

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 publicservicesector@hse.gsi.gov.uk

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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 on the hills

Responsible risk taking should be regarded as normal. HSE does not discourage members of the public from undertaking certain activities solely on the grounds that there is an element of risk. Those who are competent to judge the risk to themselves should feel free to make their own decisions so long as they do not threaten the safety of others. The nature of these pursuits is such that, where there is an accident, a fault on the part of any employer or other dutyholder cannot be presumed. HSE does not seek to get involved in the activities of voluntary associations such as hill walking clubs.

Some factors tending towards investigation

- a) The death or serious injury took place in an area classed as rugged or wild terrain which requires a reasonable level of fitness to access *and* involved a work activity such as a commercial climbing course or mountain walking activity or is being managed or led by an undertaking with duties under the Health and safety at Work etc. Act 1974; **and**
- b) There had been no assessment (or significantly 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 activity was significantly inadequate for the risks identified; **or**
- d) There is evidence that the preparation or equipment was significantly inadequate for the planned activity; **or**
- e) The actions of those in charge of the walk are likely to be considered negligent or reckless.

Some factors tending away from investigation

- a) The death or serious injury happened in an area classed as rugged or wild terrain which requires a reasonable level of fitness to access but beyond

- the provision of the land or permitting access to it, there was no work activity taking place that was relevant to the circumstances of the death or serious injury; **or**
- b) The death or serious injury happened in an area classed as rugged or wild terrain but an assessment of the risk had been made in accordance with accepted good practice such as that expected of a person competent to lead others in that environment on that activity and reasonable decisions had been taken on the conduct of the activity; **or**
 - c) Evidence suggests that the affected person was able to make informed decisions and took a risk they were aware of or should have been aware of and causation was due to individual choice or error.

Worked examples

Client falls and dies

1. Client engages the services of a mountain guide to take them along the Cuillin ridge. The guide holds a Mountaineering Instructor Certificate and has worked in the Scottish Hills for 10 years. The client is a regular hill walker with several years experience of hill walking. Both client and guide are equipped as would be expected for the activity and anticipated conditions. The client slipped on some loose material and fell to their death.
2. The activity took place in wild terrain but the guide was competent to be working in that environment. Although the guide had not written a risk assessment for this particular trip, he was able to produce significant evidence of numerous successful outings in all conditions. Both men were appropriately equipped.
3. Conclusion – would not be investigated by HSE as there is no evidence that any breach of health and safety law has occurred or that there was anything more that could reasonably have been done.

Party becomes benighted and a member dies from hypothermia

1. A hill walking club become benighted in the Cairngorms and a member dies from hypothermia.
2. Conclusion – would not be investigated by HSE as the activity was organised by a voluntary association for its members. There is no work activity.

An avalanche strikes a party and three people die before they can be rescued

1. A company offers a gap year experience to school leavers involving work with disadvantaged youth, opportunities to learn skills for work and team building experiences, which includes an adventure week in the Scottish hills in the spring.
2. During a mountain walk the party is struck by an avalanche and three members die before they are rescued.
3. The leaders of the party did not hold any winter mountain leader qualifications or evidence of competence to lead others in that environment. The party did not have any ice axes or other equipment that would reasonably be expected such as a map or compass. There was a risk assessment but it was inadequate as it did not consider any obvious hazards that could be expected in the Scottish hills in spring such as avalanche.
4. Conclusion – would be investigated as there is a work activity and there is evidence that safety management deficiencies are likely to have contributed to the deaths. However, in this scenario, the failings are so gross that corporate culpable homicide cannot be ruled out and primacy would remain with the Police until it can be ruled out or there is insufficient evidence. HSE may assist the Police under the terms of WRDP.

A school pupil falls from a path and is seriously injured

1. A school organises a hill walk during the Easter holidays for a group of pupils. The two teachers organising it have done so for many years without incident. On the last afternoon, a pupil falls from a path onto steep ground and ends up seriously injured but is expected to make a full recovery.
2. Enquiries reveal that although the teachers did not have any formal walking group leader qualifications they were experienced hill walkers. They had led the trip for the previous 5 years. The group was reasonably equipped but there were 25 pupils in it plus a parent helper who had no significant walking experience. There was a risk assessment but there was no evidence that the trip had been authorised according to the local authority's own internal policy. The head teacher had signed off the trip despite the system requiring approval from the outdoor education advisor, as it was a residential adventure activity.

3. Conclusion – this is likely to be investigated by HSE. Evidence indicates that the competence of the teachers appears appropriate and as the trip itself was conducted appropriately and all were suitably equipped, there is no indication of recklessness. However, it appears that there may be corporate safety management failings (failure to follow the local authority approval systems) that need to be addressed.

