A STUDY OF MIGRANT WORKER HEALTH AND SAFETY ISSUES IN THE UK CONSTRUCTION INDUSTRY

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ABSTRACT
This paper reviews recent literature regarding migrant worker safety within the UK construction industry. A case study investigation of migrant Polish workers is discussed and the current occupational health and safety legal framework of the UK construction industry is considered with specific regard to migrant workers. The paper is presented within two broad sections. The first section concerns health and safety with regard to migrant workers and identifies the basis of UK health and safety law and enforcement. Whilst the second section comments on the migratory nature of the construction sector and then specifically identifies relevant research on health and safety in the UK construction industry and migrant workers.

In summary, this paper serves to:
1. Review research concerning migrant workers within the UK construction industry and identify key emergent issues;
2. Identify emergent issues regarding migrant workers within the context of UK health and safety law and practice; and
3. Consider ways forward to enhance the safety of migrant workers within the UK construction industry.

Keywords: Migrant workers, Health and safety, Legislation

INTRODUCTION
On the 1st May 2004 the European Union (EU) enlarged its boarders with the accession of ten countries, eight of which were from Central and Eastern Europe (the A8 countries). Of the existing 15 EU member states only three countries (Ireland, Sweden and the UK) did not significantly restrict A8 migration. The other 12 countries introduced transitional measures to limit free movement. In an attempt to monitor A8 migrant workers the UK introduced a Worker Registration Scheme (WRS). This scheme though only targets those employed and registration with the scheme is not a proviso of entry to the UK. It is also apparent that an unknown number of A8 workers have entered and exited the UK without knowledge of the WRS scheme (Fitzgerald, 2005; McKay and Winklemann-Gleed, 2005; Currie, 2006).

Given this low level of regulation the precise number of A8 workers that work, or have worked, in the UK are unknown. Salt and Millar (2006) have though used a range of statistical sources to estimate new migration. They conclude that the entry of A8 workers to the UK is almost certainly the largest single wave of in-migration to the UK, with Polish workers constituting the largest ever single ethnic group. Regular WRS reports of A8 registration have also been released by the British government and the most recent of these indicate that since May 2004 949,185 workers have registered to work in the UK (Border and Immigration Agency, 2009). Of these registrations some 626,595 (66%) are Polish with as many as 380,000 working for recruitment agencies.
HEALTH AND SAFETY AND MIGRANT WORKERS
The International Labour Organisation have highlighted that occupational accident rates for migrant workers in Europe were twice as high as for equivalent indigenous workers (ILO, 2004). Whilst in a UK context the HSE recently recognised that migrant workers may be missing out on crucial health and safety training due to a lack of employer provision of procedures in languages other than English. Given this they jointly collaborated with the TUC to publish a health and safety leaflet in 19 separate languages (HSE, 2004). Although Bates (2006) has identified HSE officers visiting migrant workplaces with interpreters, there has been a reticence to undertake any major action, unless cost-effective, until there was strong evidence of risk. Given this ‘lack of evidence’ a study of England and Wales was commissioned by HSE in 2006 to gauge risk. The findings of the study (McKay et al., 2006) identified that even though there was not yet statistical evidence of increased risk due to an individual being a migrant worker, there was considerable need for concern. The authors argued that migrant workers were more likely to be working in sectors and occupations with a heightened health and safety risk. Further in interviews with over 200 migrant workers they found that up to a third had not been provided with any health and safety training. Moreover it was significant that twenty-five per cent had sustained some form of injury at work, which many had not reported. Injuries were often linked to a lack of acclimatisation to the job and workplace and significantly fatigue. Also highlighted were issues with regard to migrant self-employment and a lack of information on health and safety procedures.

This lack of information is interesting given the multi-lingual leaflet identified earlier, although this pre-supposes that the leaflet was widely distribution. Of interest is also that the TUC had secured agreement from the Home Office that advice and information on how A8 migrants receive national insurance numbers, pay tax and secure their rights at work would be supplied to everyone who registered on the WRS. Within the first six months of the scheme the TUC had received as many as 1,600 enquiries (UCATT, 2005). Although, at a TUC A8 meeting that one of the authors attended in 2006 it was reported that the distribution of these leaflets was only occurring intermittently. As well as this is the evidence of lack of A8 registration to the WRS scheme. Lack of information for A8 workers has been a theme throughout migrant research and often relates not to whether information is available but most importantly how accessible it is to A8 workers (Commission for Rural Communities, 2008; Fitzgerald, 2009).

