



HEALTH AND SAFETY MYTH-BUSTERS CHALLENGE PANEL: CASE
ANALYSIS

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STATEMENT FROM HSE

The report is the result of independent research conducted by the University of Exeter. However, the HSE are supportive of the research and value its findings.

NON TECHNICAL REPORT SUMMARY AND MAIN FINDINGS

The report presents an analysis of the first two years of submissions to the Health and Safety Executive's (HSE) [Myth Busters Challenge Panel \(MBCP\)](#) – 272 cases in all. It outlines the themes that recur in the cases and, in particular, the weaknesses in organisations' capacity that contribute to the questionable use of health and safety. This non-technical summary addresses seven key questions.

1. What is the problem at the heart of each health and safety myth?

Nearly half the myth cases are classified by the HSE as an excuse / poor customer service (45%), with poor communication or explanation (22%) and an over-interpretation of health and safety (20%) following close behind. The rest of the cases are either for other regulators (7%) or treated as sensible uses of health and safety (6%).

2. Where do myths come from?

The geographical spread of myths is broadly in line with UK population density by region. Though myths are found in a wide variety of sectors – sixteen in total – they are concentrated in seven main areas: leisure (24% of cases); workplace health and safety (16%); retail (15%); education (13%); food safety (8%); transport (8%); and housing (6%).

Some sectors show up in particular types of myths more than others. As might be expected, the workplace accounts for nearly one third of over-interpretation cases (31%) and nearly a quarter of over-interpretation cases come from educational establishments (24%). The leisure sector – mainly gyms and amateur sports clubs – shows up strongly in poor customer service and poor communication cases (28% and 31%, respectively).

3. Who do health and safety myths affect?

Health and safety myths affect fourteen groups of citizens, four of which bear the brunt: consumers (32%); children (20%); employees (13%) and citizens accessing public services (12%). The impact of health and safety myths on children is the most surprising finding; children are frequently prevented from engaging in activities in educational and leisure settings on the grounds of health and safety that are found to be baseless. Another surprising finding concerns volunteers. Despite the recent focus on the impact of 'elf and safety' myths on volunteers, this group is affected by myths in only 3% of the cases.

4. What are people being protected from?

The largest category of cases involve everyday objects (32%) – for example, spills from hot or cold drinks, play-related concerns and ladders. Beyond the mundane, over a fifth of the cases concern objects related to what we term 'purity' issues – these are risks affecting children or dealing with hygiene, animals or taboo issues such as drugs. The well-known conkers case is a typical example of a purity case ([case 92](#)). Consider also the case of a council banning dog training classes on its premises on health and safety grounds ([case 152](#)).

5. What are the reasons for these myths?

The rise of health and safety myths in the UK cannot be attributed to a single cause or combination of causes, but the cases submitted to the Challenge Panel do have recurring themes which relate to gaps and weaknesses that exist in three aspects of organisations' capacity.

First, problems relating to administrative pressures are prevalent. Particularly important is evidence of deficiencies in staff training (39% of cases), fear of legal action (28%) and avoidance of economic costs (25%). Analysis suggests that fear of legal action and over-interpretation of health and safety may be linked – the classic case of a council banning hanging baskets falls into this category ([case 7](#)). A similar link is found between cost avoidance and poor customer service. Take for example the hairdresser who refused to offer their customer a drink on health and safety grounds! ([case 132](#)).

Second, problems relating to analytical capacity also recur. Specifically, a generic 'better safe than sorry' risk averse mind-set shows up in over half the cases (60%) and is especially strong in instances of poor customer service. One typical example is that of a cyclist being told to remove their chained-up bicycle from a pedestrian area ([case 27](#)). An incorrect assumption that regulations exist in an area is found in nearly one third of cases (32%) and is linked in particular to myths that demonstrate an over-interpretation of health and safety. Take for example the concern that standing on an office chair to put up Jubilee bunting constituted a breach of health and safety regulations ([case 35](#)).

Finally, problems related to organisations' capacity to communicate recur in the erroneous use of health and safety. Over a third of the cases involve an individual who could be blamed for an alternative decision (37%) and may be using health and safety to avoid confrontation. The other intriguing communication issue is found in cases where there are concerns about aesthetics (30%). For example, the misguided use of health and safety to enforce school uniform policy and ban frilly socks ([case 180](#)) or prevent decorations in offices and schools ([case 104](#)).

6. How aware is the public of health and safety myths?

Analysis of press coverage and hits on the HSE's mythbusters pages demonstrates that knowledge of these myths is widespread. In its first two years, the MBCP and 58 of its cases have been the subject of 437 press stories. Only three of the cases have not been accessed online by the public. The use of hairdryers in the gym ([case 171](#)) is the most visited web page, followed by the frilly socks ban ([case 180](#)), refusal to add strawberry sauce and nuts to ice cream ([case 210](#)) and refusal of spare parts and manual for DIY appliance repair ([case 186](#)).

7. What can we conclude about health and safety myths?

The research uncovers the complex range of factors that recur in health and safety myths. As we might expect, cost avoidance is one important contributor. But, there are also less cynical factors in play. In particular, the fear of legal action, the prevalence of a 'better safe than sorry' attitude and the incorrect assumption that there is regulation in place where there is not all play major parts in myth creation. The analysis also raises awareness of particular areas where myths are flourishing. Myths prevail in expected settings – the workplace, retail and education – but also in the leisure sector. Particular groups are affected by health and safety myths – consumers as we might expect, but also children.

Identifying these trends allows the HSE to develop more focussed communications strategies that tailor advice and raise awareness in specific sectors and about particular populations. It will also enable them to support organisations to address the capacity gaps that make health and safety myths more likely.

INTRODUCTION, RESEARCH OBJECTIVES AND STRATEGY

The research objective is to analyse the first two years of the Health and Safety Executive's (HSE) [Myth Busters Challenge Panel \(MBCP\)](#) cases (April 2012 to March 2014). Specifically, the aim is to uncover the potential drivers that may lead to the creation of particular types of myths.

The report presents an analysis of 272 MBCP cases. The data are drawn from the narratives of the individual cases (available on the HSE Mythbusters webpages); the HSE mythbusters team's own case notes; data from 568 enquiries and 50 'closed' cases. We also analyse the web hit data for MBCP cases 1 to 219,¹ and media monitoring data for 2012/13 and 2013/14 (2066 stories).

Each case was coded for 48 items². Twelve cover the categories used by the HSE which address basic descriptive data such as when the case was reported, the sector, the outcome etc. The next 36 items are designed to gather three main types of information:

1. additional descriptive data about the case – e.g. the issue type; the source of the problem; whether it is a repeat case; who is affected by the case etc,
2. evidence that gaps in organisational capacity are driving the erroneous use of health and safety – we focus in particular on problems of administrative, analytical and communicative capacity, and
3. evidence of public and media attention for the cases.

The central aim of analysis is to uncover any paths or patterns that lead to the five outcome categories used by the HSE. The analytical technique deployed to explore this is Qualitative Comparative Analysis (QCA). For non-random samples of qualitative cases (like the MBCP), QCA's Boolean analysis is the most powerful analytical tool. Our QCA analysis was exhaustive³; we explored how every logical combination of factors relate to the HSE's outcomes and also to other possible types of 'outcome' – e.g. issue salience and attention. We can say with confidence, there are no robust combinations of conditions that lead to particular outcomes; the data do not display meaningful configurations. Rather, the picture is one of variation across cases.

These findings do not imply that we cannot generate useful data by other means however. The second analytical strategy is to provide detailed descriptive statistics on the MBCP cases and the attention they have received thus far. These data provide a rich summary of the cases and highlight their key facets and data patterns – e.g. the populations that are predominantly affected; the types of risks that recur etc.

To go beyond description and provide inferential statistics – i.e. that posit relationships between different factors and outcomes – we need a sufficient sample size, cell counts of five or more and a random sample. In most instances, the first two conditions are satisfied. However, the 272 cases are not a random sample; we cannot infer to the wider (and unknown) universe of health and safety myths. Yet, there is reason to be hopeful that the MBCP cases are not too far off the universe. After two years of operation, nearly one-third of the cases (29.4%) have been the subject of 'repeat cases' – i.e. similar submissions that have been rejected for consideration⁴.

Given this, where appropriate, we use the third analytical strategy of testing for association. Where cell counts are sufficient we have run Chi-square tests; the findings are only reported where they meet the strictest test of significance ($p \leq 0.001$). What can be done with these findings? Clearly we are not

¹ Monitoring of webpage hits ended at case 219.

² Please contact the report author for access to the codebook.

³ I gratefully acknowledge the work of Dr Alessia Damonte of University of Milan who co-produced the QCA analysis.

⁴ These repeats may be higher if we include the 'Myth of the Month' cases from 2007-2010.

in a position to make any statements about generalisation or causation. Rather, where the sample is non-probabilistic, inferential findings provide the basis for further exploration of specific phenomena. For the MBCP, such exploration may take the form of hypotheses to be tested in future research, or in pilot communication strategies targeting particular groups.

