THE FOUNDATION FOR SCIENCE AND TECHNOLOGY

DINNER/DISCUSSION SUMMARY

Assessing risk – are our lives unnecessarily regulated by risk?

Held at The Royal Society on 26th November, 2008

The Foundation is grateful to the Michael John Trust for supporting this meeting.

Chair: **The Earl of Selborne KBE FRS**
Chairman, The Foundation for Science and Technology

Speakers: **Sarah Veale CBE**
Member, Risk and Regulation Advisory Council and
Head, Equality and Employment Rights Department, Trade Union Congress
Judith Hackitt CBE
Chair, Health and Safety Executive
The Hon. Mr Justice MacDuff KBE QC
High Court, Queen's Bench Division

MS VEALE said the principal problem was that instinct often trumped reason when questions of risk were being considered. People thought they understood risk, and ignored science and experience. But instinct distorted policy and led to inappropriate and excessive safety measures. It was spurred on by media sensationalism and political opportunists. Unfortunately many public authorities and civil servants were risk averse; did not apply common sense; and did not stand up to such pressures. No solution to risk was simple; any solution carried social and economic consequence, such as loss of civil liberties. The Risk and Regulatory Advisory Council (RRAC)'s role was to strengthen the role of reason in dealing with risk issues. It sought to emphasize the need to use evidence and to assess impact. An important method they used for encouraging such thinking was by the use of forums, in which all interested parties concerned with an issue could discuss it and understand the perspective of others. There had recently been two such forums which had been successful - one on police and crime protection; the other on the problems SMEs had in dealing with codes from the Health and Safety Commission (HSE). Crucial tasks were understanding how to communicate with the public, both to make them aware of the social and economic consequences of risk regulation, to encourage the acceptance of degrees of personal risk and to fight the damaging mythology which grew up about risk issues (e.g. the stories about banning conkers, forbidding doormats and making trapeze artists wear hard hats). The RRAC was glad that risk was now seen as a central policy issue for government, and its role in assessing risk and developing public understanding was recognized.

MS HACKITT outlined the HSE's core mission - to prevent death, injury and ill health in the workplace and to protect the public from work related activities. It had to cope with changing work practices and patterns, new technology and changing public attitudes. The Health and Safety at Work Act (HSWA) of 1974 had replaced a myriad of authorities with the HSE with new powers and remits. Its success was shown in the drop from one thousand work related deaths in 1992 to the current two hundred. The HSWA did not seek to eliminate risk, and the HSE's principles were to minimize risk while recognizing the need for change and innovation; avoiding rigid prescription; and concentrating on generic goal setting, looking at out turns not processes. Most important was developing an understanding of risk in managers and workforces, following the mantra "those who create risk are the best placed to manage it". This meant that those whose duty it was to manage risk must consult with employees, consider proportionality and take a balanced approach. It would be the courts, who would decide whether there had been negligence, but few cases went to court and it was a function of the HSE to support managers through standard setting regulations and issuing codes of best practice. The key message was to reduce risk as far as reasonably practicable. This meant proportionality, consistency, transparency and acknowledgement of public interest. The existing regulatory structure was sufficiently flexible to cope, and did not need amendment; but it must be continually considered so that it could adapt to individual circumstances. The HSE was developing a new strategy which would emphasize proportionality, commonsense, the importance of leadership, and consultation and involvement with the workforce. But major question remained - how to reverse the culture of blame and compensation seeking, and whether and how to revisit the precautionary principle

MR JUSTICE MACDUFF said there was a real question over whether our lives were over regulated. The media revelled in quoting absurd examples - some, alas, real, most, as other speakers noted, fictitious. But desirable activities were being curtailed - school field trips cancelled, good old Gloucestershire sports such as cheese rolling abandoned, and trains delayed, because of excessive reaction to supposed risks, without consideration of probability or impact. What do we make of notices such as "danger; water is hot" attitudes such as "if it saves one life it is worth it"? The most difficult problems lay, not in prosecution for failure to observe HSE regulations, but from civil proceedings in negligence. It was to avoid the cost and reputation damage of such proceedings that public and private bodies were over cautious. He outlined the three factors involved in proving negligence - the duty of care owed to the claimant (proximity), the breach of care (to do what is reasonable), the causation (did damage occur from the act). Complex issues arose in all these factors. What was the relationship between claimant and defendant - was it employer/employee; or occupier/visitor; or a public duty such as to drive safely? Did the defendant do all that was reasonable to tell the claimant about dangers? Would the claimant have still suffered harm, whatever the defendant did? The issues were well illustrated in the case of

Tomlinson v Congleton Borough where the judge, the Court of Appeal and the House of Lords took different views. But the House of Lords judgement which emphasized proportionality, common sense and personal responsibility should bring clarity to these problems. Safety must be balanced against convenience, efficiency and practicality.

