

Right Honourable Lord Gill  
Chairman ICL Inquiry

Inquiry Secretariat  
The ICL Inquiry  
3rd Floor  
Lothian Chambers  
59-63 George IV Bridge  
Edinburgh  
EH1 1RN

8 January 2009

Dear Lord Gill,

Thank you for the letter of 26 November 2008 signed by Jillian Glass in her capacity as the Solicitor to the ICL Inquiry. We appreciate your willingness to accept further representation from the research team, which we include herewith. We believe that your letter of 26 November raises several issues of major importance regarding the scope of the ICL Inquiry, particularly the manner in which the terms of reference have been interpreted.

Before discussing these substantive issues we feel compelled to raise concerns regarding the Inquiry's response to our letter to you dated 12 November. Following a notice on the Inquiry website inviting final written representation, we emailed the Inquiry Secretariat raising issues that we had regarding the scope of the Inquiry. As the letter from Jillian Glass acknowledged, our submission was received at 14.53 on 12 November, more than two hours prior to that day's deadline of 17.00 hours. Given that the public hearings closed on the following day (13 November), it is reasonable to suppose that careful attention would have been paid to submissions received at this time.

It is remarkable that the Inquiry Secretariat is unable to provide us with an explanation as to why our email 'was not seen until 17 November'. If as is indicated the inbox was checked by 'more than one person that day' then it is legitimate to ask why its contents were not conveyed to you as Chairman in advance of the closing session. It is also legitimate to inquire whether this happened to other correspondents. That you were not shown our letter until 17 November, five days after its receipt, is quite frankly astonishing. It was the failure to receive any acknowledgement from the Inquiry to the first letter that prompted us to write to you a second time on 17 November.

### **The Terms of Reference**

We turn now to the content of our letter of 12 November, in which we expressed concerns regarding the manner in which the Inquiry terms of reference seemed to have been interpreted in practice. These terms of reference are widely known as they are readily accessible on the Inquiry website and given your intimate knowledge of them it is not necessary to repeat them here.

It appears, though, that the Inquiry has in parts applied the narrowest possible interpretation of these terms of reference as originally set down. For example, the second

aim of the Inquiry indicates a wide remit. This clause states that the aim is to *'To consider the safety issues arising from such an inquiry, including the regulation of the activities at Grovepark Mills'*. A reasonable reading of this would point to the Inquiry considering a range of issues including those relating to workplace governance, the management of health and safety at ICL, the role played regulatory bodies (principally but not exclusively the HSE) and the built environment. This is of course reflected in the statements already provided to the inquiry for instance by the company, by the Bridge of Allen safety consultant and the HSE all of whom refer to the bigger picture. Employees and ex-employees could offer further and important insights into several of these aspects

Consistent with this broad remit these and other issues are legitimate matters for the public inquiry to investigate, since they might have contributed directly or indirectly to the disaster. However, at best the Inquiry touched only briefly on some of these potentially important contextual and circumstantial factors or, at worst, failed to consider them at all. We will provide more detailed explication below when we respond to the Chairman's contention that he did not consider the 'the wider issues' we raised in our report and in our letter dated 15 May as 'appropriate for consideration' by the Inquiry.

As the transcripts reveal, the Inquiry has focused almost exclusively on the direct cause of the explosion - the gas pipes - and the circumstances surrounding them – their history, condition, maintenance, regulation and so on. Of course, this is an absolutely critical line of investigation. Indeed, the Inquiry proceedings in Phase 1 provide a volume of detailed evidence and relevant testimony stretching back decades. The problem is that this near-exclusive preoccupation has been at the expense of a fuller consideration of other issues of import that would enable general lessons to be learned and recommendations of broader applicability to be formulated. Such examinations of 'root causes' of systems, management, regulatory and other failures are standard practice in workplace health and safety investigations ranging from Flixborough to Bhopal to the recent BP explosions in the USA.

