

<b>Health and Safety Executive Board Paper</b>		<b>HSE/04/065</b>	
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## **HEALTH AND SAFETY EXECUTIVE**

### **The HSE Board**

#### **Major Incident Update and Prior Role Inquiry Recommendation Tracking**

#### **A Paper by Kate Carroll**

#### **Cleared by Justin McCracken on**

#### **Issue**

1. To update the Board on the status of Major Incident investigations (MI) as called by the Commission or as defined under the Major Incident Response and Investigation Policy and Procedure.
2. To present to the Board the collated recommendations from prior role enquiry (PRI) reports and the actions taken to address them.

#### **Timing**

3. Routine

#### **Recommendation**

4. The Board is asked to note the status of the PRI recommendations and agree the actions on the outstanding recommendations. These are detailed in Annex B (OG Status Closed Exception 4 and 10)
5. Support the change to a more formal approach to recommendation tracking.
6. Support adoption of a 'best practice' approach to producing investigation and inquiry recommendations. Each report should have a unique number allocated to it to which could then be carried through to the recommendations thus giving each recommendation its own unique number. The requirement to do this should be written into the Major Incident Procedures currently being reviewed by David Bosworth.

7. Further explore the suitability of existing software systems to track recommendations, namely Rectrac and COIN.

## **Background**

8. HSE introduced the current (version 5) Major Incident procedure in May 2001. Previous versions date back to at least 1997.
9. Between January 1999 and January 2002 there were eight major incidents; Avonmouth, Ladbroke Grove, Larkhall, Hull building collapse, Canada Square, Hatfield, Corus and Potters Bar (details of these incidents (and current incidents) can be found in Annex A). Each of these eight had a prior role investigation carried out. The other current PRI have not been included in this paper, as the investigations have not yet been fully completed.
10. Although there has been some Board discussion on these eight incidents there has been no formal centralised tracking of either the incident investigation or the recommendations made as a result of the investigation or PRI (there has been localised monitoring). As a result it has been difficult to assess whether recommendations made have been acted upon and 'closed out'. It has also been difficult to establish lines of accountability for these recommendations.
11. Investigation recommendations tend to be based around operational activity and can be actioned easily, often at a local level. Whereas PRI recommendations look at HSE policies and procedures and often need high-level consideration and can have a more fundamental impact on the way HSE operates. It is for this reason that only PRI recommendations have been reviewed for this paper.
12. HMRI have been considering this issue for some time with the result that the Rectrac project was commissioned in 2001 (a database for tracking recommendations made as a result of incident investigations). In March 2004 Philip Purkis was appointed to RDP Project 11 'Closure of the Cullen and other Recommendations' with the aim of ensuring that recommendations from Hatfield and Potters Bar are taken forward by relevant internal and external stakeholders (Ladbroke Grove is also included in this project).
13. The PRI reports for Avonmouth, Larkhall, Hull, Canada Square and Corus have now been reviewed to identify the recommendations made. The relevant investigation teams have been consulted on these recommendations. Annex B contains a table outlining the recommendations, actions, status and proposed further action.

## **Argument**

14. The PRI reports, although broadly containing the same headings have varied widely in their content and style. It has therefore been difficult to clearly identify what the recommendations are and what action is required in light of them. None of the reports have allocated responsibility for carrying out the recommendations or attached timescale for their completion (therefore recommendations made in 2000 have not been formally 'closed').
15. The table in annex B has been compiled through broad consultation with the investigation teams and the 'outcome' is that proposed in light of this consultation. As the recommendations themselves have not been measurable, a clear outcome cannot be defined.
16. In 2001 HMRI commissioned a paper from Amey VECTRA Limited on 'Best Practice for Producing Investigation and Inquiry Recommendations'. An extract from this paper is contained in annex C. The paper proposes a best practice framework for recommendations. The merit of using such a framework as a guide is high, especially

in light of growing public accountability and Freedom of Information. Recommendations should have a unique reference number stemming from a unique number for the report itself, the recommendation should have a timescale attached and responsibility for implementing the recommendation should be stated.

17. Although MIs are rare events by their very nature, they can have serious implications for industry and potentially for HSE. They can also have a high public profile. It is therefore essential that where recommendations are made there is a clear system for tracking their progress. An I.T. system would facilitate this and the relative costs and merits of COIN and Rectrac are being considered.

### **Consultation**

18. All HSE members of the investigation teams and authors of the PRI were consulted. Key personnel within OPSD and HSE who were likely to possess corporate memory on these incidents were also consulted.

### **Costs and Benefits**

19. The cost of adopting the proposed 'best practice' approach is minimal and likely to lead to improved organisational efficiency.
20. Clearer accountability would enhance HSE reputation and minimise the risk of loss of trust through a failure to act in high profile areas.

### **Financial/Resource Implications for HSE**

21. A centralised tracking system will yield benefits in efficiency and effectiveness.
22. The financial cost of adopting an I.T tracking system would depend on the system adopted. Using COIN as a basis for tracking should incur minimal cost. The cost of adopting the Rectrac system across HSE would need to be examined. Further work looking at the financial costs is to be carried out.

### **Other Implications**

23. n/a