

Health and Safety Executive Board		Paper No: HSE/09/33	
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Trim reference:			
<b>OUTCOME OF THE 2008 REGULATORY DECISION MAKING (RDM) AUDIT</b>			

### **Purpose of the paper**

1. To update the Board on the recently completed RDM audit and present proposals for taking forward the findings and making public the outcome.

### **Background**

2. HSE recently concluded a Regulatory Decision Making (RDM) Audit. RDMs are peer-review exercises to evaluate a sample of enforcement decisions taken by HSE and Local Authority (LA) inspectors during the course of accident investigations. They are facilitated and reported by Internal Audit.
3. The audit was conducted by a panel of experienced HSE and LA inspectors who reviewed the details of an investigation (without sight of the resultant enforcement action) and then agreed what they believe should have been the appropriate enforcement action. The panel's decision was then compared with the actual decision taken and the panel agreed if any divergences are significant enough to be recorded as 'material differences'.
4. The draft findings were presented to SMT and the report accepted by the HSE Audit Committee in March 2009 and the final report is attached in Appendix A. The Audit reviewed a sample of 127 accident investigations taking place in 2007. The sample was taken from two FOD Divisions, HID, ND and four LAs and was mainly restricted to accidents arising from three types of risk: falls, workplace transport and manual handling.
5. The audit reported that the panel agreed with the actual decision taken in 120 of the 127 investigations sampled. There were no circumstances where the panel considered over-zealous action had been taken. There were 7 investigations where the panel recorded material differences as it felt, on the basis of the information available, stronger enforcement action should have been taken. However in reaching these conclusions the audit panel recognised that the nature of the process can have a tendency to escalate enforcement judgements.
6. A previous RDM Audit took place in 2005/06 and was comparable in methodology, size and scope to this recent exercise, reviewing a sample of 126 investigations into accidents arising from similar risk types. As for the 2008 report, the 2005/06 audit found no instances of over-zealous enforcement action however it did record 18 material differences where it was felt stronger enforcement was appropriate.

### **Argument**

7. RDM Audits only sample a narrow range of investigation types and so wider conclusions must be approached with caution. That said the results of

the 2008 audit represent a positive improvement in finding fewer than half the material differences recorded in the 2005/06 sample. This would appear to indicate improvements in the consistency of enforcement decisions taken during investigations against the Enforcement Policy Statement (EPS).

8. The outcome of this audit should provide the Board with a greater degree of assurance that the control measures that have been put in place to support enforcement decision making against the EPS (e.g. management oversight arrangements, guidance, training), are leading to more consistent, quality enforcement decisions being made by HSE LA inspectors.

9. RDM Audits facilitated by Internal Audit provide an independent and rigorous standard of assurance with a recognised profile outside HSE but they are also resource demanding exercises (200+ staff days for the 2008 audit). FOD divisions will shortly be undertaking a programme of twice-yearly peer-reviews of investigation enforcement decisions.

10. These additional arrangements will reflect the RDM Audit approach and enable further assurance to be provided. Following evaluation of their effectiveness the ongoing use of them as complements or replacements for Internal Audit RDM Audits can be considered. The Audit function might be better used to review the effectiveness of the peer-review processes.

11. A further finding from the audit was that around half of the investigations audited did not require substantive enforcement action to be taken (i.e. a letter, enforcement notice, or prosecution). This was similar to the 2005/06 audit.

12. In deciding which incidents to investigate operational directorates follow HSE's Incident Selection Criteria (ISC). The ISC limit the resources used for investigation by seeking to direct investigations towards the more serious circumstances and also those relating to strategic priorities. The core criteria of the ISC were introduced in April 2001 in response to recommendations made by the 2000 Select Committee and lay down specific requirements of the types of incidents that should be selected. In September 2005, the ISC were supplemented with additional strategic criteria which allowed for the investigation of incidents arising from the strategic priorities of the time.

13. While recognising that these audits did not use representative samples of investigations the findings would still suggest that HSE's current arrangements for selecting incidents to investigate may not be making the best use of operational resources. Work will be undertaken to explore the application of the ISC and any sensible changes that can be made, to improve the delivery of health and safety outcomes or the use of resources, will be brought to the Board.