In a European wide report prepared for the Polish government on the impact to A8 citizens of emigration Carby-Hall highlights a range of Health and safety abuse within the context of a five part scenario. Firstly, Carby-Hall claims that many A8 migrants display ‘fear’ when questioned about exploitative conditions; secondly, that this is often difficult to challenge as A8 migrants are widely scattered in a number of economic sectors; thirdly, that some of the worst excesses of exploitation are akin to ‘forced labour’ and ‘modern slavery’; fourthly, that actual abuse is multi-faced and can not be tied down to a single practice; and fifthly, that gangmasters and some employment agencies play a significant role in this and often have a dominant controlling interest. In particular he highlights how this has a clear connection to poor health and safety practices and that in a UK context if migrants complain about their working conditions they are likely to be sacked with no legal protection in the first year of employment.

UK HEALTH AND SAFETY LAW
The Health and Safety law of the UK workplace is built upon the Health and Safety at Work etc Act 1974. The Act provides a foundation for UK construction health and safety law and also enables the development of a comprehensive framework of ‘statutory instruments’ (regulations) and associated standards and approved codes of practice.

Construction activity is subject to a range of humane regulations, of which compliance is a legal requirement, and disregard a criminal offence. Examples of some key UK construction-related health and safety regulations are listed in Table 1.
<table>
<thead>
<tr>
<th>Date</th>
<th>Legislation</th>
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<tr>
<td>1974</td>
<td><strong>Health and Safety at Work etc Act</strong></td>
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<tr>
<td></td>
<td>This act provides the basis for British health and safety law. The Act came about as a response to constantly expanding, ever more detailed, UK health and safety law. The Act consolidated much legislation and provided for the development of a 'personal responsibility' approach to health and safety. The Act is an 'enabling Act' and has a provision for the development of a framework of health and safety 'statutory instruments' (or 'regulations') and any associated standards and approved codes of practice.</td>
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<tr>
<td>1981</td>
<td><strong>Health and Safety (First Aid) Regulations</strong></td>
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<td></td>
<td>Employers are required to have adequate and appropriate equipment, facilities and personnel for employees who suffer injury or illness at work.</td>
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<tr>
<td>1987</td>
<td><strong>Control Over Asbestos at Work Regulations – Revised 2002</strong></td>
</tr>
<tr>
<td></td>
<td>Introduced to educate duty holders in the identification of materials containing asbestos and to provide guidance for its removal.</td>
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<tr>
<td>1988</td>
<td><strong>Control of Substances Hazardous to Health (COSHH) – (Amended 1994 &amp; 1999)</strong></td>
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<tr>
<td></td>
<td>Implemented as a method of ensuring that practitioners were aware of the dangers brought about through working with chemicals and other hazardous substances. The law required employers to control employee exposure to prevent illness.</td>
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<tr>
<td>1989</td>
<td><strong>Noise at Work Regulations – (Amended 2005)</strong></td>
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<tr>
<td></td>
<td>These regulations concern all people at work (not just construction) and deal with risks to hearing, not other aspects of health safety and welfare. The regulations provide for an employer responsibility to protect employees from harm caused by exposure to noise.</td>
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<tr>
<td>1992</td>
<td><strong>Workplace (Health, Safety and Welfare) Regulations</strong></td>
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<tr>
<td></td>
<td>These regulations serve to protect the health, safety and welfare of everyone in the workplace. They also give protection to other people who might have been affected by the work.</td>
</tr>
<tr>
<td>1992</td>
<td><strong>Management of Health and Safety at Work Regulations (Revised 1999)</strong></td>
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<tr>
<td></td>
<td>The Management of Health and Safety at Work Regulations first came into effect on 1st January 1993 and were revised in 1999. The regulations were developed to implement the general provisions of the European Framework Directive (89/391/EEC) – ‘measures to encourage improvements in the safety and health of workers at work’. As such the Management of Health and Safety at Work Regulations developed UK health and safety management and brought about the requirement to use risk assessment to manage health and safety as well as requiring the undertaking of health surveillance and the appointment of competent health and safety assistants within the workplace.</td>
</tr>
<tr>
<td>1992</td>
<td><strong>Personal Protective Equipment at Work Regulations</strong></td>
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<td></td>
<td>The regulations implement the European Directive 89/656/EEC – ‘to introduce minimum health and safety requirements for workers using personal protective equipment (PPE) at the workplace’. Under these regulations an employer is required to provide suitable PPE when an employee is faced with a health and safety risk.</td>
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<tr>
<td>1996</td>
<td><strong>Manual Handling Operations Regulations</strong></td>
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<td></td>
<td>The regulations facilitate the prevention of musculoskeletal disorders caused by the manual handling of heavy goods in the workplace.</td>
</tr>
<tr>
<td>1994</td>
<td><strong>Construction (Design and Management) Regulations (Replaced by CDM2007)</strong></td>
</tr>
<tr>
<td></td>
<td>The regulations were implemented to emphasise and improve the management of health and safety throughout all stages of construction projects. The regulations place responsibility on the client and designers as well as contractors and promote a pro-active approach to safety management.</td>
</tr>
</tbody>
</table>
1995 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations [RIDDOR]