The report is structured as follows. Section one summarises 272 MBCP cases: their origins; who are affected; the risk objects involved; and the three capacity gaps that underpin the cases. Section two deals with outcomes: across time; by sector; by issue type; and in relation to administrative, analytical and communicative capacity gaps that feature in the cases. Section three outlines the data on sector and explores how the main sectors covered in the MBCP cases relate to the three sets of organisational capacity challenges; and to those who are affected in the case. Section four outlines the data on the public and media attention given to the MBCP cases. The report concludes with areas for further action and future research.

SECTION 1: SUMMARISING THE MBCP CASES

Introduction This section describes the main features of the 272 MBCP cases analysed. We outline the breakdown of cases by year, the repeat cases and outcomes before exploring where the cases come from; who they involve; what issues they cover and what capacity gaps may be driving them.

1.1 The Basics: Cases, Repeats and Outcomes

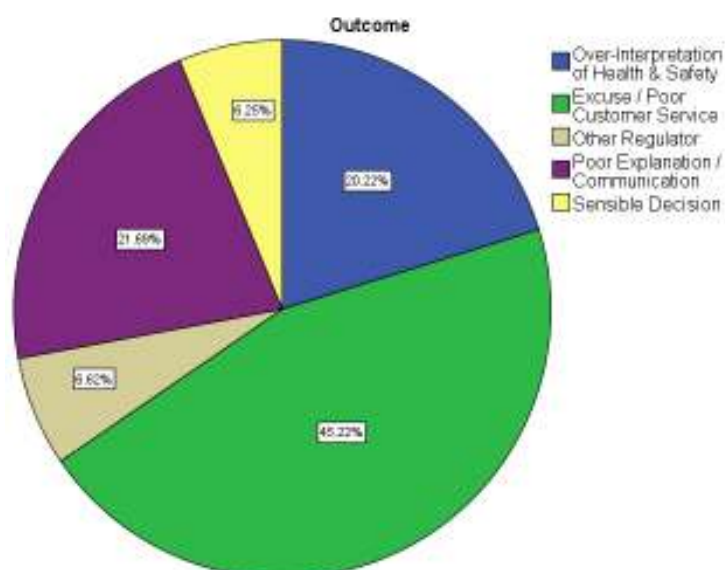
Table 1 and pie 1 describe the basics of the data. The number of cases is much lower in 2013/14 when compared with the very high number in 2012/13. Across the two years, almost a third of the cases (29.4%, N=80) have been reported more than once to the HSE – either as the exact same case or a similar type of scenario. There are 62 repeats of 2012/13 cases and 18 for 2013/14 cases (in calendar years this is 33 for 2012, 41 for 2013 and 6 for 2014).

Table 1: MBCP Cases by Year

Year	Frequency (number of cases)	%of total
2012/13	194	71.3
2013/14	78	28.7
Total	272	100.0

In terms of outcome, nearly half the cases are the result of an excuse / poor customer service (N=123) with poor explanation / communication (N=59) and over-interpretation of health and safety (N=55) making up most of the rest.

Pie Chart 1: Outcomes



Outcome	% of cases / N
Over-Interpretation	20.2 / N=55
Excuse	45.2 / N=123
Other Regulator	6.6 / N=18
Poor Communication	21.7 / N=59
Sensible Decision	6.3 / N=17

1.2 Case Origins: Region, Sector and Source

Where do the cases come from? We explore the origins of cases in three ways. First, we look at region. As table 2 demonstrates there is a good spread of cases across the UK – with citizens in all regions clearly aware of the initiative and contributing cases. The differences in numbers broadly maps on to population density.

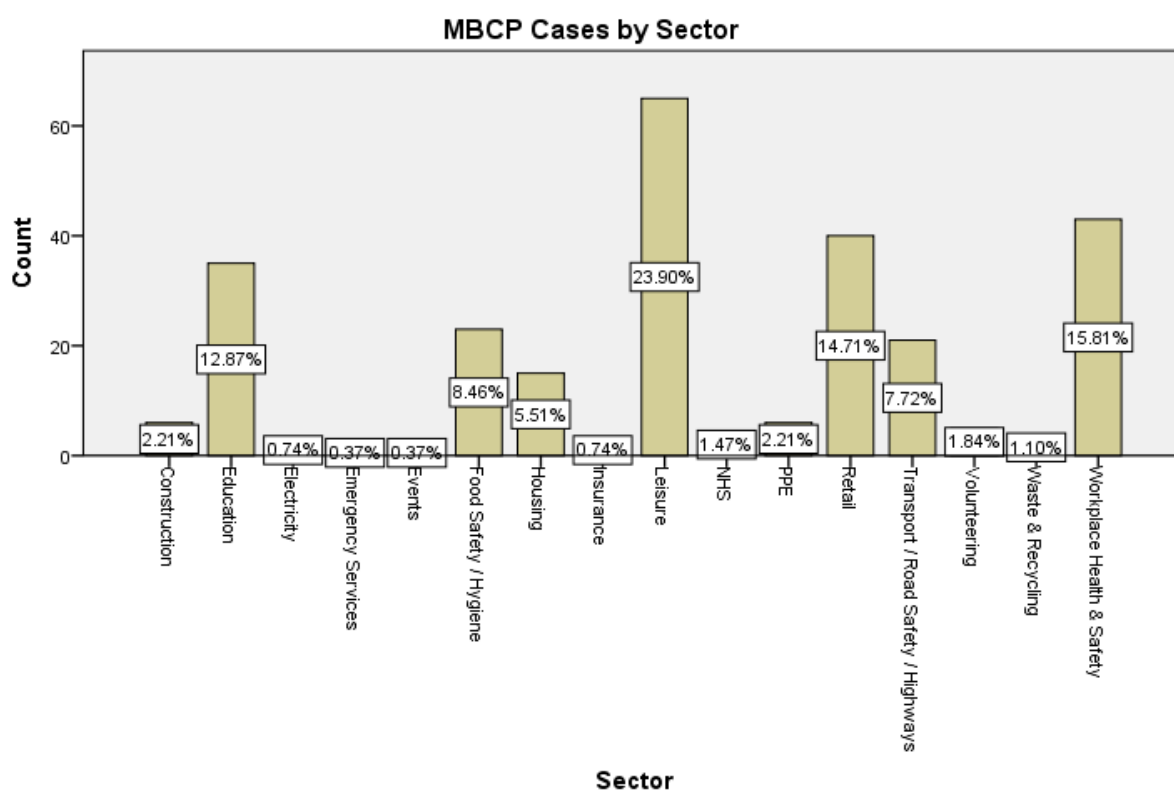
Table 2: Cases by Region

Region	Frequency (number of cases)	% of total
East and South East	63	23.2
London	32	11.8
Midlands	46	16.9
North West	23	8.5
Scotland	19	7.0
Wales and South West	30	11.0
Yorkshire and North East	41	15.1
Missing⁵	18	6.6
Totals	272	100.0

Next, we explore case origins by the sectors they cover. Using the HSE’s categories, we see that the cases are spread across sixteen sectors but are concentrated in seven areas (bar chart 1): leisure; workplace health and safety; retail; education; food safety; transport; and housing.

⁵ Missing cases are usually because a press story is the source of the case and its origins may not be specified.

Bar Chart 1: Cases by Sector



We look at where the cases come from in a third way; in terms of who is the ‘source’ of the issue – i.e. who ‘creates’ the myth in the first place. Source is coded by close reading of the cases and their associated notes. Eighteen categories were identified which offer an alternative way of understanding the spread of the cases (table 3). So, for example, we know that in the food safety sector cases deal with mainly cafés and restaurants. We also see from this data that local government is an important source of myths is not captured by the sector data alone. It is likely that in the sector data many of the local government cases are subsumed within the housing and workplace categories, but here we separate them.