3. 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.

4. 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 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.

5. Death or serious injury in a children's playground

HSE will follow the principles in the High Level Statement Children's Play and Leisure - Promoting a Balanced Approach. This statement recognises the benefits of allowing children to have challenging play opportunities. It gives good guidance on what needs to be done to control significant risks and refers to helpful industry standards such as EN 1176 as benchmarks.

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.

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

The following examples generally concern the actions flowing from clinical / professional judgements. HSE will investigate in accordance with its policies and selection criteria. These are set out on our 'Who regulates health and social care' page. It is important that any health and safety risks are balanced 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 should be free to make their own decisions, so long as they do not threaten the safety of others.

Healthcare is managed and regulated differently in England Scotland and Wales. The various regulators across Great Britain have a range of powers to secure improvement and/or justice.

From 1st April 2015 very few new incidents causing harm to hospital patients or social care service users in England will fall to HSE to investigate as the Care Quality Commission (CQC) will be a more appropriate regulator.

The current position with patient and service user incidents will remain unchanged in Scotland and Wales. HSE will continue to be the health and safety regulator for workers in health and social care in all three countries.

6. Service user dies or suffers serious injury after wandering

Some factors tending towards investigation

- a) The organisation cares for service users who could be at risk of wandering and there was no system to assess the associated risks; **or**
- b) The service user was identified by an 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 an appropriate professional to promote independence, and the precautions identified by a risk assessment for that activity had not been implemented, and this failure caused death or serious injury.

Some factors tending away from investigation

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

7. A person receiving care falls from a window

The key guidance for this topic is found in HSE information sheet, [Falls from windows and balconies in health and social care](#) (HSIS5), 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 person being cared for in premises where people are likely to be at risk of falls from a height likely to cause harm. The risk may be created by physical or mental health conditions that are either temporary or permanent.

and

- b) 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**

- c) 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 **and** who was not being cared for in premises where such vulnerable persons were likely to be present; **or**
- b) 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*).

8. 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.

9. 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 person was a known suicide risk;

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 person was able to use a method of suicide that should not have been available to them (eg a ligature point such as a fixed curtain rail or door closing device that should have been identified and removed); **or**
- c) The person had been identified as a suicide risk and was taking part in an activity which was designed or encouraged by an 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 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 person was identified by an appropriate professional as not being at risk of suicide; **or**
- b) The person 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**
- c) The person, whilst identified as being at risk of suicide was being cared for in a non-residential facility or in their own home.

10. 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 patient's 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 to 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.

11. 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 from or whilst 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 and there was no previous history that should have alerted the employer to that risk; **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 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 appropriate alternative measures.

12. A patient or service user, assessed as being at risk of falling, falls on the same level and suffers serious injury or dies

This example includes falling when standing after getting out of a bed or chair, walking alone or when being assisted. The same principles will apply if a patient

or service user should have been assessed but wasn't. It should be noted, however, that not all falls are preventable.

NICE provide helpful guidance on triggers for assessment, assessment questions/scoring and falls prevention at <https://www.nice.org.uk/guidance/qs86>

HSE do not make clinical decisions and will not investigate matters relating to clinical decisions as there are better placed regulators to do this.

Some factors tending towards investigation

a) The individual's falls assessment/care plan failed to identify well known and appropriate controls that would have significantly reduced the risk of falling in these circumstances; **or**

b) Appropriate controls which were likely to have prevented this fall were identified but were not implemented (e.g. provision of mobility aids); **or**

c) There was poor control of environmental factors (e.g. absent handrails, or presence of slip/trip hazards such as damaged carpets) that were implicated in this fall.

Some factors tending away from investigation

a) The individual's falls assessment identified appropriate controls, these were implemented, but despite this the incident still occurred; **or**

b) The individual's falls assessment identified appropriate controls, these were not fully implemented, but it was unlikely that the un-implemented controls would have prevented or significantly mitigated the fall in these specific circumstances; **or**

c) The individual had capacity to make decisions and had refused assistance, or had decided to mobilise without assistance, or the use of other measures that they knew would have reduced the risk. This assumes that help with mobilising would have been reasonably readily available; **or**

d) A temporary medical condition led to the fall.