14. Some external interest in the findings of this audit is expected. The 2005/06 audit gave rise to some public criticisms of HSE; these being that HSE should be undertaking many more prosecutions than it was and that it had not been open about the audit. In actuality HSE had publically acknowledged the audit findings when presenting its health and safety statistics and had also placed a summary of the audit outcome on the HSE website.

15. To publicise the 2008 audit findings a short summary of the report will be placed on the HSE website. The summary will include an offer to provide a copy of the audit report on request.

### **Action**

16. The Board are requested to:

- Note the outcome of the RDM Audit and the planned activities to provide further ongoing assurance.
- Note the ongoing work to investigate possible improvements in the selection of incidents for investigation.

### **Paper Clearance**

17. This paper has been cleared by Kevin Myers, Deputy Chief Executive, and reflects the RDM Audit paper presented to SMT in February 2009. Internal Audit, FOD NWHQ and Communications Directorate were consulted during drafting.



Internal Audit facilitation of:

**Regulatory Decision Making (RDM)  
Peer Review Panel Exercise  
November 2008**



### **Background and Scope**

1. The Regulatory Decision Making (RDM) audit was an exercise, facilitated by Internal Audit, undertaken to evaluate regulatory decisions made as a result of the investigation of accidents by HSE and Local Authorities (LAs). The evaluation was undertaken by a Peer Review Panel (PRP) comprising experienced field professionals from HSE and a LA.
2. A previous RDM audit was undertaken in 2005/06. As part of that audit it was agreed that the exercise would be repeated, again facilitated by Internal Audit. To support this, the RDM audit was incorporated into the 2008/09 Internal Audit Plan and approved by the HSE Audit Committee. In planning the 2008/09 audit, HSE's Deputy Chief Executive agreed that, to provide continuity and comparison, the review would follow a similar methodology, scope and sample size as in 2005/06.
3. The exercise reviewed a sample of 127 conventional accident investigations which commenced between 1/4/2007 and 31/12/2007 and mainly covered three types of accidents – Falls, Workplace Transport and Manual Handling. Annex A provides a breakdown of the sample size for each type of accident. As in 2005/06 the sample was taken from FOD (2 Divisions), HID, ND and LAs (4 LAs) with the LA sample being taken from the same geographical area as the FOD sample. Annex B provides a breakdown of the sample size by HSE Directorate and LAs. Annex C provides a breakdown of the sample size by severity of the accidents.

### **Audit Approach/Methodology**

4. Internal Audit used the criteria described above to select the investigations to be subject to review by the PRP. An 'Incident Summary' was prepared by Internal Audit for each investigation, maintaining the anonymity of the investigating inspector and others involved (e.g. company name, injured person). The summaries were compiled from:
  - Information available in the Corporate IT systems (COIN for HSE and local systems such as 'FLARE' in LAs).
  - Manual records and correspondence.
  - Interviews with the relevant investigating inspectors.
5. 85 inspectors were interviewed as part of this process. The Incident Summaries were quality reviewed by the appropriate inspector to ensure that all relevant information relating to the accident and subsequent investigation had been correctly captured.



6. The Incident Summaries were sent to the PRP members in advance of the formal meeting of the panel. The Incident Summaries did not provide details of the actual final enforcement action taken by the investigating inspector.

### **Peer Review Panel (PRP)**

7. The PRP consisted of experienced field professionals (at Principal Inspector level) from FOD, HID, ND and a Local Authority and met on 4<sup>th</sup> and 5<sup>th</sup> November 2008. It was chaired by a Band 2 from field operations and Internal Audit provided secretarial support and facilitation services.
8. PRP members discussed each case and, as a panel, agreed on the appropriate action they believe should have been taken by the inspector (i.e. this could range from no further action required right up to a Prosecution). At this stage, the PRP was not aware of the actual final action taken by the inspector. The actual action taken was then discussed and compared to the PRP's decision and the panel discussed all cases where there was a difference. The PRP then decided if the difference was significant – a 'material difference'. A material difference is any case that the PRP had a clear strength of feeling that the actual outcome was significantly different to the action they considered should have been taken.

