

Right Honourable Lord Gill
Chairman ICL Inquiry

Inquiry Secretariat
The ICL Inquiry
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28th January 2009

Dear Lord Gill,

Thank you for the letter of January 15th 2009 signed by Jillian Glass in her capacity as the Solicitor to the ICL Inquiry. We note your further comments regarding the unfortunate problems the Inquiry secretariat encountered with regard to our letter sent on 12th November and recognise that you are still unable to provide further explanation as to why our email 'was recorded as received at 14.53, but was not visible to us on the day it arrived in the system'. As we indicated in our letter of 8th January, we wish simply to establish what happened to our letter, which is a reasonable request I am sure you agree. We thank you for clarifying that no other emails were received by the email address concerned on that day. We also thank you for the further amplification on your understanding of the terms of reference of the inquiry.

However, with regard to the substantive points made in our January 8^h 2009 letter which we believe pertain precisely to the terms of reference of the Inquiry you cite, none of these points appear to have been addressed in your letter. You refer in your letter to our 'desire to have more general considerations taken into account' in the inquiry. Our desire and our aim have always been to contribute, as constructively as possible, to as open, transparent and effective an investigation as possible of the events leading up to the ICL tragedy. This necessitates careful scrutiny of the direct and indirect causes of the disaster which we believe cannot be achieved if the issues we raise are not fully considered. We will not repeat in detail the points we raised.

The Inquiry touched on 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 as the local authority and fire brigade had roles to play in both inspecting and 'approving' the building) and the built environment. This is reflected in phase one by the statements from the Bridge of Allen safety consultant and HSE staff all of whom refer to the bigger picture. We do not comprehend why these aspects were not then explored and critically scrutinised in phase two of the inquiry. A number of employees and ex-employees can offer further and important insights into several of these aspects with regard not only to what happened but also perhaps why things happened at the ICL factory. The inquiry team could have chosen to call such employees and ex-employees. Mr Laurence Connelly specifically offered such additional information to the inquiry which will go beyond his statement of case that we now note forms part of the evidence to the inquiry. We

believe that the case of Mr Connelly raises specific questions that the Inquiry should seek to answer.

As the transcripts reveal, phase two of 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. The ‘root causes analysis’ of systems, management, regulatory and other failures which are standard practice in thorough health and safety investigations across the world do not appear to have been addressed yet. For example, the US Chemical Safety and Hazard Investigation Board (CSB), and the independent Baker Report, when investigating the Texas BP explosion 2005 which killed 15 people, examined the culture of the company concerned, the role of regulatory agencies and enforcement lessons very carefully. This cannot be achieved in an inquiry such as the ICL one if the regulatory agencies are simply allowed to police themselves and to assess their own performance: some level of external and independent scrutiny is necessary. The CSB enquiry made recommendations to the company directors, the industry umbrella bodies, the government occupational health and safety agencies and the trade unions. Those recommendations related to endemic problems, to numbers of inspectors, improved training for inspectors, frequency and thoroughness of investigations, improved resources needed for inspectors to be effective.

The HSE, in terms of its policies, practices, staffing, resources, and senior management played a major part in the events leading up to the ICL explosion. A deterioration in the ability of the HSE to conduct reactive work in the period leading up to the disaster is very clearly indicated by a fall in the number of HSE investigations in Scotland from 7,199 in 2000/01 to 3,710 in 2003/04: a gross reduction of 48% (Hansard, HoC, 16 Nov 2004, col 1322W). Yet the senior manager of the lead regulatory body dealing with the factory at the time of the ICL explosion, the HSE regional director in Scotland, was not called. Effectively the inquiry has to date allowed the HSE self-assessment of its own record in phase two. How this may help to ensure future regulatory failures like that of ICL is not obvious to us.

We were not alone in expecting Phase 2 of the Inquiry to undertake a full investigation of relevant circumstances surrounding the disaster. We understand that the public hearings are now closed. However, we continue to be willing to meet with you and/or members of the Inquiry team to provide further clarification of the points that we raise above and other issues raised in our report.

Kind regards,

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