It is evident that the scope of the ICL Inquiry has been far narrower in practice than was initially promised by the UK and Scottish governments. We refer here to the official statement by the Lord Advocate for Scotland, Elish Angiolini QC, and the Secretary of State for Work and Pensions, Peter Hain MP which was made public on 1 October 2007 (<http://www.copfs.gov.uk/News/Releases/2007/10/01145844>). The Secretary of State's statement is unequivocal in its commitment to a *full inquiry* since the findings were *'likely to have significance across the United Kingdom'*. He emphasised the following,

*They [the families of the victims] have also made it clear to me that they want to see the role that the Health and Safety Executive (HSE) played in regulating these premises prior to the incident is fully investigated. I fully support them on this point. No issue relevant to the circumstances should be out of bounds.*

*It is essential that the inquiry is thorough, transparent and exhaustive but not protracted. The families have suffered already and we do not want them to have to wait unduly for answers.*

We wish to highlight the Secretary of State's agreement with the families that the role of the HSE in regulating ICL *'prior to the incident is fully investigated'* and his insistence that *'No*

*issue relevant to the circumstances should be out of bounds*'. It was this emphatic declaration of a broad remit that generated widespread confidence in the potential of the Inquiry.

### **Narrowing the Scope of the Inquiry**

However, between this announcement and the preliminary hearing (8 April 2008), it was decided that the Inquiry would be separated into two distinct phases. Phase 1 was to focus on the *'factual circumstances leading to the explosion to assist in the identification of the safety and related issues that arise from those circumstances'*. Phase 2 would *'address the regulation of the activities at Grovepark Mills in light of the safety and related issues arising from those circumstances and the lessons to be learnt from the causation and the circumstances that led up to the disaster and consideration as to the recommendations that might be made to Ministers'*. We believe that this separation has contributed to the narrowing of the Inquiry.

It is with respect to Phase 2 that we have particular concerns. The purpose of Phase 2 appears with the clarity of hindsight to be ambiguous. On the one hand, the form of words used suggests that Phase 2 should deal only with regulatory and other issues pertaining to the *'factual circumstances'* referred to in Phase 1 (i.e. in relation to the pipes). On the other hand, a broad interpretation, consistent with the spirit and intention of the Inquiry announcement and an understanding that *'circumstances'* would suggest that the Inquiry should include issues such as the role of the HSE prior to the incident.

Perhaps the clearest example of the narrow interpretation can be seen in the case of Mr. Laurence Connelly. As you recall, in our letters of 12 and 17 November we expressed our *'greatest concern'* that Mr Connelly had not been called to give evidence to the Inquiry, even though he had written to you indicating his willingness to give oral testimony in the belief that he would be able to make a meaningful contribution. In the reply of 26 November Jillian Glass reported your conclusion that Mr. Connelly had raised *'matters that are outwith his [the Chairman's] Terms and Reference'*.

We find this evaluation to be deeply problematic and inconsistent with the Inquiry's terms of reference. Mr Connelly worked for ICL for 14 years and had an unblemished record as a trusted worker. He had raised profound concerns with the HSE regarding the health and safety management and practices at ICL at least two years *before* the disaster. This is not a matter of conjecture but of established fact as the documentary evidence of correspondence between Mr Connelly, his Member of Parliament and the HSE demonstrates. It should also be recalled that Mr Connelly remained in employment at Grovepark Mills until only three weeks before the disaster. In sum, it is difficult to think of a witness more capable of illuminating many of the *'circumstances'* leading up to the disaster. Given the Secretary of State's commitment to a *'thorough, transparent and exhaustive'* Inquiry, it is legitimate to pose two questions. What were the precise criteria that informed the decision not to call Mr Connelly? What was your interpretation of the terms of reference in this respect?