### **PRP Findings**

9. The PRP agreed with the action taken by the inspector in 120 of the 127 sample cases. There were no cases where the panel considered that an inspector had been over-zealous in the action taken.
10. In terms of actual enforcement action taken; of the 127 accidents in our sample, 3 resulted in Prosecutions (all in HSE) and 14 resulted in Enforcement Notices (13 in HSE and 1 in LA). The PRP agreed with all of these decisions although in 1 of the Notices they considered that, subject to evidence, a Prosecution was also appropriate (recorded as a material difference at paragraph 12 below).
11. There were 7 cases (6 in HSE and 1 in LA) where the PRP recorded a material difference. In these cases, the PRP considered that stronger action should have been taken, including 3 instances where they considered that a prosecution was appropriate (2 in HSE and 1 in LA).



12. The table below shows the variance between the PRP decision and the actual decision for the 7 material differences:

	Case No						
	1	2	3	4	5	6	7
<b>6. Prosecution</b>			*			*	*
<b>5. Prohibition Notice</b>							
<b>4. Improvement Notice</b>	*	*		*		*	
<b>3. Letter</b>	*				*		*
<b>2. Verbal Advice</b>		*		*			
<b>1. No Further Action</b>			*		*		

Note: \* = Actual action taken by inspector.  
 \* = Action Suggested by Peer Review Panel.

13. Annex D provides a breakdown of the sample cases by actual enforcement action and Annex E shows where the material differences were recorded.
14. The PRP accepted that they might not have been aware of all local factors influencing an inspector's decision. Also, it was recognised that the team approach of the panel, combined with the somewhat artificial setting, can have a tendency to lead to decisions for stronger regulatory action.
15. The results of this RDM exercise compare favourably to the one undertaken in 2005/06. In the previous RDM exercise there were 18 material differences recorded by the PRP from a sample of 126 investigations, again all pointing to stronger action including enforcement. However, it must be recognised that both the PRP and the actual investigation conclusions are a result of the application of inspectors' professional expertise and judgement; it is not an exact science and there is never likely to be total agreement between the two. Therefore, Internal Audit would urge caution when drawing conclusions.

### **Conclusion**

16. The results of this exercise compare favourably to the one undertaken in 2005/06 with the level of material differences recorded by the panel being significantly less.
17. As such the findings of this exercise provide management with a greater degree of assurance that the actions taken following the

