

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

Situational examples

The examples are written as a series of issues that tend towards or tend away from investigation. Using the examples should not simply be a matter of adding up the number of factors on each side and seeing which side has the greater number. It is quite possible that one factor alone may outweigh a number of other factors which tend in the opposite direction. Each decision will need to be made on a case-by-case basis and turn on its own facts.

Throughout the examples, the words 'serious injury' are used – for the purposes of this guidance – this means injuries that are so serious that death might have resulted.

Questions on these examples, or suggestions for further examples, should be made to Cath Cottam 0115 971 2870 (VPN 513 2870)

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Leisure industry

The examples below all deal with circumstances where there could be an element of elective risk. The examples aim to ensure that HSE uses its resources to deal with significant risks created by dutyholders rather than informed, voluntary or tolerable risks taken by individuals.

1. Death or serious injury to a member of the public in the natural environment

HSE will follow the principles in the Visitor Safety in the Countryside Group ([VSCG](#)) guidance. The guiding principles, the risk control matrix and the case studies all give good guidance to inspectors and dutyholders, on when management intervention may be appropriate to control risk and what that management intervention could look like. Topic specific guidance (such as that dealing with tree management [SIM 01/2007/05](#)) may also support decision-making depending on circumstances.

Some factors tending towards investigation

Either

- a) The incident happened in an area classed as urban or rural (Urban is defined as easy terrain, accessible for all ages with full facilities for the less able; rural is defined as varied terrain, modest level of fitness required. Limited access for the less able.);

and

- b) There was a significant risk linked to the death or injury that had not been identified and assessed, or the control measures taken did not follow the logic in the VSCG guidance; **or**
- c) There was evidence of a failure to implement and/or maintain control measures which was a significant cause of the death or injury.

Or

- a) The death or serious injury took place in an area classed as rugged or wild (Rugged is defined as rugged terrain. Reasonable level of fitness required. Access facilities for the less able unlikely; wild is defined as extremely rugged terrain. High level of fitness required. No access facilities for the less able.) and involved a work activity such as an educational visit; **and**
- b) There had been no assessment (or inadequate assessment) of risk by those responsible for leading the trip and that failure was a significant cause of the death or serious injury; **or**
- c) There is evidence that the level of training and competence of those leading the trip was significantly inadequate for the risks identified.

Some factors tending away from investigation

- a) The death or serious injury happened in an area classed as rugged or wild (see above for definitions), but beyond provision of the land there was no other work activity taking place; **or**
- b) The death or serious injury took place in an area classed as urban or rural (see above for definitions), but an assessment of the risk had been made in accordance with the VSCG guidance and a logical decision had been taken on the presence or absence of control measures; **or**
- c) Evidence suggests that the affected person was able to make risk-based decisions and took a risk they were made aware of or should have been aware of and causation was due to individual choice or error.

2. Death or serious injury to a member of the public in open water

Some factors tending towards investigation

- a) There was a clear undertaking or employer with duties under HSWA;
- and**
- b) Swimming and/or water activity was actively encouraged; **or**
 - c) The affected person was a child or other vulnerable person cared for as part of a work activity; **or**
 - d) There was evidence of hazards that are uncontrolled or unmanaged (this includes hazards the dutyholder was aware of and those they should have been aware of had they carried out a suitable and sufficient risk assessment); **or**
 - e) The activity and the competence of the affected person required a level of training and/or supervision and that training/supervision was either not provided, or was inadequate.

Some factors tending away from investigation

- a) There was no dutyholder or undertaking (or it is difficult to define duties) for example a beach or other natural feature where the public have open access; **or**
- b) Swimming and/or water access was either not encouraged or was actively discouraged; **or**
- c) The affected person was not involved in a supervised activity under the control of a dutyholder such as a school or club; **or**
- d) Evidence suggests that the affected person (or their parent or guardian) was able to make a risk-based decision and took a risk they were made aware of or should have been aware of and causation was due to individual choice or error; **or**
- e) The nature of water and underwater hazards was made clear through unambiguous signage; **or**
- f) Supervision and training provided to the affected person were appropriate.

