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HSE'S POLICY AND PRACTICE ON SAFETY ALERTS AND THE SHARING OF INFORMATION ON SIGNIFICANT HEALTH AND SAFETY RISKS			

Purpose of the paper

1. The Board expressed a concern about the timeliness of the release by HSE of important health and safety information. This paper is aimed at addressing that concern.
2. The Board are asked to confirm the current policy, endorse current practice on releasing important health and safety messages arising from ongoing investigations and note the ongoing project that will improve the current system.

Summary of findings

3. The main findings are
   - o existing HSE policy to identify any lessons learned during an investigation and to share those lessons more widely is clearly stated in Operational Procedures (paras 7 and 8 below).
   - o Legal considerations are important, as are the protocols held with other investigating bodies when staff consider what information should be released and when. There are examples across different sectors and in a range of circumstances of where this policy is put in to practice (annex 1).
   - o The lack of codified definitions of what constitutes a safety alert, and the procedures for disseminating important information on health and safety risks are being addressed through the project described at annex 2, and will be in place by May 2009. This, along with a restatement of HSE's policy will serve as a reminder to staff of the importance HSE attaches to timely release of information on significant health and safety risks, and of the way this may be done without jeopardising other considerations.

Background

4. On 26 November 2008 the HSE Board considered paper HSE/08/28 'Adventure Activities Licensing Authority Annual Report for 2007/2008'. At para 8.3 of the report reference was made to an investigation into the death of Joe Lister while caving at a licensed activity centre and the difficulties the licensing authority encountered when attempting to put lessons learned from the tragic event either into the public domain or circulated more widely to other dutyholders. Board members expressed concern that this may be part of a wider pattern of HSE failing to disseminate lessons learned from incidents out of a disproportionate fear of damaging a possible prosecution. A paper was requested setting out the position.
5. The Legal Adviser's Briefing Note to the Board of 20 January 2009 described the legal issues relating specifically to release of information in the 'Lister' case. The

same considerations apply to releasing information during any ongoing investigation. This paper does not repeat that analysis, but concentrates on the **policy and practice** of releasing important health and safety information whilst an investigation is in progress or a trial is pending.

6. HSE's policy and practice was queried by UNITE too, during the summer of 2008 when they wrote to the Chair. They were concerned that important information on health and safety risks was not being released at an early enough stage during investigations, which left workers in other workplaces at risk (CO 20/08). The Chair indicated the Board would maintain an overview of this matter.

HSE policy on releasing information on health and safety risks during investigations

7. HSE sets out core objectives that apply to all investigations (http://www.hse.gov.uk/foi/internalops/og/ogprocedures/investigation/). Identification of lessons learned is a core objective along with ensuring appropriate remedial action is taken to prevent a recurrence. These reflect the principles of HSE's Enforcement Policy Statement paragraph 31 (http://www.hse.gov.uk/pubns/hse41.pdf). Relevant extracts for both are given at annex 3.
8. HSE's policy is to release information on significant risks that comes to light during an investigation, where it is judged necessary that this information should reach a wider audience in order to prevent a similar event occurring and in the light of legal advice about minimising the impact of the release of information in any potential enforcement action.

HSE procedure

9. The investigation procedure requires staff to consider how far any findings should be shared/ acted on because lessons learned may have wider implications beyond the dutyholder directly involved. The consideration includes what information should be shared to prevent a recurrence across similar sites operated by other dutyholders, within other industry sectors, and information that should be made more widely known within HSE.

Deciding when a safety alert is appropriate

10. The investigation procedure is overarching and therefore does not provide detailed information on the types of information that should be released and when. At present there is no definition of a 'safety alert' in the HSE system. From an analysis of the 1500 press notices since 2002 and HSE website microsites within topic areas eg COMAH and Construction, this generic term has been taken to include release of information on new and emerging risks, early findings of investigations and reminders about known hazards, often because of further incidents. That said, whatever the term used to describe the release, important and urgent safety information is being disseminated within a reasonable time.
11. Alerts are issued following major incidents, prosecutions and other enforcement action, targeted inspections such as 'blitzes', inquests and the publication of research reports. The form of the alert differs between individual Directorates/Divisions and/or press notice. Since 2008, there appear to be more examples of press notices clearly headed 'safety alert' which, with the microsite websites makes locating this important information easier.

12. Considerations on when a safety alert is appropriate will be on a case by case basis but the project led by HSE's Safety Product Section (part of Services,Transportation and Safety Unit's (STSU)) will produce intranet guidance to help staff on the criteria they should consider when making the decision. The project will also guide staff on the type of alert to use and how it should be disseminated to reach the target audience (see annex 2).