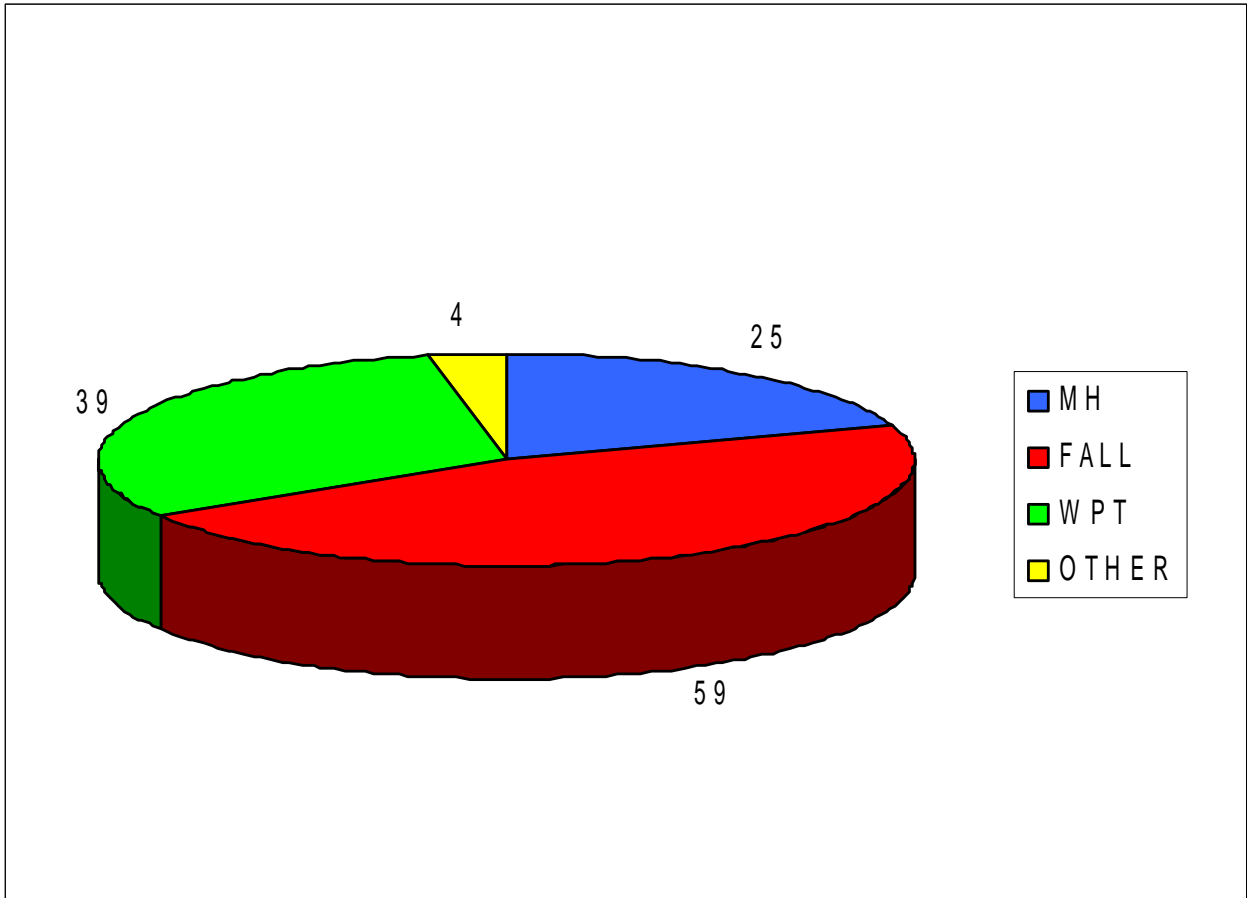


previous RDM audit are achieving the desired results and producing more consistent enforcement decision making.