3. Death or serious injury to a member of the public during a sporting activity

Some factors tending towards investigation

- a) There was a clear identifiable dutyholder such as a school or other employer;

and

- b) The affected person was a child or vulnerable person; **or**
- c) The accident appears to have been caused by the condition of the premises/playing surface or unsuitable/inadequate equipment provided by a dutyholder; **or**
- d) The accident appears to have been caused by the actions of an individual who should have held professional training qualifications, but did not, and this had not been verified or provided by the dutyholder; **or**
- e) Clearly required and known standards of supervision were not provided.

Some factors tending away from investigation

- a) There is no clear identifiable dutyholder; **or**
- b) The accident appears to be have been caused primarily by ‘the rough and tumble’ of the game; or
- c) The accident appears to have been caused by unsuitable or inadequate equipment provided by the user or other individual without the dutyholder’s knowledge (some level of monitoring equipment provision may be appropriate where children or vulnerable people unable to make risk based decisions are involved); **or**
- d) The accident appears to have been caused by a misjudgement by a trained individual such as a referee.

4. Death or serious injury in a children’s playground

Some factors tending towards investigation

- a) There was a clear identifiable dutyholder such as a school or other employer;

and

- b) The death or serious injury occurred primarily due to a failure to provide or maintain an adequate safety surface in circumstances where a safety surface is required by relevant British Standards; **or**
- c) The death or serious injury occurred because of poor design or installation of equipment, or a failure to maintain the equipment; **or**
- d) The affected person was being supervised as part of a work activity (such as a school or playgroup), but the supervision was inadequate and contributed directly to the accident. For example young children being allowed to play on equipment designed for older children. Supervision levels should be based on a risk assessment or where applicable, guidance from national Education Departments.

Some factors tending away from investigation

- a) There is no clear identifiable dutyholder; **or**
- b) The affected person was not involved in a supervised activity under the control of a dutyholder such as a school or club; **or**
- c) The equipment was built and maintained in accordance with relevant standards; **or**
- d) The death or serious injury occurred as a result of the 'rough and tumble' of active play rather than a defect with the equipment.

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Health and social care *[some examples dealing with secure accommodation are listed separately]*

The following examples all concern clinical judgement, and the need to balance the health and safety risks to service users against the need to ensure that the independence and personal rights of individuals are not unnecessarily curtailed. Within this sector, responsible risk-taking by service users should be regarded as normal. Service users should not be discouraged from undertaking certain activities solely because there is an element of risk. Those who are competent to judge the risk to themselves should be free to make their own decisions, so long as they do not threaten the safety of others.

5. Service user dies or suffers serious injury after wandering

Some factors tending towards investigation

- a) The organisation cared for service users who were at risk of wandering and there was no system to assess the associated risks; **or**

- b) The service user was identified by a clinician or other appropriate professional as being at risk from wandering, was known to be unable to make risk based decisions, and either (i) the risk assessment which identified vulnerability did not identify precautions to prevent wandering, or (ii) the precautions identified by the risk assessment had not been implemented, and this failure was a significant cause of the death or serious injury; **or**
- c) The service user was taking part in an activity designed or encouraged by a clinician or other appropriate professional to promote independence, and the precautions identified by a risk assessment for that activity had not been implemented, and this failure was directly causative of the death or serious injury.

Some factors tending away from investigation

- a) The service user was assessed by a clinician or other appropriate professional as being able to make risk based decisions; **or**
- b) Wandering was foreseeable and the precautions and control measures identified the risk assessment had been implemented; **or**
- c) The service user, whilst identified as vulnerable, was taking part in an activity designed or encouraged by a clinician or other appropriate professional to promote independence and precautions identified by the risk assessment had been implemented.

6. Fall from a window

The key guidance for this topic is found [SIM 7/2007/07](#), NHS Estates Health Technical Memorandum No 55 Windows (1998) or (in Scotland) Estates Safety Action Notice SAN (SC) 98/47 and Hazard Notice HAZ (SC) 04/02.