Other stakeholders' role

13. Other stakeholders have a role to play in disseminating urgent information so that, for example, users of their products or members of their Trade Association are alerted to a safety issue. Their contribution reflects the new HSE Strategy theme that 'everyone has a role' in bringing about improvements. HSE would continue to encourage stakeholder involvement in sharing lessons learned and bringing about improvements and, where appropriate, will reference the information issued by others on HSE's safety bulletin webpages.

Consulting others before information is released

14. HSE is not the only decision maker on whether information arising during an investigation may be released or not. There will be other parties to consider, depending upon the type of investigation. In fatal investigations, for example, the Work Related Deaths Protocol (WRDP) requires an agreed media strategy between the Police and health and safety investigators. HSE must consult and seek agreement before any information is released. An addition was made to WRDP in 2006, to accommodate the release of early information on defective products. This was agreed with the Association of Chief Police Officers and is incorporated within STSU's product safety system.
15. In some circumstances HSE will need to consult with the industry or the manufacturer and seek agreement on the content of any information release. There are a number of benefits in undertaking this action, for example if the manufacturers are consulted there is less opportunity for them to object to the information contained within the alert. This also ensures that the action requested is fully understood by the parties concerned. This approach was taken with alerts targeted at the entertainment industry concerning defective gas valves where a safety modification was agreed with the manufacturer (not illustrated in annex 1 examples).

Legal considerations

Releasing information when an investigation is ongoing

16. Staff must be aware of potential legal constraints. Releasing information while the investigation continues may cause problems for the investigators – for example if witnesses are still to be interviewed whose recollection could be influenced by what they may read before their statement is given. However this can be, and has been done (eg Buncefield).

Releasing information when a trial is pending

17. When a trial is pending, a Prosecutor should not, in general, disclose information or material to third parties. If such material were published, it could lead to suggestions that the defendants cannot receive a fair trial because of the

publicity which has been given to it. Publishing material which gives rise to a substantial risk that the course of justice will be impeded is a contempt of court. Furthermore, there is the danger that comments or analysis attributed to witnesses may be seen as inconsistent with evidence in the case.

18. Disclosure means a loss of control over the material and information and can lead to further dissemination. Information which HSE might give in a safety alert or to a particular community could be used by others in a different context with a different impact on the criminal trial. There is a strict court – supervised regime which applies to the disclosure of unused material, that is, material HSE is not intending to rely upon at trial. If HSE discloses this material voluntarily to a third party (albeit for other reasons) it can be argued that defendants should be provided with the same unused material, which would mean a departure from this established procedure.
19. Although these are general principles which apply to making disclosure decisions, they are not fixed rules of law which prevent it absolutely. The issue then becomes the reasons for releasing information which need to be balanced with the risk or prejudice which may be caused. Preventing a recurrence is one of the purposes of investigation, as recognised in the Enforcement Policy Statement, but there is a balance between providing sufficient details to communicate the risks, precautions and action required without releasing detailed information about the investigation itself. This is a common feature of those safety alerts in annex 1 and exemplifies where this balance has been achieved. These alerts were subject to detailed, case by case consideration and specific legal advice, making them resource intensive to ensure we maintain this balance. However, it is worth noting that very few of HSE's investigations uncover information requiring a safety alert to be issued.

Special factors in Scotland

20. In Scotland, the wording of general warnings needs to be agreed with the Procurator Fiscal to minimise jeopardising any later proceedings. The Work Related Deaths Protocol Scotland applies to fatal accidents and similar principles are followed to those used when a decision is made to release information during an ongoing investigation where the incident is not a work related death. Provided proceedings are not active, that is, no indictment or complaint has been served, there is no contempt of court should prejudicial material be published, although HSE may be subject to criticism should we release information without agreement. In each case a judgement would be made on whether the public interest of publicising a risk and relevant precautions, outweighs the risk of criticism – HSE is not required to follow the advice of the Procurator Fiscal but in practise does. Therefore in principle, Scotland and England/Wales have the same policy position, albeit with different procedures.

Argument

HSE practice

21. HSE **does** issue alerts before the completion of an investigation in accordance with the policy and procedure, as may be seen in the examples at appendix 1. These are not intended to be exhaustive. They are examples from major

incidents, high profile fatal incidents and matters that would give rise to public concern.