Table 3: Source of the Issue

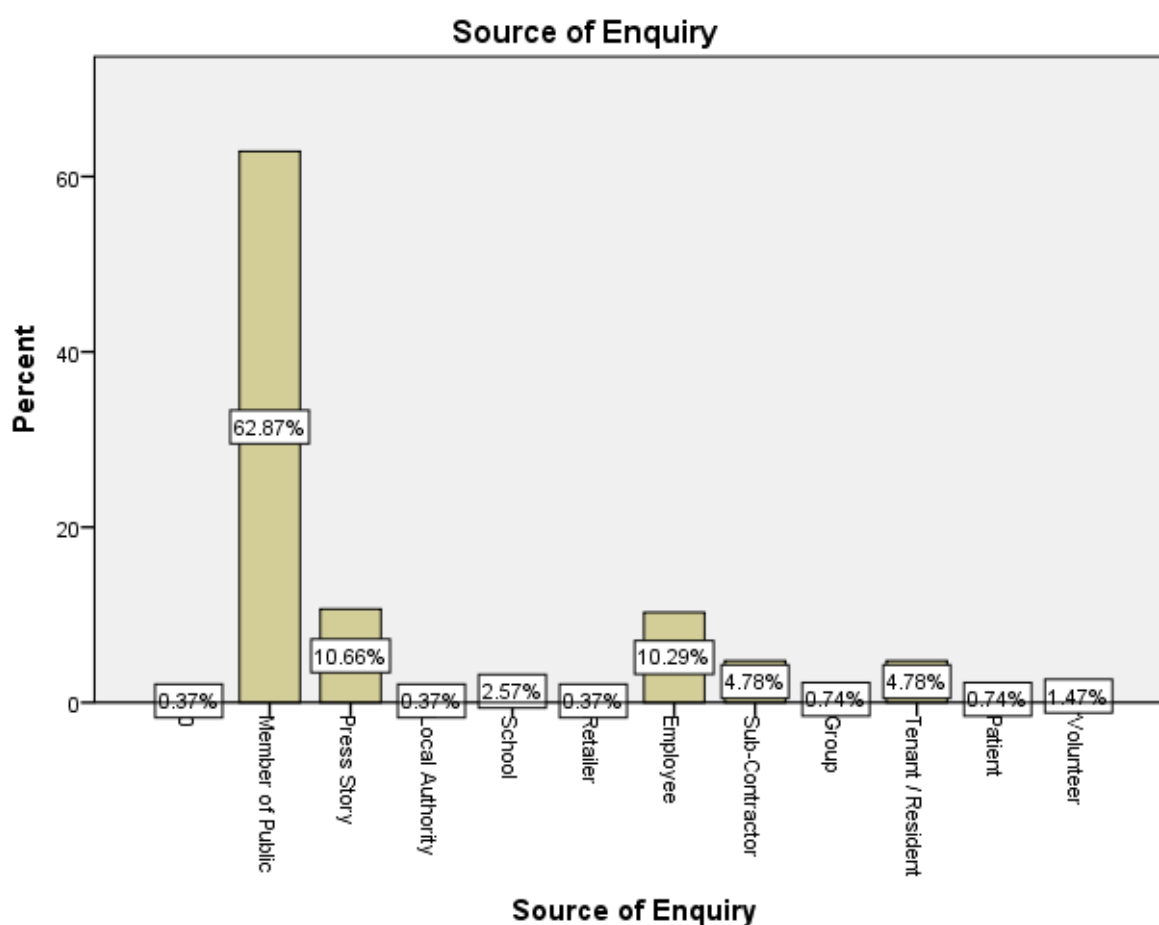
Source of the Myth	Frequency (number of cases)	% of total
Industry / Private Organisation	58	21.3
Education (nursery to university)	36	13.2
Gyms / Sports Clubs / Events	35	12.9
Retailer	33	12.1
Local Government	31	11.4
Food (café / restaurant)	19	7.0
Housing Association / Landlord	13	4.8
Charity / Church	9	3.3
Town / Borough / Parish Council	7	2.6
Hotels	6	2.2
Post Office / Royal Mail	5	1.8

Museum	4	1.5
National Government / Agencies	4	1.5
Rail	4	1.5
Hospital	3	1.1
Pubs	3	1.1
Health and Safety Officer / Consultant	1	0.4
Insurers	1	0.4
Total	272	100.0

1.3 Who are Affected?

Who are affected by the cases? We explore this in two ways. First, we coded who reported the suspected myth. This is tricky to code because the role of the member of the public is not always obvious from the available information. Where we can glean that the person making the report had a specific role in the case – for example, they are a housing tenant or a hospital patient – we have recorded it. Bar chart 2 illustrates that the majority of cases come from ordinary members of the public (63%) followed by the press (11%) and employees (10%).

Bar Chart 2: Who Reported the Case?



We also code the cases for the population groups affected by the suspected myth. We identified fourteen population categories that are implicated in the cases. As table 4 shows, there are three tiers

of populations that make up more than 4% of cases. First, we can think of people in their role as consumers as heavily affected (32.4%). Second, children, employees and citizens (as they engage with the public sector) very affected (19.9%; 12.5%; 12.1%). And third, specialist groups of hobbyists, tenants and sub-contractors are affected (6.3%; 4.8%; 4.0%).

Beyond consumers, citizens and employees – groups we would expect to be in the cases – some of the other populations perhaps stand out as worthy of attention. Children are very well-represented in the cases – frequently when in educational and leisure settings. This is reinforced by the data on ‘risk object’ (outlined in section 1.4) which shows the pre-eminence of issues that relate to children and fears about their safety (‘purity’ category – table 5). Hobbyists and tenants are also worthy of attention.

Given the recent focus on the impact of ‘elf and safety’ myths of volunteers, it is perhaps surprising that this group is found in only 2.9% of the cases. Of course, this could be an artefact of the sample itself. While we cannot rule out the role of coding in this low incidence, who is affected was coded in terms of the dominant messages in the cases. So, where the complaint was that volunteering or charitable works would be affected it was coded as such. Moreover, when we look at the source of the issue (table 3) and who reported it (bar chart 2) the voluntary sector is there but it is low.

Table 4: Who are Affected?

Population Affected	Frequency (number of cases)	% of cases
Consumers	88	32.4
Children	54	19.9
Employees	34	12.5
Citizens	33	12.1
Hobbyists / Amateur Sports	17	6.3
Tenants	13	4.8
Sub-Contractors	11	4.0
Volunteers	8	2.9
Patients	4	1.5
Education Officials	3	1.1
Retailer / Industry	2	0.7
Landlords	1	0.4
Protestors / Demonstrators	1	0.4
Public Administration Officials	1	0.4
Other / Missing	2	0.8
Total	272	100.0

1.4 Risk Objects

Next we explore what types of problems are involved in the cases. Here, we code in terms of the ‘risk object’ at the heart of the case. What are people purportedly being protected from? We identify ten categories of risk object in the cases (table 5). The majority of the categories are self-explanatory, however it is worth defining three in greater detail. The category we call ‘purity’ draws on the risk governance literature and concern those issues which relate to children, hygiene, drugs and ‘taboo’ issues. ‘Everyday’ issues are exactly that – spills from hot drinks, ladders, play-related, slips etc. ‘Risk society’ is again inspired by the risk literature which identifies a new group of risks that result from

changes in technology and security in the late twentieth century. So, here we are thinking about mobile phones, genetically modified organisms (GMOs), terror alerts, etc.

Everyday risks, which are perhaps best negotiated with common sense, dominate the MBCP. These mundane matters account for nearly one third of the cases (31.6%) and contrasts sharply with the much vaunted technological dilemmas of the risk society which account for only 2.6% of cases. Neither the importance of workplace risks, nor the framing of purchased goods as posing risks, is surprising.

As noted earlier, issues that often relate to children – in the ‘purity’ category – account for just over a fifth of the cases. Typical examples of this would be case [123](#) where a child is stopped from bringing hot food to school in a flask and case [119](#) where a mother and child were escorted to a shop toilet on health and safety grounds.

Finally, while it is low, the treatment of disability as a risk issue is also notable and something which has not been brought into relief in other data.

Table 5: What are the Risks?

Risk Object	Frequency (number of cases)	% of cases
Everyday	86	31.6
Purity	57	21.0
Workplace	50	18.4
Purchased Goods	33	12.1
Group Event / Gathering	15	5.5
Garden / DIY	13	4.8
Disability	7	2.6
Risk Society	5	1.8
Transport	3	1.1
Weather	2	0.7
Missing	1	0.4
Total	272	100.0

1.5 What Capacity Challenges Underpin the Cases?

We want to understand what factors may be driving health and safety myths. The data do not allow us to make any statements on causation. However, the wider literature on risk communication and blame avoidance, and the qualitative analysis of the cases themselves, suggest that there will be gaps and problems in organisational capacity that recur across the cases.

1.5.1 Administrative Capacity

Here, we identify three sets of capacity problems that may underpin some of the cases. First, we look at what we call *administrative capacity*. Specifically, we focus on five resource management and the operational challenges that may affect how decisions are negotiated. We code cases for evidence that each case is linked to:

1. economic cost avoidance
2. income generation
3. other resource constraints (e.g. time)

4. training deficiencies
5. fear of legal action

Table 6: Administrative Capacity Challenges

Administrative Capacity Challenges	Frequency (number of cases)	% of total cases (N=272)
Evidence that the case is linked to economic cost avoidance	68	25.0
Evidence that the case is linked to income generation	23	8.5
Evidence that the case is linked to resource constraints	25	9.2
Evidence that the case is linked to training deficiencies	107	39.3
Evidence that the case is linked to fear of legal action	76	27.9

1.5.2 Analytical Capacity

Next we look at a group of elements we think of as *analytical capacity* challenges. Specifically we code the cases for five pieces of evidence that may suggest a lack of understanding or comprehension of the nature of the risk at hand. We look for evidence that each case is underpinned by:

1. a 'better safe than sorry' risk averse attitude
2. an incorrect assumption that regulations exist
3. complexity
4. confusion about what the HSE regulates
5. an incident that resulted in injury

As table 7 illustrates, the first two of these analytical gaps are frequently found across the cases.