Some factors tending towards investigation

- a) The death or serious injury occurred to a service user who was vulnerable in such a way that windows posed a serious hazard. This vulnerability could be due to physical or mental health conditions that are either permanent or temporary;

and

- b) The establishment was one where such vulnerable service users are likely to be present;

and

- c) The window concerned was one that should have been designed (quality of glass and type of restrictor) in accordance with the relevant standards and those standards were not met; **or**
- d) The window concerned was designed (quality of glass and type of restrictor) in accordance with relevant standards, but not maintained to an acceptable level.

Some factors tending away from investigation

- a) The death or serious injury occurred to a service user or other person who was not considered to be specifically vulnerable to falls from windows; **or**
- b) The establishment was one where vulnerable people were unlikely to be present; **or**
- c) The window was designed and maintained in accordance with relevant standards, but despite this the incident still occurred. For example, the window was smashed using a piece of furniture (*but note situational example dealing with suicide*), or the opening was within acceptable limits and egress still occurred.

7. Death or serious injury due to service user choking

Some factors tending towards investigation

- a) The organisation cared for service users who were at risk of choking and there was no system to assess the associated risks; **or**
- b) The service user was assessed to be at risk of choking, an assessment made clear they should not be able to access certain items (food or otherwise), and they choked on one such item because the supervision of the service user was inadequate or the storage of restricted items was inadequate.

Some factors tending away from investigation

- a) The service user, whilst vulnerable, was not specifically at risk of choking and was able to make risk-based decisions in relation to what they ate; **or**
- b) The service user choked on something that they were allowed access to (according to the risk assessment); **or**
- c) The supervision and storage of restricted items was adequate.

8. Suicide

Some suicides can often be easily identified, whereas others may be more difficult to define (such as an elderly, confused person falling from or jumping through a window). It is the Coroner's (Procurator Fiscal in Scotland) role to define suicide as a cause of death. This guidance deals with those circumstances where evidence suggests that suicide is the most likely cause of death.

Some factors tending towards investigation

- a) The service user was a known and clinically diagnosed suicide risk in the care/detention of a custodial service or residential care setting;
- and**
- b) The assessment that identified suicide as a risk did not identify precautions to manage the risk, or the precautions identified by the risk assessment had not been implemented such that the service user was able to use a method of suicide that should not have been available to them (eg a ligature point such as a curtain rail or door closing device that should have been identified and removed); **or**
 - c) The service user had been identified as a suicide risk and was taking part in an activity which was designed or encouraged by a clinician or other appropriate professional to promote independence, and precautions identified by a risk assessment for that activity which could have prevented the death had not been implemented; **or**
 - d) A one to one supervision level (or other similar supervision arrangement designed to prevent suicide) had been identified as a control measure to prevent suicide and it had not been properly implemented. *(Inspectors should note that the purpose of a supervision regime - except when it is one to one - is usually to monitor the service user's mental state. It is not normally a control measure to prevent suicide).*

Some factors tending away from investigation

- a) The service user was in the care/detention of a custodial service or residential care facility, but was not identified by a clinician as being at risk of suicide; **or**
- b) The service user, whilst identified as a suicide risk, used a method of suicide that could not have been controlled without affecting the service user's dignity; **or**
- c) The service user acted in such a way that their actions were beyond the reasonable control of those caring for him/her (for example, the person had the capacity and ingenuity to obtain items to assist in suicide without the knowledge of carers); **or**
- d) The service user, whilst identified as being at risk of suicide was being cared for in a non-residential facility or in their own home.

9. Drug error causing death or serious injury

HSE does not investigate deaths or illness that occur due to a failure to diagnose and effectively treat a medical condition, if the cause of death was that medical condition. However, HSE may, subject to other criteria being met, investigate deaths where the direct cause was not the medical condition being treated, but was caused by failure of some aspect of the medical treatment process such as a drug error or related equipment failure.

Some factors tending towards investigation

- a) The incident was directly caused by inadequate training in the use of equipment, such as syringe drivers used to administer drugs; **or**
- b) The error was directly caused by poor storage of similarly labelled drugs; **or**
- c) The error can be directly linked to a failure to implement known and communicated actions set out in MHRA, NPSA or other safety alerts.