13. Service user dies following healthcare associated infection (e.g. Clostridium difficile)

Healthcare associated infections (HAI) are not reportable to HSE under RIDDOR and will not normally be investigated. The following criteria set out some of the factors tending both towards and away from investigation:

Factors tending towards investigation

- a) There has been a recognised infection outbreak which has resulted in deaths; **and**
- b) There has been a clear failure to meet an established standard; **and**
- c) This was due to a systemic management failure; **and**
- d) Factors (b) and (c), on balance of probability, led to the outbreak and consequential deaths. The death certificates indicate that the infection was a contributory or causal factor.

Some factors tending away from investigation

- a) There is no clear evidence that a breach of an established standard led to the outbreak or deaths; **or**
- b) A failure to meet an existing standard was not directly attributable to systemic management failure; **or**
- c) The deaths could not, on balance of probability, be attributed to these failures

Police, Fire and Prisons

14. 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.

15. 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.

16. Death or serious injury to a member of the public during or following Police contact

Death or serious injury to a member of the public during or following contact with the police is often of a controversial and high-profile nature. Police forces have a statutory duty to refer all such cases to the Independent Police Complaints Commission (IPCC) in England and Wales, to the Police Investigations and Review Commissioner (PIRC) in Scotland, and in most cases to HSE under

RIDDOR requirements. A death or serious injury is a situation in which a person has died or sustained serious injury and:

- had been arrested or was otherwise detained in custody at the time;
- had contact of any kind with a person serving with the police that may have caused or contributed to the death or serious injury.

Police Officers work in what are often dangerous, emotionally charged and unpredictable situations involving members of the public. Such unpredictability may influence the tactics deployed and there may be issues of self-defence for them to consider. These factors will introduce a greater complexity into any investigation.

It is essential that there is early engagement between IPCC and HSE investigators in these cases to determine the potential for joint or parallel investigation, and to maintain a consistent approach to evidence collection, evidence sharing and communications between IPCC and HSE, the affected families and the media. There is an agreement between IPCC and HSE which sets out the arrangements for joint investigation. There is also an agreed protocol between PIRC and HSE in Scotland.

Death or serious injury following police contact includes (but is not necessarily limited to) those occurring: -

- during or following police custody where injuries and/or medical problems that contributed to the death were sustained during the period of detention;
- in or on the way to hospital (or other medical premises) following or during transfer from scene of arrest or police custody;
- as a result of injuries and/or other medical problems that are identified or that develop while a person is in custody;
- while a person is in police custody having been detained under Section 136 of the Mental Health Act 1983 or other related legislation.
- where the police are assisting medical staff with a patient who is not under arrest.

In these cases, the IPCC/PIRC will lead an investigation into the circumstances of the incident in the first instance. IPCC/PIRC will focus mainly on the behaviour of the individual officers involved in the incident. HSE may also wish to investigate either jointly with IPCC/PIRC or in parallel and focus on the management of health and safety at the corporate level.

Factors tending towards HSE investigation of the Police Force

- a) where injuries/medical conditions that may have contributed to the death (or serious injury) were sustained during the period of police contact; **and**
- b) there are indications of inadequate identification of risks, unclear objectives and limited monitoring and review at corporate level to ensure controls were implemented; **and/or**
- c) there are indications that the police **tactics and equipment** deployed during the period of police contact did not meet current nationally accepted standards; **and/or**
- d) there are indications that the **training and competence** of the police officers in risk identification, appropriate deployment of tactics and equipment, and detention techniques did not meet current nationally accepted standards.

In cases of death or serious injury occurring where the police contact involves assisting medical staff with a patient who is not under arrest; -

- there are indications of inadequate arrangements with the care provider, such as a lack of clarity of roles & responsibilities, and co-operation & communication for the management of potentially violent and aggressive patients.

It may also be appropriate to consider factors tending towards investigation of the care provider as follows;

- In England, in accordance with the Memorandum of Understanding between the Care Quality Commission (CQC) and HSE/LA, incidents should be discussed with the CQC if the care provider is registered with them
- In Scotland and Wales, this includes inadequate arrangements for managing potentially violent and aggressive patients (e.g. policies and

procedures, risk assessment, staff training) which has meant the situation has escalated to require police involvement, or inadequate arrangements with the police such as clarity of roles & responsibilities and co-operation & communication regarding the management of potentially violent and aggressive patients.

Factors tending away from HSE investigation of the Police Force

- a) The death/serious injury was due to unforeseen natural causes and occurred despite the appropriate deployment of tactics, equipment and monitoring of the individual during the period of police contact;
or
- b) The death/serious injury was due to the failure of a medical treatment and/or a clinical decision by a medical professional.
- c) The IPCC/PIRC investigation has been unable to establish any causal link between the police contact and the death

Local Government

17. 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).

18. 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

19. 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.

20. 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.

21. 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.

Transport

22. 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.