Table 7: Analytical Capacity Challenges

Analytical Capacity Challenges	Frequency (number of cases)	% of total cases (N=272)
Evidence that the case is linked to a 'better safe than sorry' risk averse attitude	161	59.2
Evidence that the case is linked to an incorrect assumption that regulations exist	86 ⁶	31.6
Evidence that the case is linked to complexity	27	9.9
Evidence that the case is the result of confusion about what the HSE regulates	26	9.6
Evidence that the case is result of an incident that resulted in injury	22	8.1

1.5.3 Communicative Capacity

Finally, we explore the extent to which *communicative capacity* issues might feature in the MBCP cases. Here we are interested in evidence that particular communication barriers play a part in the generation of myths. We look at three in particular:

1. attempts to establish an informal norm or local rule
2. evidence of that an identifiable person could be blamed for an alternative decision
3. evidence that the case is linked to aesthetic concerns that may be unpopular

Table 8: Communicative Capacity Challenges

Communicative Capacity Challenges	Frequency (number of cases)	% of total cases (N=272)
Evidence that the aim is to establish an informal norm or rule	17	6.3
Evidence of an identifiable person involved who could be blamed for an alternative decision	101	37.1
Evidence that the case is linked to aesthetic concerns	80	29.4

⁶ In these cases, the misunderstanding is *not* generated from poorly drafted or unclear legislation but rather from: an over-interpretation of health and safety (N=34); poor customer service / excuse (N=27) or poor communication (N=18).

SECTION 2: OUTCOMES

Introduction As outlined in section 1, the HSE categorises each MBCP case into one of five outcomes: over-interpretation of health and safety; excuse poor customer service; other regulator; poor explanation/communication; and sensible decision. We examine the spread of the outcomes overall; across time and across sectors. We then describe how the outcomes relate to different issue types; the source of the issue, and who is affected by the case. Finally, we outline the frequency with which capacity gaps and needs are associated with different outcomes.

2.1 Outcome Breakdown

Table 9 details the breakdown of all MBCP cases by outcome. Over-interpretation, poor customer service and poor communication clearly make up the bulk of the cases.

Table 9: Cases by Outcome

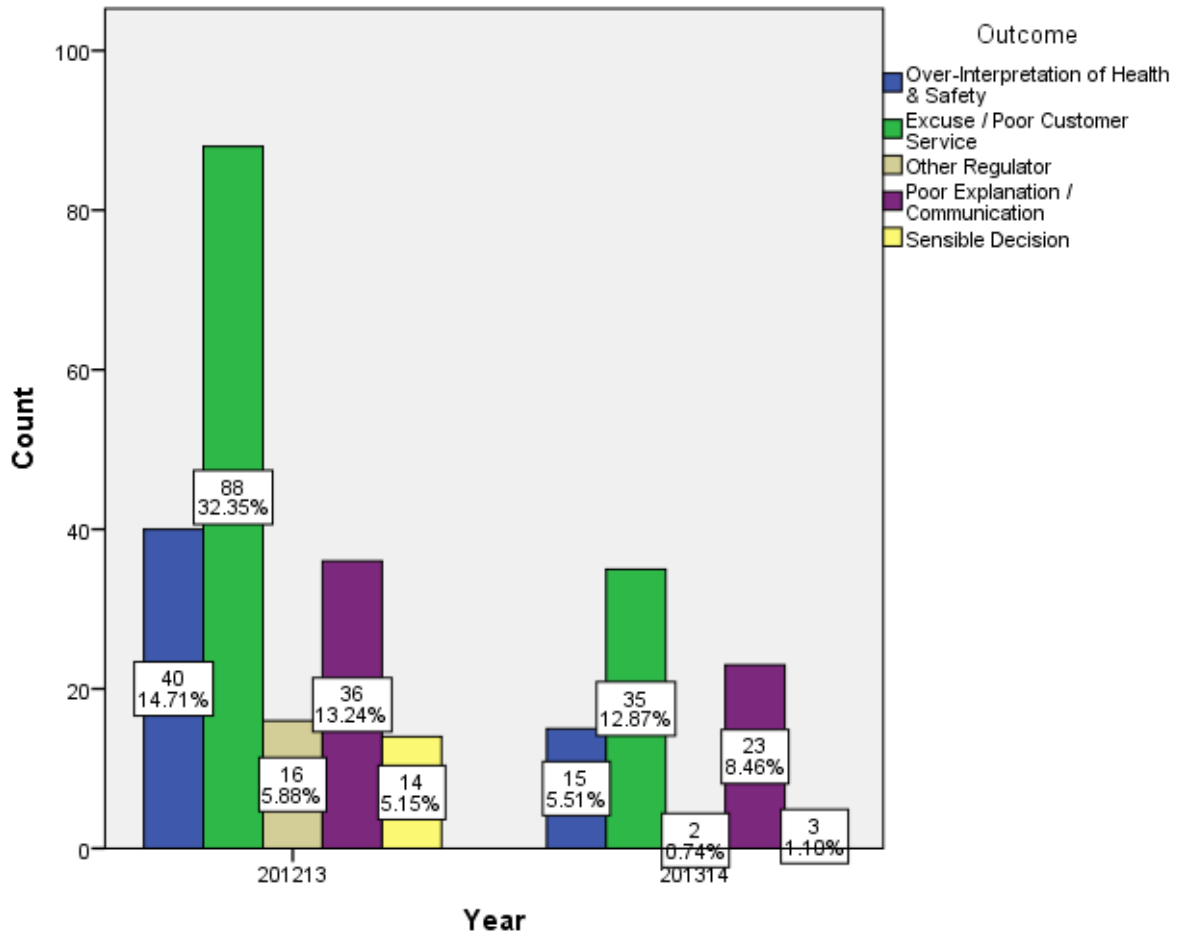
Outcome	Frequency (number of cases)	%
Over-interpretation of health and safety	55	20.2
Excuse / poor customer service	123	45.2
Other regulator	18	6.6
Poor explanation / communication	59	21.7
Sensible decision	17	6.3
Total	272	100.0

2.2 Outcomes in Time

How do these outcomes look over time? Described in bar chart 3, in 2013/14 with the MBCP more established all the cases have decreased but none of the decreases are disproportionate given the number of cases analysed in each year. Slight variations may also be explained by repeat cases the reporting of which increased from 38 in 2012/13 to 72 in 2013/14⁷.

⁷ We should note that the date when repeat cases were reported is distinct from the date of the cases they repeated (see Section 1 for a breakdown of the latter).

Bar Chart 3: Outcomes 2012/13 and 2013/14



2.3 Outcome by Sector

What sectors are associated most frequently with what outcomes? Here we take each outcome in turn.

2.3.1 Over-interpretation by Sector

Over-interpretation of health and safety cases are found in thirteen of the sixteen sectors with the majority from workplace health and safety, education and leisure (table 10). Construction, education and workplace health and safety are slightly higher than would be expected on the basis of the sample, and food hygiene and leisure slightly lower.

Table 10: Outcome 1 – Over-Interpretation of Health and Safety

Sector	Frequency (number of cases)	% of Over-Interpretation Cases (N=55)
Construction	4	7.3
Education	13	23.6
Electricity	1	1.8
Events	1	1.8
Housing	3	5.5
Leisure	6	10.9
NHS	1	1.8
PPE	3	5.5
Retail	3	5.5
Transport / Road Safety / Highways	2	3.6
Volunteering	1	1.8
Workplace Health & Safety	17	30.9
Total	55	100.0

2.3.2 Excuse / Poor Customer Service by Sector

Cases of poor customer service – which make up the majority of the outcomes – are similarly spread across the sectors (twelve of the sixteen). But, leisure and retail dominate accounting for 27.6% and 23.6% of this outcome. Food hygiene and workplace health and safety are also well-represented (12.2% and 11.4%). Only retail is slightly over-represented in this outcome category, and no sector is under-represented.