Some factors tending away from investigation

- a) The drug error was due to an incorrect clinical decision – a clinician prescribed the wrong drug, wrong dosage or drug formulation; **or**
- b) The drug error was due to a prescription being wrongly fulfilled by a pharmacist; **or**
- c) The person administering drugs (or making associated measurements and calculations such as a patients weight) was a properly trained, authorised healthcare professional and the error made was a genuine mistake by that individual; **or**
- d) The error was due design failure of medical equipment which was unknown or had not been made known to the organisation through appropriate channels such as MHRA or other safety alerts.

10. Service user dies or suffers serious injury in connection with use or 'non-use' of bedrails

Some factors tending towards investigation

- a) The incident arose from a failure to assess whether bedrails should, or should not, be provided for a clearly vulnerable person, as set out in MHRA or HSE guidance; **or**
- b) The incident involved the service user becoming trapped in the bedrail or between the bedrail and another part of the bed, e.g. the mattress or headboard, as a result of:
 - Bedrails not being fitted in accordance with established standards e.g. as laid down in MHRA or HSE guidance; **or**
 - The bedrails being in poor condition from lack of maintenance; **or**
 - A failure to adequately assess the compatibility of the occupant and the bedrails – e.g. occupant's head or body being small enough to pass through the bed rail bars; **or**
- c) The care plan for a service user has not been followed and the service user either dies as a result of the injury they sustain or suffers serious injury.

Some factors tending away from investigation

- a) A clinical or healthcare professional decision has been made that bedrails should not be used and the service user has fallen while attempting to get out of bed; **or**
 - b) A service user who has bedrails fitted as a result of a clinical or healthcare professional decision, tries to climb over the bedrails and falls from the bed;
- or**
- c) A service user falls from a bed, which has no bedrails fitted. There is a clinical or healthcare professional decision that bedrails should be used but there is a record that the family or service user specifically requested that the bedrails be removed. The provider has discussed the issue, made the risks involved clear and has provided the most acceptable alternative measures.

Police, Fire and Prisons

11. Death or serious injury in custody

In prisons, probation hostels, immigration detention centres and the courts (where the prisoner or detainee was under escort managed by the relevant service), HSE will lead on investigations of deaths and serious injuries to detainees when the incident arises out of a work activity. This includes the work a detainee was doing, a transport accident, or if the injury was due to the structure or fabric of the building, and the types of circumstances dealt with in this example. The IPCC (Procurator Fiscal in Scotland) would lead on death or serious injury to detainees in Police custody and may involve HSE under the WRDP. The IPCC have no remit in Prisons or other detention facilities. Depending on the circumstances, the examples dealing with suicide and violence between service users may provide more specific guidance.

Some factors tending towards investigation

- a) No risk assessment had been made of the detainee, or the control measures identified by the assessment had not been implemented; **or**
- b) There is evidence of a systemic failure to properly monitor and supervise detainees; **or**
- c) There is evidence that alarm systems failed to operate; **or**
- d) Established and current guidance on the design of custody facilities had not been implemented.

Some factors tending away from investigation

- a) A risk assessment had been made in accordance with the custody service requirements; **or**
- b) The control measures identified by the assessment had been properly implemented; **or**
- c) The death or serious injury occurred as a result of the (non-systemic) behaviour (commission or omission) of individual officers. The behaviour of individual officers could be investigated by the IPCC or Police; **or**
- d) The death or serious injury occurred as a result of a failure to identify a risk of self harm by a doctor, police officer, or prison officer; **or**
- e) The death or serious injury was due to unforeseen natural causes and occurred despite suitable monitoring and supervision of the detainee.

12. Death or serious injury to service user due to violence between service users in secure accommodation

This example deals with those situations where there is a real and serious potential for fatal violence between prisoners/service users who are kept in some form of secure accommodation. A death or serious injury as a result of violence between two prisoners/service users is likely to be investigated as murder or other criminal offence by the police. HSE inspectors would only investigate organisational matters that may have exacerbated the situation. Inspectors must liaise with the relevant police force to ensure the two investigations proceed in accordance with the WRDP.