22. HSE is addressing the Union's concern too. As part of HSE's response to UNITE, STSU informed the Union of their project to formalise current good practice in disseminating information. The aim of the project, which is being taken forward within existing budgets, is to build on current good practice, raise awareness of the importance of considering safety alerts during investigations and promote a consistent approach across Divisions/ Directorates. Annex 2 provides further detail of the system under development. A further update on this project will be provided to the Board in due course.

23. The safety alerts procedure will be part of a safety bulletin system (also including safety notices and advice that have less urgency) which is expected to be operational by the end of May 2009 and will also accommodate our responsibilities under EU Directives relating to product safety. We are required to act promptly and notify the Commission where a fatal incident has arisen and defects in equipment are found (Operational Circular OC 165/9 Work Related Deaths: liaison with police prosecuting authorities, local authorities etc para 21 (b)(ii) refers http://www.hse.gov.uk/foi/internalops/fod/oc/100-199/165_9.pdf).

24. Current practice indicates that where there is a serious risk that must be brought to others' attention, HSE is not hampered in doing so by legal considerations (and, to return to the case that prompted this paper, the death of Joe Lister, HSE's position is that appropriate and timely information was released in that case). We should acknowledge that field staff will have in mind their responsibilities for disclosing information arising from investigations only strictly in accordance with established procedure and practice otherwise they may attract criticism and/or jeopardise any future criminal proceedings. Staff are aware of the rules on disclosure for both criminal or civil proceedings, and how they should respond when they receive a request under the Freedom of Information Act or Data Protection Act. HSE's expectations with respect to proactive release of information on significant health and safety risks whilst an investigation is ongoing may be less well known. A restatement of the policy as given in paragraphs 7 and 8 of this paper, along with the new safety alert website and supporting procedures should help to mitigate this concern and to ensure that HSE staff are not unduly cautious.

Action

25. The Board is requested to
    - o confirm the current policy as given at paragraphs 7 and 8
    - o endorse current practice on releasing important health and safety information during investigations
    - o note the project led by STSU (Product Safety Section) that will support our policy and enhance delivery in practice
    - o note staff will be reminded of HSE's policy (paragraph 24) and that the policy supports appropriate release of information

Paper clearance

26. Consultation within HSE – FOD, HID, OSD, ND, LAU, Policy Group, HSE Scotland, PFPD and Legal Advisors Office. This paper has been cleared by David Ashton.

Annex 1 - Examples of where information on lessons learned was released during an ongoing investigation.

Buncefield

Explosion 11 December 2005. Safety alerts placed on the COMAH Safety Alerts website 21 February 2006 advising operators of similar installations of the capability of a very large hydrocarbon leak to create a massive explosion with destructive power beyond that previously considered. Operators were advised to review their procedures and practices and that inspectors would be making sites visits without delay. Same information sent direct to operators at the same time.

Second alert issued on June 2006 on the testing of high level tank switches so that the switches are left in full working order following testing.

Pirbright

Outbreak of Food and Mouth Disease in August 2007. HSE alert issued 7 September 2007. The alert draws employers and other dutyholders' attention to steps they should take immediately in ensuring their policies and procedures accord with their licence requirements.

Domestic hot water systems

A large volume of near boiling water poured through bedroom ceilings onto occupants sleeping below in two incidents on 30 May 2002 and 12 Dec 2006. HSE alert issued 19 July 2007 as a press notice aimed at homeowners, tenant, landlords and plumbing industry about a potential scalding risk from certain domestic hot water systems.

Explosion risk from redundant domestic back boilers

Alert issued 9 May 2008 aimed at homeowners, tenants, landlord and heating professionals on the dangers of leaving redundant solid fuel back boilers at the back of a fireplace and lighting a coal or wood fire in front. A death occurred on 11 November 2007 and HSE became aware of four other incidents over the preceding 5 years.

Tower cranes – 3 incidents

On 21 May 2000, three men died when the top of a tower crane erected at Canary Wharf, London overturned and fell. In February 2003 a discussion paper was issued to publicise lessons learnt from the review of the 'climbing frame' systems used to extend the crane height in the UK.

Tower crane collapse in London on 26 September 2006 causing the death of a worker and a member of the public. Safety alert issued 17 October 2006 to remind those working on projects where tower cranes are in use of the importance of the safe erection, operation, maintenance and dismantling of such cranes.