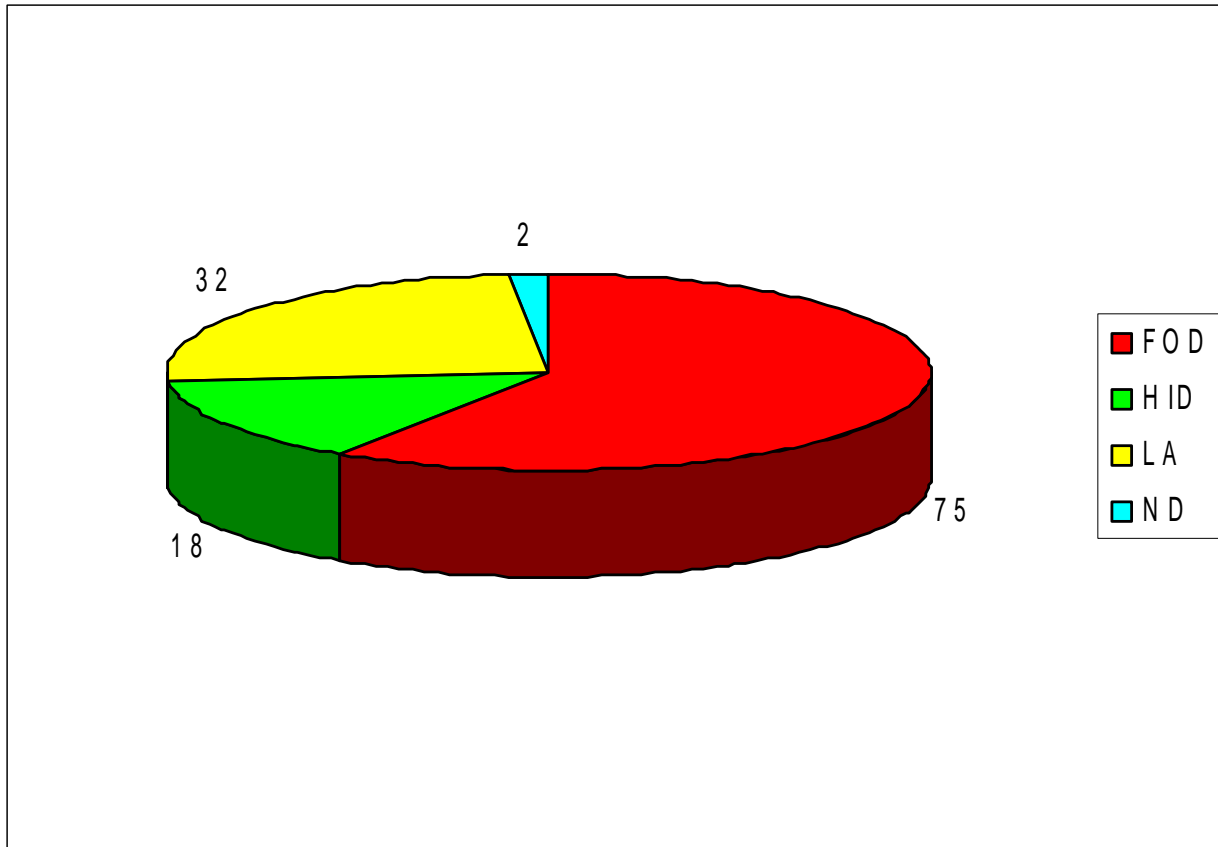
### **Next Steps**

18. The results of this exercise are now shared with management who will determine any action to be taken arising from the findings.