Some factors tending towards investigation

a) The death occurred on the premises under the control of the dutyholder;

and

b) The prisoner/service user is known to be violent or at significant risk of violence (for example due to the nature of their offending) and no risk assessment has been carried out; **or**

c) The precautions and control measures identified by the assessment have not been implemented; **or**

d) The response strategies to deal with an incident have not been identified or have not been implemented. For example, call systems not working or inadequate number of trained staff available.

Some factors tending away from investigation

a) Violence occurred away from premises and whilst the service user was not under the direct control of the dutyholder; **or**

b) Violence by either service user was not foreseeable; **or**

c) Violence was foreseeable, but a risk assessment had been carried and the precautions and control measures identified had been implemented; **or**

d) Response strategies were adequate and appropriate to the risk assessment and had been implemented.

13. Death or serious injury during or following police restraint in a hospital setting

Police officers may be called to assist hospital staff in managing a patient who has become confused and agitated and is considered a source of danger either to themselves and/or others within the hospital environment. Police officers may need to use restraint tactics in order to subdue the patient.

Death or serious injury to a hospital patient during or following the use of police restraint is always subject to investigation by the IPCC of the conduct of the officers involved. The IPCC will take the lead in these cases but should work with HSE in accordance with the IPCC/HSE agreement and WRDP principles. HSE will investigate the role of the police force, the role of the healthcare organisation and any health and safety management failings by either party.

These situations are generally very unpredictable and volatile. Such unpredictability may influence the tactics deployed and there may be issues of self defence for the police officers and hospital staff involved. All of these factors will introduce a greater complexity into the investigations.

Some factors tending towards investigation

Police Force

- a) None, inadequate or outdated policies on the management of aggressive and potentially violent patients and vulnerable individuals; **or**
- b) None, inadequate or outdated training in control and restraint techniques and strategies for dealing with aggressive patients. Inadequate training in the use of restraint equipment. Training must contain the most up to date information about the risks associated with prolonged restraint, particularly to those who are vulnerable because of their illness or medication, and how they should be managed; **or**
- c) None or inadequate communication arrangements between the police and the healthcare organisation on the handling of aggressive and potentially violent patients. Such protocols should clearly define the roles and responsibilities of each party and recognise the need for cooperation between the parties.

Healthcare Organisation

- a) None or inadequate arrangements between the healthcare organisation and the police on the handling of potentially violent and aggressive patients. Such arrangements should clearly define the roles and responsibilities and recognise the need for cooperation and exchange of patient information; **or**
- b) Inadequate arrangements for managing the risks of violent and aggressive patients, which has meant the situation has escalated to the police becoming involved. Such arrangements would include policies and procedures, risk assessments, and staff training.

Some factors tending away from investigation

Police Force

- a) The death was due to unforeseen natural causes and occurred despite appropriate use of restraint tactics and monitoring of the patient during the restraint; **or**
- b) The death was due to the failure of a medical treatment and/or clinical decision.

Healthcare Organisation.

- a) The death was due to the failure of a medical treatment (such as the administration of a drug) and/or clinical decision.

Local Government

14. Death or serious injury involving facilities for which the Local Authority has responsibility (e.g. open spaces, buildings and structures)

HSE does not deal with road traffic or other accidents that occur on the **highway**, or its associated footpaths, if they are due to a failure by the Highways **Authorities** to carry out **their** statutory functions, in maintaining the surface of the highway or footpath. Neither does HSE deal with issues such as the provision and placement of road signage, except where a construction activity or road works are taking place. The example below deals with other aspects of Local Authority infrastructure, such as Local Authority owned buildings or other structures. Depending on the circumstances, the examples dealing with the Leisure Industry may provide more specific guidance.