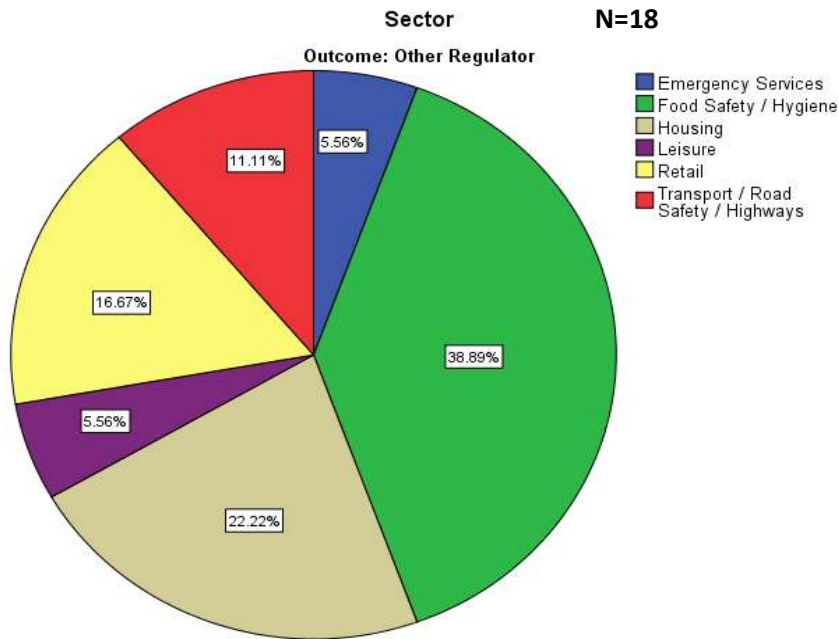
Table 11: Outcome 2 – Excuse / Poor Customer Service

Sector	Frequency (number of cases)	% of Excuse Cases (N=123)
Education	10	8.1
Food Safety / Hygiene	15	12.2
Housing	4	3.3
Insurance	2	1.6
Leisure	34	27.6
NHS	2	1.6
PPE	2	1.6
Retail	29	23.6
Transport / Road Safety / Highways	8	6.5
Volunteering	3	2.4
Workplace Health & Safety	14	11.4
Total	123	100.0

2.3.3 Referred to Other Regulator by Sector

As we would expect, where they are for another regulator cases are concentrated across a few sectors (see pie chart 2) – food safety accounts for 38.89% of these cases; housing 22.2% and retail 16.67%. Food safety, housing and emergency services are all over-represented in this outcome; no sectors are under-represented.

Pie Chart 2: Outcome 3 – Other Regulator



2.3.4 Poor Explanation / Communication by Sector

The fourth outcome is poor explanation / communication, and covers 59 of the 272 cases. This outcome is found in twelve of the sixteen sectors, but the category is dominated by cases from the leisure sector (30.5%), education (16.9%) and workplace health and safety (16.9%). No sectors were under-represented, and only waste & recycling was over-represented.

Table 12: Outcome 4 – Poor Explanation / Communication

Sector	Frequency (number of cases)	% of Poor Explanation Cases (N=59)
Construction	1	1.7
Education	10	16.9
Electricity	1	1.7
Food Safety / Hygiene	1	1.7
Housing	4	6.8
Leisure	18	30.5
NHS	1	1.7
PPE	1	1.7
Retail	3	5.1
Transport / Road Safety / Highways	5	8.5
Volunteering	1	1.7
Waste & Recycling	3	5.1
Workplace Health & Safety	10	16.9
Total	59	100.0

2.3.5 Sensible Decision by Sector

The final outcome – sensible decision – covers only 17 of the 272 cases. Table 13 below illustrates that this is found in only six categories with leisure and transport dominating. Indeed, transport is over-represented in this outcome.

Table 13: Outcome 5 – Sensible Decision

Sector	Frequency (number of cases)	% of Sensible Decision Cases (N=17)
Construction	1	5.9
Education	2	11.8
Leisure	6	35.3
Retail	2	11.8
Transport / Road Safety / Highways	4	23.5
Workplace Health & Safety	2	11.8
Total	17	100.0

2.3.6 What Sectors Dominate the Three Main Outcomes?

In looking at the sector data across the three key outcomes – over-interpretation; excuse / poor customer service and poor explanation / communication – three sectors dominate (table 14). The presence of workplace health and safety across these three outcomes is perhaps unsurprising. But, the pre-eminence of the education and leisure sectors is notable.

Table 14: What Sectors Dominate the Key Outcomes?

Sector	% of Cases Over-Interpretation (55 cases)	% of Cases Excuse / Poor Customer Service (123 cases)	% of Cases Poor Explanation (59 cases)
Education	23.6	8.1	16.9
Leisure	10.9	27.6	30.5
Workplace Health and Safety	30.9	11.4	16.9

2.4 Outcomes and Issue Types

We move beyond sectors to get more fine-grained detail on the types of issues that make up the three main outcomes. In particular, we coded the data to explore the risk objects at stake; the source of the problem; and the population groups affected.

2.4.1 Outcomes and Risk Objects

Table 5 (in Section 1) summarises the type of risks identified for each case. When we break these down by outcome, focussing on the three main outcomes described above, the trend remains broadly the

same for each outcome. As table 15 shows everyday issues; those relating to purity (e.g. children and food); and workplace risks dominate the outcome categories. Purchased goods are only important with regard to poor customer service cases.

In the over-interpretation outcome, workplace risks are over-represented, while purchased goods are under-represented. The reverse is the case where the myth is the result of poor customer service: workplace risks show up less than we would expect and purchased good are over-represented. Finally, for poor explanation cases, only purchased goods were found to be disproportionate – they are under-represented.

Table 15: What Risk Objects Dominate the Key Outcomes?

Risk Objects	% in Over- Interpretation (55 cases)	% in Excuse / Poor Customer Service (123 cases)	% in Poor Explanation (59 cases)
Everyday Issues	34.5	31.7	30.5
Purity Issues	18.2	22.0	16.9
Workplace	36.4	5.7	28.8
Purchased Goods	1.8	24.4	1.7

2.4.2 Outcome and Source of the Problem

We now look at the source of the issue or problem – i.e. who or what organisation generated the myth? Five sources dominate (see table 3, in Section 1). When we categorise these by outcome, we find that: industry is over-represented in the over-interpretation outcome; retail cases are more frequent than expected in the poor customer service outcome; and gym and sports related cases are over represented in poor communication cases while retail is under-represented.

Beyond the five pre-eminent sources, there are some noteworthy examples of sectors that are found more frequently and less than expected. In the over-interpretation outcome food (cafés/restaurants) appears less than expected (at 3.8% within that outcome). In the outcome concerning excuse / poor customer service at 6.5% charities / churches are over-represented.

Table 16: What Issue Sources Dominate the Key Outcomes?

Source	% in Over- Interpretation (55 cases)	% in Excuse / Poor Customer Service (123 cases)	% in Poor Explanation (59 cases)
Industry / Private Organisation	40.0	15.4	22.0
Education	21.8	8.1	20.3
Retailers	5.5	21.1	1.7
Gym / Sports Clubs	3.6	13.0	22.0
Local Government	10.9	8.9	15.3

2.4.3 Outcome and the Affected

Finally, we look at outcomes in terms of who are affected each case. Recall, that we outlined three tiers of people affected by MBCP cases: consumers are heavily affected (32.4% of all cases); children, employees and citizens very affected (19.9%; 12.5%; 12.1%); and specialist groups of hobbyists, tenants and sub-contractors are affected (6.3%; 4.8%; 4.0%) (table 4, in Section 1 provides the full breakdown). We explore how these groups are represented in the three key outcomes.

Employees are most affected by cases of over-interpretation; consumers bear the brunt of poor customer service, and poor communication is spread across the main population groups. What is notable though is the extent to which children are represented in the outcomes. This reinforces the data on issue type where ‘purity’ issues can be found in the three key outcome cases (table 17). That amateur sports people and tenants are found across the outcomes may also be of interest.

In terms of representation of populations in each outcome, we find that employees and sub-contractors appeared more frequently in the over-interpretation outcome than expected, while consumers are under-represented. In the excuse / poor customer service outcome sub-contractors are under-represented and consumers over-represented. Consumers are under-represented in the poor explanation category.

Table 17: What Populations are Affected by Outcomes?

Population Affected	% in Over- Interpretation (55 cases)	% in Excuse / Poor Customer Service (123 cases)	% in Poor Explanation (89 cases)
Consumers	14.5	49.6	10.2
Children	20.0	17.1	25.4
Employees	25.5	6.5	18.6
Citizens	5.5	13.0	15.3
Hobbyists / Amateur Sports	3.6	5.7	10.2
Tenants	5.5	3.3	5.1
Sub-Contractors	10.9	0.8	5.1

2.5 Organizational Capacity and Outcomes

Finally, we look at the organizational capacity gaps introduced earlier (in Section 1). Taking the instances where these capacity gaps are present we explore where they are found in the outcome categories. In addition to the descriptive analysis, tests of association were also conducted for all of these data. Clearly, we must emphasise that this is not a random sample and so any significant findings cannot be inferred beyond the MBCP cases. But, by applying the strictest significance level ($p \leq 0.001$) we hope to uncover evidence of potential associations that could be the subject of further investigation, or form the basis of a hypothesis to be explored.

Table 18 deals with administrative capacity issues. Recall, this concerns the rules, training and policies that companies, local government, schools etc have in place to guide their work. Significance tests suggest that cost avoidance and fear of legal action may be fruitful areas for further investigation⁸. Specifically, there is very strong evidence that fear of legal action is over-represented in over-interpretation cases and under-represented in poor customer service cases, that cost avoidance is

⁸ Cost Avoidance Chi-square = 28.230, df = 8, $p \leq 0.001$; Fear of Legal Action Chi-square = 26.862, df = 8, $p \leq 0.001$.

over-represented in poor customer service cases. With regard to this latter situation case [132](#) is typical where a hairdresser refuses to give a customer a drink on health and safety grounds.