## **Key Questions Unaddressed by the Inquiry**

In our letter of 12 November we expressed surprise that we had not been given the opportunity to provide oral testimony, since we believed that our report had raised questions that were germane to an Inquiry with the stated terms of reference and that members of our research team could provide important circumstantial clarification in several areas. It seemed to us that our contribution was consistent with the broader purpose of Phase 2 of the Inquiry. As you recall we raised many of these issues in our letter to the Inquiry on 15 May where we laid out some 'Key Issues and Questions for the ICL Inquiry'. We refer you to this document since it details many of the issues that we believe that the Inquiry has failed to address fully so far. We wish to re-emphasise the following.

### ***The Management of Health and Safety at ICL***

We raised the important question that the immediate cause of the explosion could not be separated out from the everyday management of health and safety at the plant. The systemic failure of ICL to fulfil regulatory requirements under existing legislation led directly to the disaster. Of course, the Inquiry's focus on the gas pipes has led it to consider questions of health and safety management, but it seems that this has happened largely insofar as this pertained to the gas pipes. The testimony of workers and ex-workers that we presented in our report suggested a deeply flawed health and safety culture at the plant. We believe that, in keeping with the terms of reference and the clear intention of the Secretary of State, the Inquiry could and we believe should have been far more extensive in its examination of these matters. As you recall, we documented the apparent failings of ICL management in many respects highly pertinent to understanding the failures to identify and manage the hazards and risks of explosive gases, including :

- The lack of control of hazardous substances and processes
- The failure to provide the minimal requirements for extraction and local exhaust ventilation systems at various times
- The failure to provide suitable personal protective equipment necessary to protect the workforce
- The failure to conduct risk assessments at various critical stages
- The failure to conduct risk assessments and consult employees about them in respect of the important Health and Safety Consultation with Employees Regulations (HSCER, 1996)
- The failure to supply workers with the results of COSHH assessments over a significant period of time

These are not peripheral but central considerations. We can illustrate their importance by reference to the HSCER regulations. Had ICL management properly consulted with employees on health and safety matters, and had there been an open and responsive health and safety culture in the plant, then it is quite possible that problems with the pipes could have been identified and dealt with much earlier and effectively . As our report demonstrates workers were aware of problems with gas pipes ([http://www.hazards.org/icl disaster/icl\\_stockline\\_report.pdf](http://www.hazards.org/icl disaster/icl_stockline_report.pdf) p.102). In an open health and safety culture which has proactive management, effective communication channels, regular

participative risk assessments and knowledgeable and empowered safety reps the chances of remedying problems with the pipes would have been greatly increased.

On the basis of reading the transcripts we believe that the Inquiry has failed to investigate fully the extent and details of the breaches of the law, codes of practice and regulations governing the management of health and safety. The lessons to be learned in this respect are general ones that apply to very many workplaces. Surely one of the major lessons to be learned from the tragedy is the active encouragement of worker participation in health and safety and the importance of regulations such as HSCER in the prevention of future disasters.

### ***The Health and Safety Executive, Regulation and Enforcement***

In our letter of 15 May, we identified a range of issues in relation to regulation and enforcement. We quote here from the text of our letter.

'The disaster raises fundamental questions about how best to secure legal compliance and good practice in sites such as ICL. Our report documented issues in relation to the following regulatory matters, including:

- How the HSE maintains open lines of communication with all workers, whether unionised or not, and management.
- How hazards of the complexity and gravity that workers were exposed to in the plant indicate the need for a more comprehensive approach to the ongoing inspection of safety critical features.
- Procedures used to plan and conduct follow-up visits and regulatory contacts.
- The organisation of site visits.

We also documented how the ability of frontline inspectors to comport responsibilities such as those outlined above has been under pressure for several years, was apparently affected specifically in 2003 and is currently under pressure due to a series of political and resource issues. Several questions are suggested that the Inquiry should explore.

- What have been the consequences of the decrease in HSE resources in general and of frontline inspectors in particular in Scotland?
- To what extent has the erosion of HSE resources impacted on the morale and effectiveness of the HSE in Scotland?
- Is there evidence that the decline in resources did impact on the ability of frontline inspectors to conduct comprehensive assessments and the necessary follow-up visits at ICL?