These regulations serve to ensure that workplace ‘occurrences’ are reported to the HSE. The occurrences include:

- Fatal and serious accidents.
- Accidents that prevented employees working for 3 or more days.
- Dangerous incidents where people were put in danger.
- Specified diseases associated with a person’s job.

1996 The Construction (Health, Safety and Welfare) Regulations

(Now revoked and replaced by CDM2007)


2005 Work at Height Regulations

These regulations were introduced to further address the UK construction industry’s single biggest cause of injury and fatality. The regulations apply to all work at height where there is a risk of a fall liable to cause personal injury.

2007 Construction (Design and Management) Regulations 2007

These regulations were initially introduced in March 2004. The 2007 regulations (CDM2007) revoke and replace the 2004 regulations. CDM2007 also revoke and replaced the Construction (Health, Safety and Welfare) Regulations.

ENFORCEMENT

A breach of duty imposed by the Act or non compliance with regulations (issued under section 15 of the Act) is a criminal offence. Premises and work activities subject to health and safety inspection are identified in the Health and Safety (Enforcing Authority) Regulations 1998. Schedule 2 of these regulations details the Health and Safety Executive’s (HSE) responsibility, which extends to building sites, factories and manufacturing, nuclear installations, railways, schools and hospitals. With specific regard to construction, the Health and Safety Executive employ some 134 inspectors to visit sites across the UK, undertake enforcement action and investigate accidents. This limited number of inspectors results in there being only a small possibility of a site receiving an inspection visit. Further to this the HSE periodically carries out ‘national inspection initiatives’. These initiatives serve to strategically target activities where accident rates are viewed as increasing. One recent example of such a ‘national inspection initiative’ was a much pre-publicised targeting of refurbishment sites in March 2009. Disappointingly, of 1,759 refurbishment sites visited enforcement actions were served on 348 of the sites where serious safety risks were discovered (HSE, 2009a).

In carrying out the refurbishment inspection initiative, HSE inspectors considered the following good practice criteria (HSE, 2009a):

- Jobs that involved working at height had been identified and properly planned to ensure that appropriate precautions were in place;
- Equipment was correctly installed / assembled, inspected and maintained and used properly;
- Sites were well organised to avoid trips and falls;
- Walkways and stairs were free from obstructions;
- Work areas were clear on unnecessary materials and waste;
- The risks associated with exposure to asbestos were managed and carried out correctly;
The work force was made aware of risk control measures. Nearly twenty per cent of the refurbishment sites inspected fell seriously short of adequately achieving the above good practice criteria. This does not suggest a continuation of the statistical trend of construction health and safety enforcement of recent years (2002-06) where a steady decline has been evidenced in the issue of improve notices, prohibition notices, the number of informations laid, and the number of prosecutions (Howarth and Watson, 2009). It also does not suggest significant progress in delivering site level improvements in workplace health and safety management.

THE MIGRATORY NATURE OF THE CONSTRUCTION SECTOR

Construction activity is mainly location specific with cost-reductions often relying on the migration of labour (Baganha and Entzinger, 2004). Baganha and Entzinger (2004: 11) argue that EU regulation encourages employers to seek migrants from within, rather than outside the EU. Interestingly, Balch et al. (2004) argue that in a UK context cheap foreign labour is an ‘embedded, structural feature of the UK construction sector’ (ibid: 191). This occurs at the mid to low skilled end of the labour market and is often based on informality, with a lack of enforcement of regulations, which is likely to be supported by recruitment agencies. More recently a study of ‘bogus self-employment’ has estimated that for every A8 construction worker directly employed there are 11 self-employed (Harvey and Behling, 2008: 24). If this is the case then the 36,750 A8 workers who have registered with employers in construction (Border and Immigration Agency, 2009), of which Polish workers make up approximately 63%, becomes over 400,000 who have actually worked in the sector. HSE (2009c) themselves have recently estimated that a quarter of foreign workers in UK construction were Polish. Given this UK context, including light touch regulation, the most obvious issues with a transitory foreign workforce are training and education with regard to new working environments. Most significantly, there is the pressing issue of who will assimilate an accession workforce into the health and safety culture of a UK building site. This is of course not least tied into language and terminology challenges.