Table 18: How Administrative Capacity Challenges Link to Outcomes

Administrative Capacity Challenges	Over-Interpretation	Excuse / Poor Customer Service	Poor Explanation
% within evidence that the case is linked to cost avoidance (68 cases)	11.8	69.1	11.8
% within evidence that the case is linked to income generation (23 cases)	21.7	56.5	8.7
% within evidence that the case is linked to resource constraints (25 cases)	16.0	60.0	24.0
% within evidence that the case is linked to training deficiencies (107 cases)	21.5	51.4	15.0
% within evidence that the case is linked to fear of legal action (76 cases)	35.5	28.9	25.0

Table 19 outlines where analytical capacity challenges are found in the outcomes. Analytical capacity concerns the factors that may prevent individuals and organisations from understanding the context within which they make a decision. Significance tests highlight the potential importance of two analytical capacity issues: ‘better safe than sorry’ risk averse attitudes and evidence of an incorrect assumption that regulations exist⁹. There is very strong evidence that, in this sample, a risk averse attitude is under-represented in excuse or poor customer service cases. While incorrect assumptions are over-represented in over-interpretation cases.

⁹ ‘Better Safe than Sorry’ Risk Averse Chi-square = 26.507, df = 8, p<0.001; Incorrect Assumptions of Regulation Chi-square =38.696, df =8, p<0.001.

Table 19: How Analytical Capacity Challenges Link to Outcomes

Analytical Capacity Challenges	Over-Interpretation	Excuse / Poor Customer Service	Poor Explanation
% within evidence that the case is linked to a 'better safe than sorry' risk averse attitude (161 cases)	25.5	34.2	24.8
% within evidence that the case is linked to an incorrect assumption that regulations exist (86 cases)	39.5	31.4	20.9
% within evidence that the case is linked to complexity (27 cases)	18.5	29.6	18.5
% within evidence that the case is the result of confusion about what the HSE regulates (26 cases)	23.1	38.5	30.8
% within evidence that the case is result of an incident that resulted in injury (22 cases)	22.7	9.1	27.3

Table 20 outlines how communicative capacity gaps are distributed across the three main outcomes. Significance tests offer no leads for further analysis.

Table 20: How Communicative Capacity Challenges Link to Outcomes

Communicative Capacity Challenges	Over-Interpretation	Excuse / Poor Customer Service	Cases Explanation	Poor
% within evidence that the aim is to establish an informal norm (17 cases)	35.3	17.6	29.4	
% within evidence of an identifiable person involved who could be blamed for an alternative decision (101 cases)	19.8	46.5	22.8	
% within evidence that the case is linked to aesthetic concerns (80 cases)	11.3	56.3	22.5	

SECTION 3: SECTORS

Introduction This section summarises the data on sectors. We look at how the main seven sectors relate to the three sets of organisational capacity challenges identified, and to those affected in the case. We cannot go beyond descriptive data here because there are too few cases in too many of the cells which prevents significance test validation.

3.1.1 Sector and Administrative Capacity Challenges

Table 21 outlines where administrative capacity challenges are present across the main sectors of the MBCP cases. The data are as expected, in terms of the sample, with the exception of the number of retail cases with training deficiencies which were higher than expected.

Table 21: Administrative Capacity Challenges in the Seven Main Sectors

Administrative Capacity Challenges	% in Leisure (65 cases)	% in Workplace H&S (43 cases)	% in Retail (40 cases)	% in Education (35 cases)	% in Food Safety (23 cases)	% in Transport (21 cases)	% in Housing (15 cases)
Evidence that the case is linked to cost avoidance	6.2	18.6	37.5	11.4	43.5	19.0	26.7
Evidence that the case is linked to income generation	13.8	2.3	10.0	0.0	17.4	9.5	6.7
Evidence that the case is linked to resource constraints	9.2	7.0	10.0	5.7	8.7	14.3	20.0
Evidence that the case is linked to training deficiencies	36.9	32.6	62.5	34.3	43.5	23.8	53.3
Evidence that the case is linked to fear of legal action	26.2	27.9	20.0	34.3	8.7	23.8	20.0

3.1.2 Sector and Analytical Capacity Challenges

Table 22 describes where analytical challenges are found in the sectors. Food safety is under-represented in terms of the presence of a better safe than sorry attitude and prevalence of incorrect assumptions. No sectors were over-represented in any of the analytical capacity gaps.

Table 22: Analytical Capacity Challenges in the Seven Main Sectors

Analytical Challenges	Capacity	% in Leisure (65 cases)	% in Workplace H&S (43 cases)	% in Retail (40 cases)	% in Education (35 cases)	% in Food Safety (23 cases)	% in Transport (21 cases)	% in Housing (15 cases)
Evidence that the case is linked to a 'better safe than sorry' risk averse attitude		61.5	60.5	55.0	77.1	21.7	57.1	66.7
Evidence that the case is linked to an incorrect assumption that regulations exist		23.1	39.5	40.0	28.6	8.7	14.3	53.3
Evidence that the case is linked to complexity		10.8	9.3	0.0	2.9	17.4	42.9	6.7
Evidence that the case is the result of confusion about what the HSE regulates		6.2	14.0	10.0	11.4	8.7	14.3	13.3
Evidence that the case is result of an incident that resulted in injury		9.2	9.3	2.5	2.9	8.7	14.3	0.0

3.1.3 Sector and Communicative Capacity Challenges

Table 23 outlines where communication gaps are found in the seven main sectors. Again the data are as we expect with only one exception. There are more housing cases where decisions have suggested that an informal, local rule is being established without official sanction.

Table 23: Communicative Capacity Challenges in the Seven Main Sectors

Communicative Capacity Challenges	% in Leisure (65 cases)	% in Workplace H&S (43 cases)	% in Retail (40 cases)	% in Education (35 cases)	% in Food Safety (23 cases)	% in Transport (21 cases)	% in Housing (15 cases)
Evidence that the aim is to establish an informal norm	4.6	4.7	5.0	8.6	0.0	4.8	33.3
Evidence of an identifiable person involved who could be blamed for an alternative decision	43.1	27.9	35.0	42.9	34.8	28.6	53.3
Evidence that the case is linked to aesthetic concerns	32.3	37.2	20.0	28.6	30.4	38.1	26.7

3.2 Sectors and Who are Affected?

Table 24 describes the main populations affected in each of the seven main sectors. In leisure the populations are as we would expect. Though the residual data suggest that hobbyists and amateur sports people are over-represented, the nature of the category makes this unlikely. The data on workplace health and safety cases; education; food safety and housing are as we would expect. Children are slightly under-represented in retail and transport but again this makes sense given the nature of the sectors.

Table 24: Main Actors Affected in the Seven Main Sectors

Population Affected	% in Leisure (65 cases)	% in Workplace H&S (43 cases)	% in Retail (40 cases)	% in Education (35 cases)	% in Food Safety (23 cases)	% in Transport (21 cases)	% in Housing (15 cases)
Consumers	30.8	25.6	75.0	2.9	73.9	33.3	0.0
Children	29.2	11.6	2.5	74.3	13.0	0.0	0.0
Employees	0.0	37.2	2.5	5.7	4.3	14.3	0.0
Citizens	15.4	11.6	12.5	2.9	0.0	33.3	6.7
Hobbyists / Amateur Sports	23.1	0.0	0.0	0.0	8.7	0.0	0.0
Tenants	0.0	0.0	0.0	0.0	0.0	0.0	86.7
Sub-Contractors	0.0	9.3	5.0	0.0	0.0	9.5	0.0

SECTION 4: PUBLIC AND MEDIA ATTENTION

Introduction This section outlines data that relate how the MBCP cases have been received by the public and media.

4.1 Public Engagement

We explore the debate generated by the MBCP cases in terms of the public attention they have received. We coded the HSE's enquiries database and found a total of 568 enquiries – 256 in 2012/13 and 312 in 2013/14. Of these, 110 were reports of cases that repeated or were similar to ones that had already been dealt with by the panel. 80 distinct repeat cases were found in total – these were spread across the outcomes and sectors proportionately.

The enquiries database also records cases where member of the public have queried cases or decisions – we found 29 of these in the 272 cases (10.7%).

