Guidance for FOD in responding to (non-construction) public safety incidents where Section 3 of HSWA applies

[To be read in conjunction with the Investigation Operational Procedure, the Enforcement Policy Statement (EPS), the Work Related Death Protocol (WRDP), the situational examples and other industry specific guidance. The attached flowchart summarises the decision making process.]

Introduction

1. HSE's policy on Section 3 HSWA is clear that we will prioritise enforcement in areas such as major hazards and construction, and will give less priority to other areas.

2. This guidance supplements that policy. It provides a framework for FOD Principal Inspectors to guide them through the key features they must consider when deciding how to deal with (non-construction) incidents involving members of the public. The aim is to ensure effective and consistent prioritisation of FOD's available resource.

3. The situational examples do not give definitive answers to every possible scenario involving a member of the public. Each decision will need to be made on a case-by-case basis and turn on its own facts. The examples chosen, however, describe broadly typical incidents that are reported to HSE.

Overarching criteria for selecting incidents for investigation

4. If an incident is reportable under RIDDOR, or if reportability is initially unclear, Principal Inspectors should follow HSE's published incident selection criteria when deciding whether to investigate. Principal Inspectors should however follow the rest of this more detailed guidance with respect to initial enquiries, reviewing investigations and recording decisions for incidents harming members of the public.

5. With a non-RIDDOR reportable incident which has caused death, (or where the injuries are so serious that death might have resulted), Principal Inspectors should only initiate an investigation if **all** the serious incident criteria in paragraph 9a-d are met. If not, an investigation should not commence.

6. Principal Inspectors will often need initial enquiries to be made; to help them decide whether the criteria in paragraph 9a-d have been met, and if an investigation should commence. The situational examples give guidance on the questions to consider when making, or reviewing the information from initial enquiries.

7. FOD will not investigate non-reportable fatalities solely because of a request from the Police or Coroner (or Procurator Fiscal in Scotland). If resources allow, however, Heads of Operations may agree to provide advice to the Police, Coroner or other regulators to support their investigations.

Fatalities (or serious incidents) not reportable under RIDDOR which should be considered for investigation

8. HSE's policy recognises that the scope of Section 3 is very broad, that Section 3 will apply to incidents that are not RIDDOR-reportable and that individual decisions must therefore be made on the circumstances of the case. There may therefore be serious incidents that are not RIDDOR-reportable, but which HSE should decide to consider further.

9. In these cases, initial enquiries may be necessary, and decisions on whether or not to investigate must be endorsed by a Head of Operations. To proceed to investigation, **all** the following criteria need to be met:

(a) the incident resulted in death (or where the injuries are so serious that death might have resulted); and

(b) there are, in relation to the circumstances that caused the incident, expected health and safety standards that are defined and known by the industry/sector in question; and

(c) a clear and likely causal link has been established between a failure to achieve those expected standards and the resulting harm (it may be appropriate to wait for a post mortem to confirm causality); and

(d) admissible evidence is likely to be available. Admissible evidence may not be available, for example where there is a significant length time delay before HSE is involved, or where witnesses are unlikely to be traceable.

Investigation decisions in specific circumstances

10. FOD will not usually re-investigate incidents or take over investigations that have been investigated by another (usually more appropriate) body, especially where a report on such an investigation has been published. Specific exceptions include: incidents where a transfer has been made in accordance with the Enforcing Authority Regulations and incidents transferred to HSE under the Enforcing Authority Regulations because of a agreed conflict of interest; or where there is an existing agreement that covers transfers with that body - such as a Memorandum of Understanding or the WRDP.

11. FOD does not, in general, investigate matters of clinical judgement or matters related to the level of provision of care. Other legislation and regulatory bodies deal with these issues. Examples of 'provision of care' include situations where poor hydration, poor nutrition or the development of pressure ulcers was the primary cause of death.

12. FOD does not investigate incidents to members of the public that are connected to the level of service provided by public authorities, such as the emergency services, carrying out their functions. This includes protecting or rescuing people from risks that do not arise directly from the public authorities' undertaking. However, FOD may be properly involved in these incidents if there is evidence that the public authority introduced another risk to an emergency situation; or through their actions, exacerbated ongoing risks and this caused death to members of the public (or the injuries are so serious that death might have resulted).

13. FOD does not investigate incidents that occur solely as result of the condition of the highway, unless a work activity such as a construction activity is taking place. FOD will continue to follow the guidance in OM 2009/02 (HSE's role in the investigations of work-related road accidents and advice on responding to enquiries on managing work-related road safety) when deciding whether to investigate other deaths on the highway.

Resource considerations and recording decisions not to investigate

14. RIDDORs that meet the selection criteria must be investigated unless there are no reasonably practicable precautions or an investigation is impracticable. A Head of Operations can decide not to investigate a non-RIDDOR incident if they do not have adequate resources available within the Unit.

15. This decision should be recorded on COIN for both RIDDOR reportable incidents and for those non-RIDDOR reportable incidents that meet the criteria in paragraph 9a-d.

Review of investigations

16. It is HSE's policy that investigations are kept under regular review by Principal Inspectors. Investigations involving members of the public will only be continued if the emerging evidence suggests that one or more of the circumstances described in section 16 of the Enforcement Policy Statement (EPS) apply. Examples include, but are not limited to: reckless disregard of health and safety requirements; repeated breaches which give rise to significant risk, or persistent and significant poor compliance; and where the dutyholder's standard of managing health and safety is found to be far below what is required by health and safety law and to be giving rise to significant risk.

17. Where the emerging evidence indicates that the decisions or actions of an individual (rather than the poor management of health and safety by an organisation) primarily caused the incident, the guidance in OC 130/08 'Prosecuting individuals' should be followed. FOD will not normally pursue investigations into possible Section 7 breaches where there was a genuine error of judgement or if there was an isolated lapse. FOD will, however, normally continue investigations if the emerging evidence suggests that the actions of the individual involved reckless disregard of health and safety requirements, or a deliberate act or omission.

18. Once a decision not to investigate, or to curtail an investigation, has been made, FOD will only reconsider this decision if substantive new information becomes available.

Matters of on-going public risk

19. Where an investigation reveals that there is a risk of serious personal injury, inspectors should, where appropriate, consider serving a Prohibition Notice. However, where there is another regulator, with more appropriate remits or mechanisms to effect more widespread and continuing improvements in public safety, it may be more appropriate for that regulator to address longer term matters of on-going public safety rather than HSE. That regulator should be informed promptly, in writing, of any matters arising from the investigation which are relevant to on-going public safety.