It is reasonable to conclude that with the reduction in scheduled inspections, and other visible shifts away from enforcement activity, fewer cases in Scotland (such as at ICL) will be brought to light through routine inspection and investigation. This would appear to be a major issue of concern for Phase 2 the Inquiry'.

Unfortunately, the proceedings indicate that these matters were not considered by the Inquiry. In particular, it is remarkable how little concentration there has been on the role of the HSE given the fact by definition the disaster is reflective of a broader regulatory failure. It is surprising that the Director of the HSE in Scotland at the time of the disaster was not called to provide testimony on the role of the agency in respect of ICL.

We also note that the HSE have provided a variety of statements in Phase 2 of the enquiry that do not appear to have been subjected to any critical scrutiny and hence their accuracy and value is very limited. For instance, statements are made about the HSE record by the HSE without independent scrutiny. Further statements are made by the HSE about their lack of documentation as to why HSE justified exemptions of SMEs from some gas regulations and provisions.

#### ***The Health and Safety Executive and Mr. Laurence Connelly (Snr)***

We mentioned above our concern regarding the Inquiry's rejection of Mr Connelly as a witness. We also raised in our letter of 15 May the importance of the testimony of Mr Connelly in relation to the HSE. We believed that the case of Mr Connelly raised specific questions that the Inquiry should seek to answer as follows.

- Why did the HSE fail to respond promptly and effectively to the concerns about health and safety and working conditions raised by Mr Connelly from mid-2002?
- Why does the HSE make no reference in its correspondence to Mr Connelly's MP, Ann McKechnie, of the Health and Safety Consultation with Employees Regulations (1996), which would have been of considerable relevance in the organisational context of ICL?
- Why did Mr Connelly receive no prior notification by the HSE of their visit of June 2003, which had been prompted by his contact with the HSE?
- Why, at this visit, was Mr Connelly identified in front of managers as a 'whistleblower', by a HSE inspector?

This case raises a more general question regarding the scope of the 1998 Public Interest Disclosure Act (1998). PIDA does not cover employees in the private sector where, statistically, there is a far greater risk of injury and fatality. Surely, employees such as Mr Connelly who raise legitimate concerns in the public interest should be afforded legislative protection.

On the basis of the evidence of the Inquiry transcripts it appears that none of these questions have been addressed. We believe that it is in the public interest that the HSE responses to Mr Connelly's should have been fully investigated. As the transcripts reveal,

there is a long history of HSE involvement with ICL. It is legitimate to ask whether this history was considered by the HSE following Mr Connelly's communication. If it was not then explanations are required. To repeat, these are central questions which the Inquiry appears not to have pursued.

One difficulty that might arise from this omission is a perception that the Inquiry has failed to investigate fully the role of the HSE 'prior to the incident', an outcome that contrasts with the Secretary of State's statement of intent and which reflected the wishes of the families of the victims.

### ***The Built Environment and Regulation***

In our letter of 15 May we raised questions regarding the built environment based upon Section 7.4-7.6 our report. We reported anecdotal evidence provided by workers for a Frontline Scotland television programme for BBC Scotland (5 October 2004) which suggested that the Grovepark Mills building was showing signs of being under considerable stress (see page 93). Consequently, we argued, the Inquiry should

- Conduct as thorough an investigation as is possible of the conditions of the building prior to the explosion. A key source of evidence in this respect will be the testimony of the former employees.

Workers' testimonies also indicated that relatively major structural alterations had been carried out on the building during the previous 20 years. Such work was of a scope and scale that would have required a Building Warrant. A search of the records held by Glasgow City Council, Environmental Protection Services, Building Control and Public Safety was then undertaken. A letter from Glasgow City Council (dated 25 May 2005) confirmed there was no record of any application for a Building Warrant submitted after 1981 (other than an unprocessed application for storm damage). All drawings before this date would have been passed to the City Archivist in the Mitchell Library, but no warrant of any work conducted on the building exists. It was in the light of these findings that we believed the Inquiry should investigate several important questions.