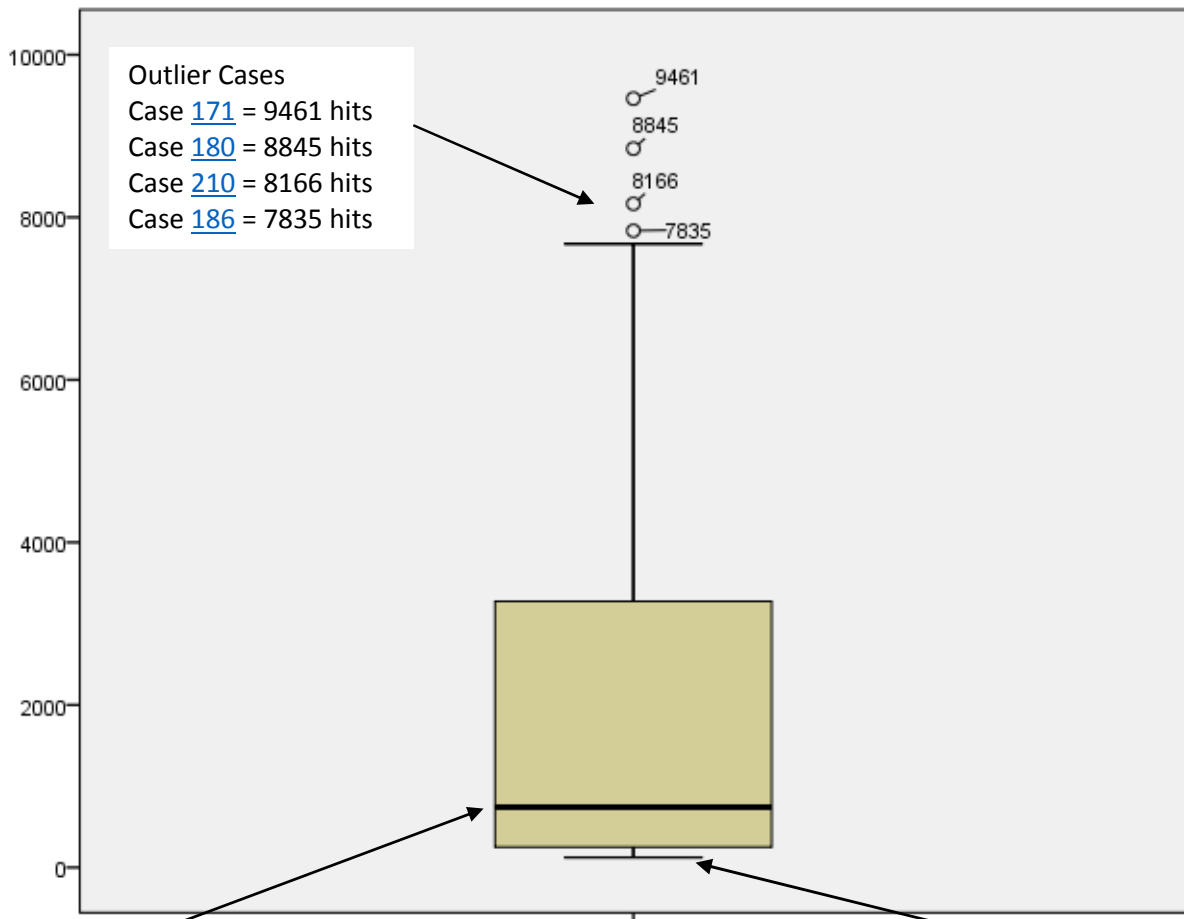
4.2 Web Data

Next we explore public attention to the MBCP stories using the web data available for 219 of the cases.

4.2.1 Web Hits by Visit

We find that all but three of the case webpages – on football being banned in primary schools; refusal to cut a piece of wood to size; and housing management company charging for 'health and safety inspections' (case ids [108](#); [155](#); [156](#)) – have recorded visits¹⁰. The lowest number of hits recorded for a case is 124 ([case 63](#) – furniture purchase) while the highest is 9461 hits for the hairdryers in gym case ([case id 171](#)). The frilly socks ban ([180](#)); refusal to add strawberry sauce and nuts to ice cream ([210](#)) and refusal of spare parts and manual ([186](#)) cases follow close behind as the most popular. The boxplot summarises the web hit rate by visit.

¹⁰ We treat these three 'no visits' with caution. Given that the lowest number of hits is 124, it seems unlikely that the next lowest would be zero.



Boxplot: MBCP Case Web Hits by Visits 216 / 219 cases

Median 741.50 hits
 50% cases are on or below this hit number

Minimum = 124 hits
 ([case 63](#))

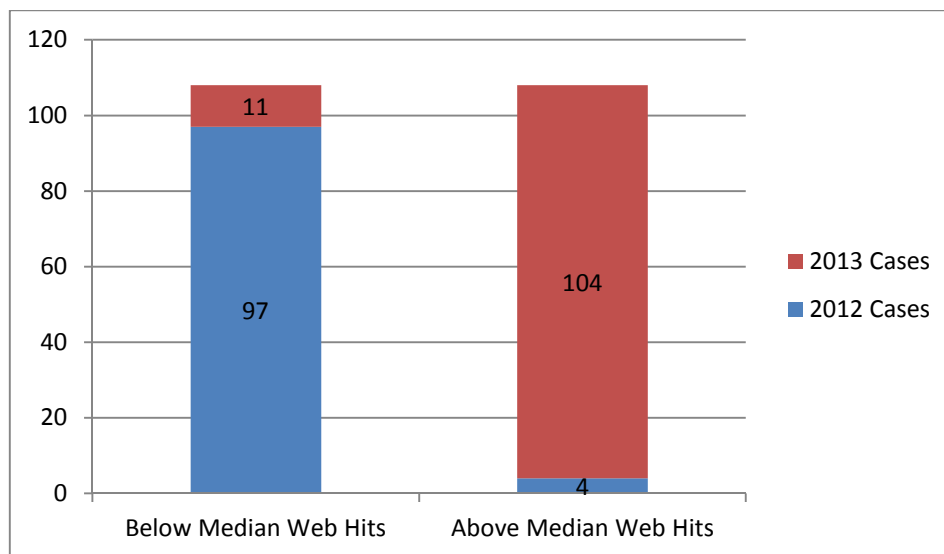
4.2.2 Average Number of Seconds by Page

We also analyse the average number of seconds spent on the case webpages. In the 216 cases visited, the average number of seconds spent on the page ranged between 19 and 130 seconds; with a median of 44 seconds. These times do not seem particularly short for webpages whose content is as succinct as the MBCP cases.

4.2.3 Web Hits by Time

For 2012/13 cases, there is an even split between web hits below and above the median – 107 case below and 84 above. This trend reverses for 2013/14 cases with 1 below and 24 above. This hit rate picture is clearer if we consider the trend across calendar years. Bar chart 4 demonstrates that as the MBCP took off and as people signed up for the email digest, hit rates for 2013 cases increased.

Bar Chart 4: Web Hits Above and Below the Median for 2012/13 and 2013/14 Cases



4.2.4 Web Hits by Sector

Table 26 outlines web hits by sector. The balance within each sector is evenly matched with the exception of housing; retail, and workplace health and safety whose above median rates are higher than expected.

Table 26: Web Hits by Sector

Sector	% Below Median Web Hits (108 cases)	% Above Median Web Hits (108 cases)
Construction	3.0	1.9
Education	11.1	13.9
Electricity	1.9	0.0
Emergency Services	0.9	0.0
Food Safety / Hygiene	11.1	7.4
Housing	6.5	3.7
Insurance	0.9	0.9
Leisure	25.0	25.9
NHS	2.8	0.9
PPE	3.7	1.9
Retail	9.3	16.7
Transport / Road Safety / Highways	10.2	6.5
Volunteering	2.8	1.9
Waste & Recycling	2.8	0.0
Workplace Health & Safety	7.4	18.5

4.2.5 Outcomes by Web Hits

Finally, we examine the interrelation between cases outcomes and number of hits. As table 27 shows, those cases where the myth was the result of an excuse or poor communication both achieve more hits on the HSE site. This is unsurprising given that these stories are more plentiful, and are often more entertaining and outlandish than myths that arise from an over-interpretation.

Table 27: Linking Web Hits to Outcomes

Web Hits by Visits	% in Over- Interpretation (39 cases)	% in Excuse / Poor Customer Service (100 cases)	% in Poor Explanation (44 cases)
Below Median Hits	61.5	46	38.6
Above Median Hits	38.5	54	61.4

4.3 Press Attention

4.3.1 Press Coverage of the Panel and Cases

Finally, we analyse the media attention recorded for MBCP itself and its stories. The HSE's media monitoring data (supplied by Gorkana) contains 2066 stories in total: 1306 in 2012/13 and 755 for 2013/14¹¹. These stories deal with health and safety themes generally, not only the MBCP and 'elf and safety' culture stories.

The panel itself is explicitly referred to in 254 stories. There were 181 panel-related stories in 2012/13 and 73 in 2013/14. Though the media data for 2013/14 covers eleven not twelve months (up to the end of February 2014), the drop-off in coverage is noteworthy.

Turning to the cases, 58 of the 272 cases have been covered in 183 national, regional or specialist press stories (table 27). The stories are in single figures for all but two cases. [Case 92](#) has by far the most coverage – 41 stories – but this conkers case originated as a press story. Next comes the golf buggies case which has 13 stories (case id [37](#)) and two cases that each have nine stories (case ids [26](#); [38](#)) on Blu Tack® in schools and postal deliveries.

4.3.2 Press Coverage by Time, Sector, Affected and Outcome

The majority of press stories (52 of 58) relate to cases from the first year of the MBCP 2012/2013. Included in these are the four cases with the highest level of press attention (ids 26; 37; 38; 92) which are all from 2012 (calendar year).

