisational learning from incidents are not very clear at all.

As part of their project to refresh HSG65, HSE have been engaged in a debate with stakeholders about what to do with their core paradigm, POPIMAR (Policy, Organisation, Planning/implementation, Monitoring and Review). Should we retain it or change to a simpler PDCA (Plan, Do, Check, Act) model? Arguments here can seem more that a bit theological at times. My own view is that, while risk management models are useful, what we badly need is much more empirical

research to establish in practice what kinds of management process actually deliver successful implementation of control measures, particularly in higher performing SMEs - but this is actually a very long term project. So we have no choice but to proceed from current consensus.

So if they are to approach their commission professionally what Löfstedt and his colleagues will need to consider at the outset is whether current risk management duties in law are both understandable and truly 'scaleable' in different settings. If there are gaps, then these need to be identified, together with ideas on how they might be filled in the most appropriate way. Only then will it be meaningful to look at how to brigade more effectively the large amount of regulatory detail that has accumulated since 1974 and after 1992 in particular. Anything else, such as just trying to return to the letter of particular Directives (often unworkable in a UK setting) runs the risk of tinkering at the edges and creating even less clarity.

The same breadth of vision and depth of understanding are needed to deal the final part of the review about the legal position of employers in cases where employees act in a grossly irresponsible manner. On occasions some employees do act with total disregard for their own or others' health and safety (and in breach of their duties under Section 7 of the HSW Act). But the resurgence of interest in crude behaviourist models of safety management and the resurrection of outdated ideas about accidents being caused mainly by 'unsafe workers' seem almost unstoppable. It is to be hoped that Professor Löfstedt and his panel members will do their homework here and study excellent HSE publications such as HSG48 (*'Reducing error and influencing behaviour'*) to help get causation factors in perspective.

And my final point of concern is the timescale. It took Alf Robens and his colleagues over two years to arrive at their report; quite an achievement when you consider the amount of ground they covered. How the Löfstedt team will be able to deliver on what they have been asked to do in just four to five months is not at all clear.

I would urge readers to 'watch this space' and feed in their ideas to the review as it proceeds.

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