As well as these particular UK factors are an added A8 country issue with regard to the informal nature of a growing section of the central and eastern European labour economies. Woolfson (2007, 2006; with Calite and Kallaste, 2008; and Sommers, 2006; Woolfson et al., 2003) argues that these newly ‘freed’ economies have moved from stable but repressive control through to a harsh free market. Informalism is increasingly as unemployment and poor trade union representation lead to domineering employers. The significance here is that entering accession these countries offered a cheap labour alternative, which has indeed been utilised in construction (Woolfson and Sommers, 2006). Important in Woolfson’s work is his reference to fatalities and injuries at work not least due to a number of abusive employer practices (Woolfson, 2006). The significance for our argument is that the UK construction sector has a reliance on cheap foreign labour; a considerable number of the self and bogus self employed; and finally this is supported by recruitment agencies. When this is added to many of the conditions outlined by Woolfson an assumption maybe drawn that a number of existing workplace practices, including health and safety, will be undermined.

MIGRANT WORKERS HEALTH AND SAFETY IN CONSTRUCTION

Clarke and Gibling (2008) report that the Heathrow Airport T5 terminal construction project operated an exemplary health and safety system. This site included an on site CSCS test centre and a strong trade union presence. Although, the authors conclude that this approach to safety on a large construction project was not typical of UK construction projects (Clarke and Gibling, 2008).

In support of this conclusion, a study in the North East of England (Fitzgerald, 2006) found that the mainly Polish migrant workers were being exploited and abused. The clearest examples of abuse were expressed through direct violence towards workers and excessive hours of working. What bound many of these workers to the employer were their poor language skills and the reliance on the employer for their accommodation needs. It also became evident that many workers had self-
employed or illegal contracts (confirmed by solicitors working with the project). There was no training identified and importantly industry regulation through such things as the CSCS card was also not evident. The project did not have health and safety as a central concern but two main examples are worth highlighting. The first was reported by a sub-contractor who spoke about new sub-contractors supplying Polish labour to the sector. He identified that a refurbishment site in Newcastle was being used as accommodation by a group of Polish building workers. It was accessed at night via climbing up the scaffolding surrounding the building. Secondly a trade union official reported that a Polish owned sub-contractor working on a housing development had been ‘caught’ using pallets for its Polish workers instead of scaffolding. Overall poor employer practices were underpinned by a lack of information about UK employment rights, including those relating to health and safety. This and poor language skills meant it was very difficult for Polish workers to initially change employer or seek assistance. On a wider note Dench et al. (2006) in a government funded study into employer use of migrant labour identified that some of the construction employers they spoke to provided no training for their migrant workers. They also highlighted that some had a poor attitude with regard to translation of English health and safety instructions. Also highlighted in a number of other studies, for example in Pemberton and Stevens (2006) in the North West of England.

There has been further discussion of what actually happens if migrants complain about workplace health and safety. For example Anderson and Rogaly (2005) identify that HSE construction inspectors admit to being powerless to assist migrants who are dismissed by their employers following a report of a health and safety incident. Owen (2007) takes our discussion further by actually accessing the available health and safety statistics, which are not broken down by ethnicity. He states that he was encouraged by a decline in fatalities and serious injuries in construction prior to 2006 and 2007. However, he notes a recent rise and remarks that this is likely to be due to the introduction of large numbers of migrants with poor language skills. Blackman (2007), the lead construction officer for Unite the Union is direct in arguing that this rise in migrant worker construction fatalities is due to the introduction of rogue gangmasters who had previously been operating in the food processing sector. He believes that their introduction into construction followed the Gangmasters (Licensing) Act 2004 legislation which lead to the formation of the Gangmasters Licensing Authority (GLA) in the food processing industry. He argues for an extension of the GLA into construction. Although, this was initially publicly rejected by government (BERR, 2008) the recent inquiry into construction fatalities does now recommend an extension of the legal framework in construction, including an extension of the GLA into construction (DWP, 2009).