A major concern in the following discussion was the prevalence of the "blame culture", the search for compensation for any injury, and the enormous costs incurred in defending claims, or insuring against them. The "blame culture" was not solely due to a desire to get compensation, it was also stemmed from media and politicians' cries for someone to be "held responsible" and be punished. There was public misunderstanding - as well as frustration - in repeatedly learning that in many cases, corporate complexity or confusion between authorities meant that no one person could be found to whom blame could be attached. But was recent legislation on "corporate manslaughter" or the duty of directors, the answer? Would it have lead to better results in rail accident cases? It was important, as was intended, that prosecution which might lead to imprisonment should only be used when there was a flagrant record of attempts to avoid or breach regulations. Particular problems arose when public bodies were pursued for a breach of regulations, which simply involved fining them, so they then had to replace the fine with additional public funding. It was suggested that such fines, or public inquiries ensured greater care from the authority targeted; but this was doubtful. Was the NHS more successful because it was fined for breaching regulations? This was quite a different issue from negligence cases, where the financial consequences to the NHS were a legitimate result of their activities. A major problem in compensation issues was the financial consequences if a company lost a case, or, indeed won but could not recover costs. Sums for compensation awarded by the Courts had increased seven to eight times greater than inflation since 1992. This was due to increase both in lawyer's fees and insurance costs, which were reflected in the compensation. This lead to companies settling out of court, even if they had a strong case to win. This in turn will lead to further insurance costs. There was a real question of whether the economy could stand such sums being paid out, and the cost and effect on the insurance industry.

Further discussion turned on the issue of proportionality; and how to develop an understanding in the public of the damage that excessive risk aversion caused in the public safety sphere. For example, the probation service had to take risks in allowing prisoners to be released on parole. Sometime, inevitably, the judgment was faulty, and the prisoner committed further crimes, and a public outcry arose - no parole. But this would be extremely damaging to the welfare of prisoners, their ability to adjust to the outside world, and probably increase recidivism. Proportionality meant a greater acceptance of personal responsibility in accepting risk. How was this to be taught? Parents must accept that children have little understanding of risk and they must increase their efforts to explain and restrain, if children were to have opportunities (such as field trips) which must contain a greater element of risk than everyday life. Proportionality also meant accepting that there were different degrees of risk in different occupations, and that, for some occupations - notably the emergency services - greater degrees of risk must be accepted. That did not mean that risk should not be considered, but it did mean that judgments about action might have to be taken at great speed and without the deliberation that would otherwise be appropriate. It also meant considering the counterfactual - what would be the result of not taking this risk; would it, overall, be beneficial or not.

There was fear that application of the precautionary principle might stifle innovation and cause economic and social damage. It was a principle much endorsed in EU discussions, in which each state found it politically desirable to define the principle in a way which would seek to avoid any possible harm. So it was the ultimate blocking mechanism. But it had its successes - notably in the allowing the biotechnology industry to develop in such a way that it was now possible to relax some constraints. The same might be true of the nanotechnology industry. It had also been effective in environmental concerns on global warming. But it did not properly consider probability, and did need to be revisited. The Dutch example of trying to assess all risks to the population and deciding what proportion of risk was acceptable - e.g. one in a million - was cited as a good way of looking at probability. There was general support for the HSE strategy that was being developed and for their efforts to educate the public and to ensure consistency. But, as with all large organizations, there were always problems in ensuring that all staff down the line followed the principle in the new strategy. There had been examples of excessive prosecution, and large damages, but these should now become less frequent as a better understanding of risk regulation and its consequences spread.

Sir Geoffrey Chipperfield KCB

Presentations from the meeting are on the Foundation web site at www.foundation.org.uk.

Web Links:

The Foundation for Science and Technology
www.foundation.org.uk

Hazards Forum
www.hazardsforum.org.uk

Health and Safety Executive
www.hse.gov.uk

Health and Safety at Work Act 1974
www.hse.gov.uk/legislation/hswa.htm

High Court, Queen's Bench Division
www.hmcourts-service.gov.uk/cms/queens.htm

Risk and Regulation Advisory Council
www.berr.gov.uk/deliverypartners/list/rrac/index.html

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