Some factors tending towards investigation

- a) A dutyholder has a clear responsibility for maintenance of the infrastructure concerned;
- and**
- b) There is a failure to provide a level of safety specifically required by relevant statutory provisions or relevant guidance such as a British Standard; **or**
- c) There is evidence of a failure to maintain the infrastructure concerned; **or**
- d) The death or serious injury occurred in a way that the person harmed could not have foreseen but the dutyholder would reasonably be expected to be aware of and take action to prevent. For example, as a result of a latent or invisible defect, such as the structural stability of a boundary wall or electrical safety of an item of street furniture (rather than a failure by the item to carry out its intended function); **or**
- e) There was a work activity taking place that was a significant cause of the death or serious incident (e.g. construction work or cleaning activity).

Some factors tending away from investigation

- a) The dutyholder had a responsibility for the infrastructure, but due to the nature of the facilities (e.g. open spaces classed as rugged or wild in the Visitor Safety in the Countryside guidance) no reasonably practicable precautions exist to control the risk; **or**
- b) The death or serious injury occurred because of recent vandalism or recent damage caused by weather conditions (if the incident occurred directly as a result of vandalism, this may be investigated by the Police); **or**
- c) The death or serious injury occurred because the affected person took a risk they were made aware of, or any reasonable person would be aware of (e.g. walking on slippery or uneven surfaces).

15. Death or serious injury to a member of the public in domestic social housing

Where appropriate, Inspectors should also refer to the [SIM 07/2008/07](#) – Domestic safety issues in Local Authority and other rented housing.

Some factors tending towards investigation

- a) The death or serious injury occurred in common parts of housing rather than in an individual's own home, and the condition of the premises or a work activity taking place there, was causative; **or**
- b) The death or serious injury occurred in an individual's own home and a work activity being carried out in the home was directly causative (eg live electrical conductors left exposed whilst work was taking place); **or**
- c) The incident was RIDDOR reportable and caused by a failure to maintain a gas appliance; **or**
- d) The death or serious injury was caused by a failure to maintain or provide something which is specifically required by a relevant statutory provision that HSE enforces such as a lifting appliance used as a piece of work equipment, where the Lifting Operations and Lifting Equipment Regulations 1998 apply; **or**
- e) The death or serious injury occurred due to a failure to maintain equipment where the landlord had entered into a contractual duty to maintain that equipment (such as a contractual duty to maintain a solid fuel appliance).

Some factors tending away from investigation

- a) The death or serious injury occurred in an individual's own home and the cause was poor quality of work carried out by a tradesman, such as a poor electrical installation (the exception being work on a gas appliance). These matters should be dealt with by Trading Standards or Local Authority Building Control; **or**
- b) The death or serious injury was caused by a failure to provide or maintain something which is required by statute, and another organisation enforces those provisions; **or**
- c) The death or serious injury is attributed to the fabric or structure of a building that meets the requirements of current relevant Building Regulations and Standards, or those that were in place when it was constructed/refurbished; **or**
- d) The death or serious injury occurred because a householder took a risk they were made aware of, or any reasonable person would be aware of.

Agriculture and the wider land based industries

16. Death or serious injury in agriculture to children or young persons

Some factors tending towards investigation

Either

- a) There is a clear identifiable duty holder e.g. farmer or farm business (whether employed or self-employed);

and

- b) The death or serious injury involved a child (i.e. of Compulsory School Age as defined¹) or a Young Person² ;

and

- c) The child was a member of the farmer's family or a member of the public.

Or

d) The young person was a member of the farmer's family or employed or on a work experience scheme;

and

e) The death or serious injury occurred in relation to agricultural activity i.e. an activity connected with arable, dairy, livestock, mixed farming etc. amenity or production horticulture etc aquaculture, arboriculture, forestry or landscaping amenity etc.

Some factors tending away from investigation

a) There is no clear identifiable duty holder.

Notes:

¹ Compulsory School Age (CSA) - see the Children and Young Persons Act 1933. The formula for working out CSA was introduced by s8 of the Education Act 1996 under which there is a single leaving date i.e. the last Friday in June in the school year in which a child reaches the age of 16; providing that the child's 16th birthday is before the beginning of the next school year. In Scotland, the Education (Scotland) Act 1980 applies

² Young person – defined as 18 years of age under the Health & Safety (Young Persons) Regulations 1997.