THE STATISTICAL EVIDENCE BASE
The preceding case studies and wider research supporting a hypothesis that migrant workers are more prone to accidents at work mainly relate to small numbers of building employers in an industry which in 2006 had 186,107 firms (ONS, 2008). The central theme throughout all of this work is the need for statistical evidence with regard to migrant fatalities and injuries in the workplace. A recent piece of work by the Centre for Corporate Accountability (CCA) provides some assistance here with regard to fatalities at work. The study uses a Freedom of Information Act (FOIA) request to the HSE to report that since 2002 the HSE has been able to ascertain how many migrant worker deaths there have been in construction (CCA, 2009). This is of course based on reported incidents. They identify that migrant worker deaths in construction were almost a fifth of all construction deaths in the 2007-2008 period (ibid: 10). Further that migrant worker deaths in construction have gradually increased rising from two in 2002-2003 to three in 2003-2004. Following the accession the 2004-2005 period witnessed five deaths which grew to eight in the next period and then by a further fifty per cent in 2007-2008 to twelve. Overall HSE data indicate then that there has been a substantial three hundred per cent rise in migrant deaths in construction since the accession of the A8 countries. However, this HSE data is constituted via a manual trawl of HSE records and was not provided specifically by nationality. The CCA (2009) does though have their own managed database of migrant fatalities since 2001-2002, which although not exactly comparable to the HSE data has clear synergies and allows a closer inspection of the rise in fatalities since 2004 by ethnic group. Here of the 46 migrant worker deaths identified 24 were in
construction. Further of these 24 construction fatalities 18 followed the A8 accession, of which forty-four per cent (8) were Polish.

The concern here is not only that this has occurred due to poor employer practices but also because of a gradually reduced HSE presence in the workplace. In a previous piece of work by the CCA for Unite the Union it was highlighted that there has been a gradual decline in the investigation of major injuries to workers in construction. In the 2006-2007 period when eight migrants died only fourteen per cent of all construction major injuries were investigated (CCA, 2008: 12). Whilst in the same period only two per cent of ‘over three day injuries’ were investigated. The CCA note that this was a twenty per cent decline in investigation of the former and fifty per cent decline of the latter since the 2001-2002 period. They conclude that ‘in failing to investigate such high numbers of injuries and dangerous occurrences, the HSE has overseen the virtual institutionalisation of a culture of impunity… The HSE/C’s failure to argue the case for more money for investigations shows they do not see accountability as a high priority. (CCA, 2008: 30). Further more controversially that:

…the Government has set a context for the work of the HSE – both in terms of allocation of resources, and through its wider messages about ‘burdens on business’ – in which safety at work is increasingly devalued, and seen as an interference with the business of doing business. (CCA, 2008: 31)

This is perhaps too harsh a criticism and the HSE have been actively involved in seeking to support vulnerable workers, which has been contributing to improvements in workplace health and safety in the UK. The term vulnerable has become common in Government and TUC dialogue and represents a range of workers, including those working for recruitment agencies and migrant workers. The HSE Construction Industry Advisory Committee (CONIAC) vulnerable workers group has highlighted the need for more freely available health and safety information for employers (HSE, 2009b). Interestingly, though, with regard to migrant workers the working group have three main recommendations. First that CONIAC should support the HSE construction division provision of more multilingual outreach workers; second that they should encourage more multi-media projects for migrants and; third that they should identify how the Construction Skills ‘Safety Critical Communications’ tools for migrant workers can be widely used.

CONCLUDING SUMMARY

This paper has identified five main areas which research has focused on when discussing health and safety and UK migrants. It has also introduced significant statistical evidence which supports this research in showing an increase in migrant worker fatalities since the May 2004 accession of the A8 countries. These areas are:

- Abusive and exploitative employer practices which underpin a working context. This can lead to fear of reprisals if lapses of health and safety are reported;
- A serious lack of information regarding a number of aspects of working in a new workplace – this of course makes movement away from poor employers more difficult;
- Poor migrant language skills and support which again feeds into the two areas above;
- A lack of basic employer health and safety training;
- Lastly a much wider issue, particularly in construction, of self employment.

ConstructionSkills, a UK industry body involving amongst others employers and trade unions, has attempted to alleviate these practices in construction. One early action considered was the setting up of a permanent ‘On-site Assessment Training’ (OSAT) centre in Poland in order to certify those seeking to work in construction in the UK (cited in Chan et al., 2008). However, in an industry such as construction there is a need for wider employer awareness that migrants require acclimatisation
to unfamiliar construction sites. This is of particular importance when issues of language and differing health and safety cultures are likely to be a major feature in the early stages of employment. Although, employer engagement with this may be difficult, particularly at a time of economic recession, the recent suggestion of an extension of the construction legal framework is an encouraging step.

REFERENCES