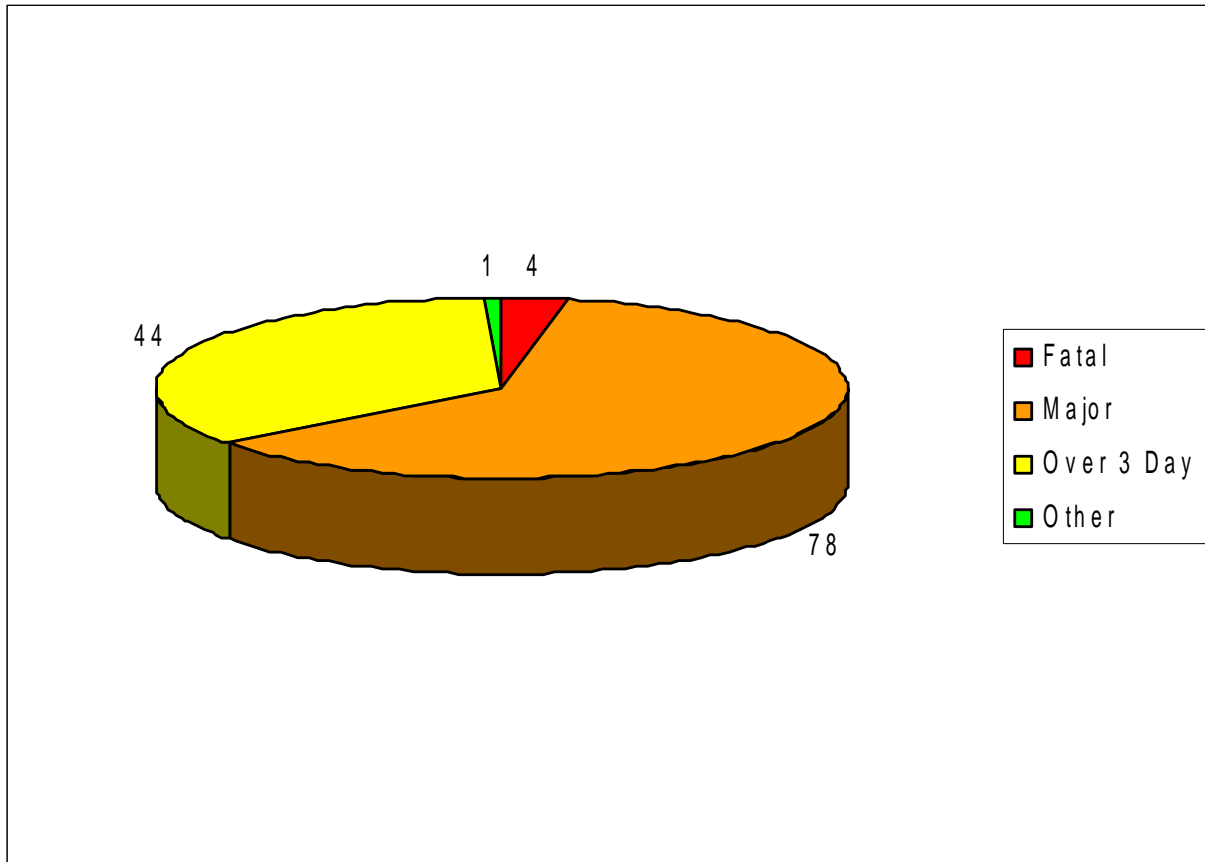
Breakdown of cases by accident type



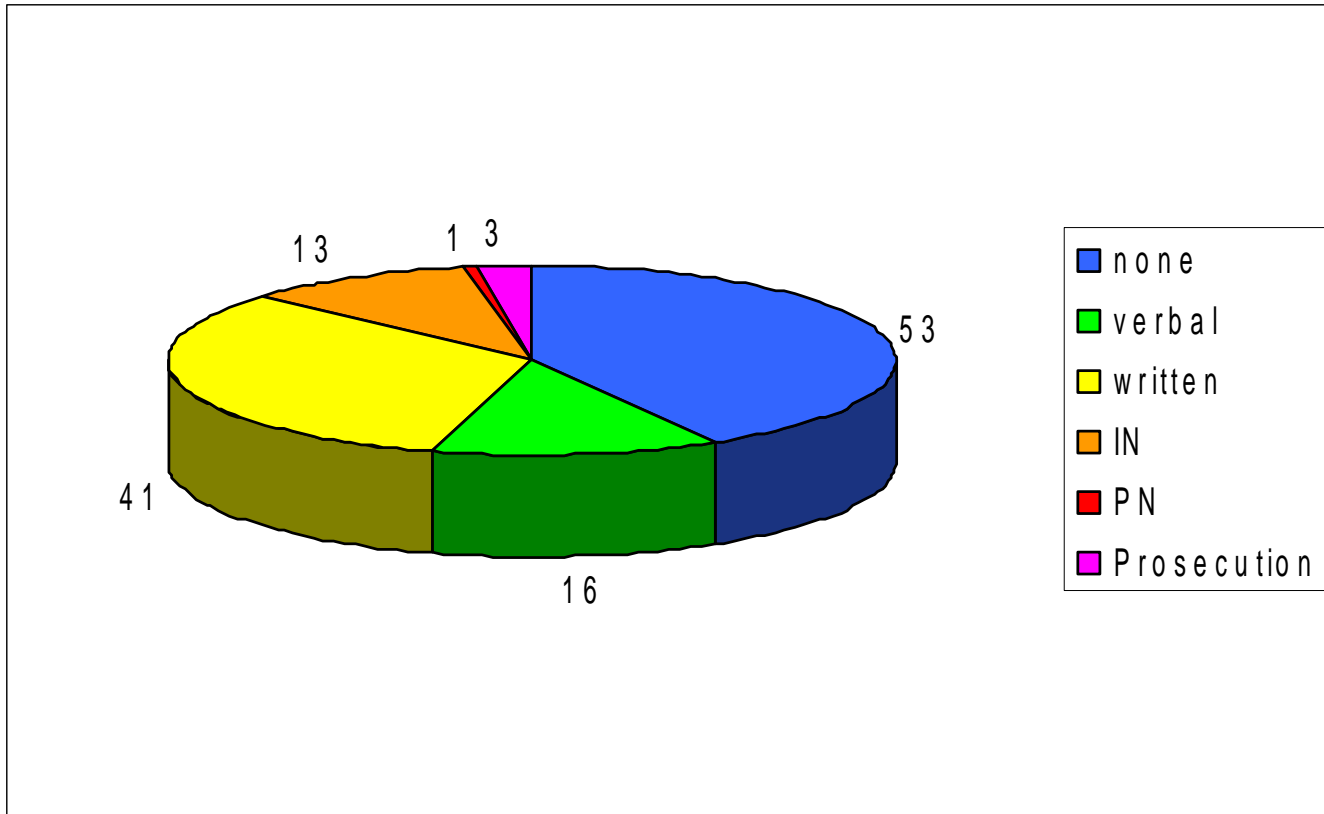
Breakdown of cases by directorate



Severity of accidents investigated



Break down of cases by actual enforcement action



Material differences (MD) by enforcement action (there are 7 material differences)