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17. Death or serious injury to a member of the public due to a tree falling down

HSE will follow the principles in the National Tree Safety Group guidance – Common Sense Risk Management of Trees

[http://www.forestry.gov.uk/PDF/FCMS024.pdf/\\$FILE/FCMS024.pdf](http://www.forestry.gov.uk/PDF/FCMS024.pdf/$FILE/FCMS024.pdf)

and HSE guidance on Tree Management SIM 01/2007/05

http://intranet/operational/sims/ag_food/010705.htm .

Some factors tending towards investigation

Either

- a) There was a significant risk from the tree linked to the death or injury that had not been identified and assessed, or the control measures taken did not follow the logic in the NTSG guidance; **or**
- b) There was evidence of a failure to implement and/or maintain control measures which was a significant cause of the death or injury.

Some factors tending away from investigation

- a) An initial assessment of the risk had been made by a competent person in accordance with the NTSG guidance and a logical decision had been taken on the need for control measures;

and

- b) An inspection system was in place for future years.

18. Death or serious injury in agriculture to members of the public attacked by cattle

Some factors tending towards investigation

a) There is a clear identifiable duty holder e.g. farmer or farm business (whether employed or self-employed);

and

b) The death or serious injury was to a member of the public [MOP];

and

c) The MOP was present in a field or enclosure with a statutory right of way or other form of permitted access;

and

d) Cattle were also present in the field, either because they were purposely placed in the field/enclosure or because they had escaped from another field or enclosure;

and

e) The death or serious injury occurred in relation to agricultural activity e.g. an activity connected with dairy, livestock, mixed farming etc.

Some factors tending away from investigation

- a) There is no clear identifiable duty holder **and/or**
- b) The MOP was trespassing.

Notes:

¹ The Wildlife & Countryside Act 1981 specifies recognised breeds of dairy bulls which should not be kept in fields or enclosures.

² Agriculture Information Sheet 'Cattle and public access in England & Wales [AIS17EW] – in Scotland AIS17S – detail the standards required.

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Transport

19. Death or serious injury to a member of the public in the perimeter of a bus station

HSE will follow the principles in the DfT Guidance on the safe design and operation of bus stations 2011 <http://www.cpt-uk.org/uploads/attachment/1822.pdf> . This is an interpretive standard.

Some factors tending towards investigation

There is evidence of deficiencies in existing measures (operating procedures, management arrangements and physical control measures) for reducing the likelihood of MoPs being struck by buses. In particular:

- a) passengers dropped off within bus carriageways; **or**
- b) easy pedestrian access to and from the bus carriageway at street level; **or**
- c) pavements adjoining the bus station; **or**
- d) lack of pedestrian barriers at aprons and building corners; **or**

- e) lack of signage prohibiting pedestrian entry and/or advising of safe pedestrian routes; **or**
- f) dirty, poorly decorated and lit subways; **or**
- g) lack of speed measures at entry and exit slips; **or**
- h) lack of pedestrian deterrent floor surfaces; **or**
- i) poor control of reversing buses e.g. buses not fitted with reversing aids, design not reviewed to reduce or eliminate reversing buses, no agreed safe system supported by training for all bus station users; **or**
- j) buses double parking on stands; **or**
- k) poor management arrangements such as liaison meetings between station owner and bus operating companies not held, no allocated management responsibility for safety.

Some factors tending away from investigation

The deficiencies are not of sufficient significance such as to oblige MoPs to expose themselves to the risk of being struck by vehicles. In particular:

- a) well-signed and useable separate pedestrian access is available to/from/in the bus station that separates MoPs from vehicles; **or**
- b) physical barriers channel and segregate MoPs from vehicles; **or**
- c) the bus station operates a one-way system for vehicles, has speed control measures and compliance is monitored and enforced; **or**
- d) good control of reversing buses e.g. buses fitted with reversing aids; the use of banksmen avoided and only used as a last resort; and an agreed safe system supported by training for all bus station users **or**
- d) suitable and sufficient management arrangements including allocated management responsibility for safety and good communication (e.g. meetings) between the bus station owner and the bus operating companies.