Table 28 outlines the twelve sectors these stories cover (all the seven main sectors are represented); the press story data broadly maps on to the MBCP cases as a whole. Tables 29 and 30 outline press stories by who are affected and outcomes respectively, and tell a similar story where the press stories map broadly onto the wider MBCP case characteristics.

¹¹ The data for 2013/14 covers eleven not twelve months (up to the end of February 2014).

Table 28: Press Stories by Sector

Sector	% in Press Stories (58)	% in MBCP (272 cases)
Education	17.2	12.87
Food Safety / Hygiene	6.9	8.46
Housing	1.7	5.51
Insurance	1.7	0.74
Leisure	24.1	23.9
NHS	5.2	1.47
PPE	1.7	2.21
Retail	13.8	14.71
Transport / Road Safety / Highways	8.6	7.74
Volunteering	1.7	1.84
Waste & Recycling	3.4	1.10
Workplace Health & Safety	13.8	15.81

Table 29: Press Stories by Affected

Who are Affected?	% in Press Stories (58)	% in MBCP (272 cases)
Citizens	19.0	12.1
Children	20.7	19.9
Retailer / Industry	1.7	0.7
Education Officials	3.4	1.1
Public Admin / Govt	1.7	12.5
Employees	6.9	12.5
Consumers	31.0	32.4
Amateur Sports / Hobbyists	5.2	6.3
Sub-Contractors	3.4	4.0
Patients	3.4	1.5
Volunteers	1.7	2.9
Tenants	1.7	4.8

Table 30: Press Stories by Outcome

Outcome	% in Press Stories (58)	% in MBCP (272 cases)
Over-Interpretation of Health & Safety	19.0	20.2
Excuse / Poor Customer Service	55.2	45.2
Other Regulator	8.6	6.6
Poor Explanation / Communication	15.5	21.7
Sensible Decision	1.7	6.3
Total	100.0	100.0

4.3.3 Relating Press and Web Coverage

We look at how those cases with most press attention fare in terms of web attention (table 31). The press stories are evenly split in terms of web hits on the case page on the MBCP website: 31 cases (56.4%) are below the median and 24 cases (43.6%) are above¹². Yet, this even split does not provide the full picture. Of the four cases with the highest level of press coverage only case [92](#) – ‘conkers’ – has web hits over the median level; the other three which came in the first few months of the MBCP are below the median of 741.5 web hits). The final column of table 30 demonstrates that, with the exception of case [69](#), above median web attention is given to press stories that came after the conkers case. While the conkers case may not have driven more press stories (there were 30 stories up until and including it and 28 after), the increased web attention may suggest that this iconic case helped put the MBCP and its webpages on the map from late 2012¹³.

When we take the top twenty cases by web hits – running from case [171](#) with 9461 hits to case [197](#) with 4984 hits – six of these cases are also press stories (see table 32).

Finally, we analyse the nature of the coverage using the favourability data coded by Gorkana. Table 33 details the results – 53.5% of the 183 stories were either unfavourable or highly unfavourable to the HSE, 11.5% neutral and 35.9% favourable or highly favourable.

Table 31: Press Coverage by Case

Case ID	National	Regional	Specialist	Press Total	Above or Below Median Web Hits
1	2	0	0	2	Below
5	0	0	1	1	Below
6	1	0	0	1	Below
7	2	0	0	2	Below
11	1	0	1	2	Below
21	1	0	0	1	Below
26	7	1	1	9	Below
30	0	2	0	2	Below
33	1	0	0	1	Below
34	0	3	0	3	Below
36	0	7	0	7	Below
37	6	7	0	13	Below
38	9	0	0	9	Below
42	5	2	0	7	Below
44	0	0	1	1	Below
46	1	5	0	6	Below
49	3	0	0	3	Below
63	0	2	0	2	Below
64	0	1	0	1	Below
67	1	0	0	1	Below
68	1	0	0	1	Below

¹² Note there are three missing values here since the web analytic data only covers up to and including case 219.

¹³ We should approach this conjecture with some caution. We need to know when the HSE mythbusters email digest started. The web analytic data suggests it started in April 2013 (around the time of case 153).

69	0	1	0	1	Above
70	0	1	0	1	Below
72	0	1	0	1	Below
74	1	0	0	1	Below
84	1	1	0	2	Below
86	0	1	0	1	Below
88	2	1	0	3	Below
89	0	2	0	2	Below
90	1	2	0	3	Below
92	18	20	3	41	Above
99	1	0	0	1	Below
104	2	0	0	2	Above
111	0	3	0	3	Above
118	2	0	1	3	Above
121	1	3	0	4	Above
124	0	1	0	1	Above
136	1	0	0	1	Above
139	1	0	0	1	Above
150	3	0	0	3	Above
152	0	1	0	1	Above
162	0	0	1	1	Above
163	0	0	1	1	Above
170	1	1	0	2	Above
174	3	0	0	3	Above
178	3	0	0	3	Above
179	1	0	0	1	Above
180	3	3	0	6	Above
188	1	0	0	1	Above
190	1	0	0	1	Above
194	0	0	1	1	Above
197	5	1	0	6	Above
203	0	1	0	1	Above
217	1	0	0	1	Below
218	1	0	0	1	Above
230	0	0	1	1	n/a
235	0	1	0	1	n/a
246	0	0	1	1	n/a
Totals	95	75	13	183	n/a

Table 32: Top Press Stories found in Top Twenty Web Hits

Case id	Month / Year	Total Number of Stories	Web Hits
170	May 2013	2	7174
174	May 2013	3	5045
178	June 2013	3	6126
179	June 2013	1	5763

180	June 2013	6	8845
197	July 2013	5	4984

Table 33: Press Coverage by Case and Favourability

Case ID	Press Total	Highly Favourable	Favourable	Neutral	Unfavourable	High Unfavourable
1	2	1	1	0	0	0
5	1	0	0	0	0	1
6	1	0	0	0	0	1
7	2	1	0	1	0	0
11	2	1	0	0	0	1
21	1	0	0	0	0	1
26	9	2	1	0	2	4
30	2	1	1	0	0	0
33	1	0	0	0	0	1
34	3	3	0	0	0	0
36	7	6	0	0	0	1
37	13	6	0	0	1	6
38	9	0	0	1	2	6
42	7	0	0	1	4	2
44	1	1	0	0	0	0
46	6	1	0	2	0	3
49	3	0	0	0	0	3
63	2	1	0	0	1	0
64	1	1	0	0	0	0
67	1	0	1	0	0	0
68	1	0	0	0	0	1
69	1	0	0	0	0	1
70	1	0	0	0	0	1
72	1	0	0	0	0	1
74	1	0	0	0	0	1
84	2	0	0	0	0	2
86	1	1	0	0	0	0
88	3	0	0	1	0	2
89	2	1	0	0	0	1
90	3	0	0	0	0	3
92	41	9	10	8	3	11
99	1	0	1	0	0	0
104	2	1	0	1	0	0
111	3	1	1	1	0	0
118	3	0	0	0	0	3
121	4	0	1	2	0	1
124	1	1	0	0	0	0
136	1	0	0	0	0	1
139	1	0	0	0	0	1

150	3	0	0	0	0	3
152	1	1	0	0	0	0
162	1	0	0	0	0	1
163	1	0	0	0	0	1
170	2	0	1	0	0	1
174	3	0	0	0	0	3
178	3	2	1	0	0	0
179	1	0	0	0	0	1
180	6	1	0	0	0	5
188	1	0	0	0	0	1
190	1	0	0	0	0	1
194	1	0	0	0	0	1
197	6	0	0	1	0	5
203	1	0	0	0	0	1
217	1	0	0	1	0	0
218	1	0	0	1	0	0
230	1	1	0	0	0	0
235	1	1	0	0	0	0
246	1	0	0	0	0	1
Totals	183	45	19	21	13	85

CONCLUSIONS

The research uncovers the complex range of factors that recur in health and safety myths. As we might expect, cost avoidance is one important contributor. But, there are also less cynical factors at work. In particular, organisations' fear of legal action, the prevalence of a generalised 'better safe than sorry' risk averse attitude and the incorrect assumption that there is regulation in place where there is not all play major parts in myth creation. The analysis also raises awareness of particular areas where myths are flourishing. Myths prevail in expected settings – the workplace, retail and education – but also in the leisure sector. Particular groups are affected by health and safety myths – consumers as we might expect, but also children (both in education and at play).

The MBCP, and the publicity it generates around health and safety myths, offers an innovative way to stimulate social dialogue and critical reflection of this issue. Analysis of the cases suggests that the HSE can go even further than delivering column inches and web attention. Collecting and analysing myths enables a greater understanding of them which can be turned into tangible benefits for citizens. By identifying trends, the HSE can develop communications strategies that tailor advice and raise awareness in specific sectors about the particular populations affected by myths and the capacity gaps that make these myths more likely.

Analysis of these myths should continue. This would be usefully supplemented both by the evaluation of more tailored communications initiatives and research that examines the impact of myth stories on citizens' perceptions and understandings of health and safety regulation.