- If relatively major structural works had been carried out in the recent past to the factory, then why was there no evidence of a Building Warrant?
- Did the management carry out any risk assessments as to whether the building structure could support the additional loadings from palletised materials and new processes?
- Why were the repairs to the areas of the building that were clearly showing structural stress (floor deflections) of a makeshift nature?
- Given that these structural problems were evident to many of the workforce why did the management not engage a structural engineer to undertake a use and condition survey?
- Why was a factory, which was clearly demonstrating symptoms of structural stress, allowed to accommodate a variety of hazardous processes with a high risk of explosion?

- Who was primarily responsible for ensuring that the structural integrity of the factory was regularly assessed and what statutory/executive agency is responsible for ensuring that such inspections occur?

We do not know whether the condition of the building contributed to its catastrophic collapse and to the scale of the fatalities and serious injuries. We do believe, however, that this was a legitimate question for the Inquiry to consider. It is difficult to understand how matters concerning the built environment, building use and regulatory compliance were not considered to fall within the remit of the Inquiry.

### **Conclusion**

In your reply to us of 26 November you stated that as academics our research interests lay beyond the remit of the Inquiry. To re-iterate, we do not believe this to be a justifiable response in the light of the original intention of the Inquiry, its stated aims and the clear intention of the Secretary of State. We were not alone in expecting Phase 2 of the Inquiry to undertake a full investigation of relevant circumstances surrounding the disaster. In practice, however, Phase 2 appears to have been a continuation of the Phase 1, focusing on issues directly or indirectly relating to the gas pipes. Like others we were surprised at the limited number of sessions involved and the speed with which proceedings were concluded. The transcripts reveal that Phase 2 consisted of only nine sessions including the final concluding session on 13 November.

We would like make clear our objection to not being called to the Inquiry. Since we began our research in autumn 2004, we have been motivated solely by the hope that we can help ensure that there is no repetition of the disaster at ICL. When people leave their homes to go to work they and their families have the fundamental right to expect that they will return home safe and well. We believe that as a research team we have a contribution to make to the Inquiry and to helping to learn lessons that will prevent such recurrence.

A reading of the Inquiry 'Proceedings Protocols' indicates that the Chairman has considerable latitude in deciding what information is admissible. Clause 9.3 states *'The Chairman will determine what information and/or evidence is relevant to his Terms and Reference etc'* and 18.1 refers to *'the Chairman's absolute independent discretion to interpret his Terms of Reference as he deems fit and to determine what issues and aspects to consider in the course of his Inquiry'*. Given the extent of your discretion we believe that it would be helpful if you could provide us with:

- a) a fuller explanation as to why you consider the issues we raise are outwith the remit of the Inquiry *and*
- b) your interpretation of the terms of reference of the Inquiry particularly in respect of Phase 2.

We understand that the public hearings are now closed. However, we would be willing to meet with you and/or members of the Inquiry team to provide further clarification of the points that we raise above.

Kind regards,

Professor Matthias Beck, University of York

Professor Christine Cooper, University of Strathclyde

Dr. Andrea Coulson, University of Strathclyde

Thomas Gorman, University of Stirling

Dr. Stirling Howieson, University of Stirling

Jim McCourt

Professor Phil Taylor, University of Strathclyde

Professor Andrew Watterson, University of Stirling

Dr. David Whyte, University of Liverpool

Contact: Professor Phil Taylor

Professor of Work and Employment Studies

Department of Human Resource Management

University of Strathclyde

Glasgow, G1 1XU

Tel – 0141-548-3555

Email - [philip.taylor@strath.ac.uk](mailto:philip.taylor@strath.ac.uk)