A second crane collapse in Liverpool on 15 January 2007 resulted in the serving of a prohibition notice. Alert of 17 October 2006 reissued on 16 January 2007 and followed up by press release 19 January 2007 publicising the enforcement action HSE had taken. Following the inquest, on 31 July 2008, HSE issued a technical report. This was sent to all UK tower crane hire/ supply companies with a request that they: (i) consider the findings; (ii) liaise with crane suppliers to identify whether they needed to take precautions to prevent a similar incident; and (iii) promulgate information to hirers and operators. This was supported by further technical bulletins issued by the Construction Plant Hire Association. The technical report was also published on HSE's website on 1 August 2008. Finally, in 17 October 2008, HSE issued a press notice to announce that legal proceedings would not be taken following completion of the investigation.

Fall arrest equipment - Scotland

In May 2007 a fatal accident (fall from height) occurred in a wind turbine (construction activity). Fall arrest equipment manufactured by HACA was being used at the time. During the investigation information came to light which suggested there was an ongoing risk with the use of the specific HACA equipment. With the Procurator Fiscal's agreement, HSE posted a safety warning about the HACA fixed rail vertical fall arrest system type 0529.7102 (http://www.hse.gov.uk/falls/fixedrail011007.htm) and advised the most relevant stakeholders groupings (e.g the British Wind Energy Association (BWEA)). HSE's completed investigation report was submitted to the office of the Procurator Fiscal in November 2007. No decision has yet been made on legal proceedings.

Annex 2 – Safety Bulletin system

Background

STSU (Product Safety Section) is in an advanced stage in developing a safety bulletin system, originally as part of the product safety system, but now expanded to include all types of Safety Bulletins with guidance on producing safety alerts and other notifications, and a single point of access to bulletins across the HSE web-site.

Aim: to introduce a comprehensive HSE-wide web based safety bulletin system that formalises and builds upon current policy and good practice

The project will deliver:

- A safety bulletin website for both internal and external access that will form the central repository for safety alerts, notices and advice with links to information held elsewhere on HSE's website
- Automatic notification of new Bulletins via a sign up system for all stakeholders such as trade associations and H&S professionals where they can specify the "industry" they are interested in, so they can choose not to receive unrelated notifications.
- Guidance for HSE staff to inform their decision making on when and in what format a safety bulletin should be drawn up, and when it **is not** appropriate – these decisions to be recorded.
- Guidance (incl an outline template) for staff to use to help them in the drafting of safety alerts and other bulletins
- Guidance on the best and most appropriate means to disseminate the alerts to reach the target audience, such as via all available means, through trade association contacts; trade press; national media etc
- Tracking, clearance and recording procedure for the production and management of safety bulletins, including the role of LAO where appropriate.

Timetable for delivery

- Internal website with links to guidance for Safety Alerts and other types of bulletin work by the end of May 2009
- External pages to provide single point access to the various types of existing safety bulletins on HSE's Website will be available by end of May 2009. This will include the ability of Stakeholders to view and receive automatic notifications of Safety Alerts via a "one-stop" page (at present Safety Alerts are in a number of various parts of HSE's website)

(The above dates are subject to the outcome of some further ongoing consultation within HSE)

Annex 3 – Extracts from Operational Procedures and the Enforcement Policy Statement (paragraph 7 of this paper refers)

Operational Procedures for investigation

http://www.hse.gov.uk/foi/internalops/og/ogprocedures/investigation/

Policy

HSE's policy is to conduct investigations in accordance with HSC (E)'s Enforcement Policy Statement

For further guidance on this, please see pares 31-32 of:

- **HSE's Enforcement Policy Statement**[1]

The selection of incidents for investigation will follow publicized selection criteria. When deciding which incidents to investigate and the level of resource to be used, account will be taken of the:

- severity and scale of potential or actual harm;
- seriousness of any potential breach of the law;
- duty holder's known past health and safety performance;
- enforcement priorities;
- practicality of achieving results
- wider relevance of the event, including serious public concern.

Exceptionally, HSE may decide not to investigate where:

- there are no reasonably practicable precautions;
- it is impracticable to follow-up/investigate, or
- there are inadequate resources to follow-up/investigate.

Definition

Investigation is a reactive process which includes all those activities carried out in response to an incident or a complaint to:

- gather and establish the facts
- identify immediate and underlying causes and the lessons to be learned
- prevent recurrence
- detect breaches of legislation for which HSE is the enforcing authority
- take appropriate action, including formal enforcement.

Enforcement Policy Statement paragraph 31
(http://www.hse.gov.uk/pubns/hse41.pdf)

31 Investigations are undertaken in order to determine:
- causes;
- whether action has been taken or needs to be taken to prevent a recurrence and to secure compliance with the law;
- lessons to be learnt and to influence the law and guidance;
- what response is appropriate to a breach of the law.