

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 4th and 5th 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
6. Prosecution			*			*	*
5. Prohibition Notice							
4. Improvement Notice	*	*		*		*	
3. Letter	*				*		*
2. Verbal Advice		*		*			
1. No Further Action			*		*		

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

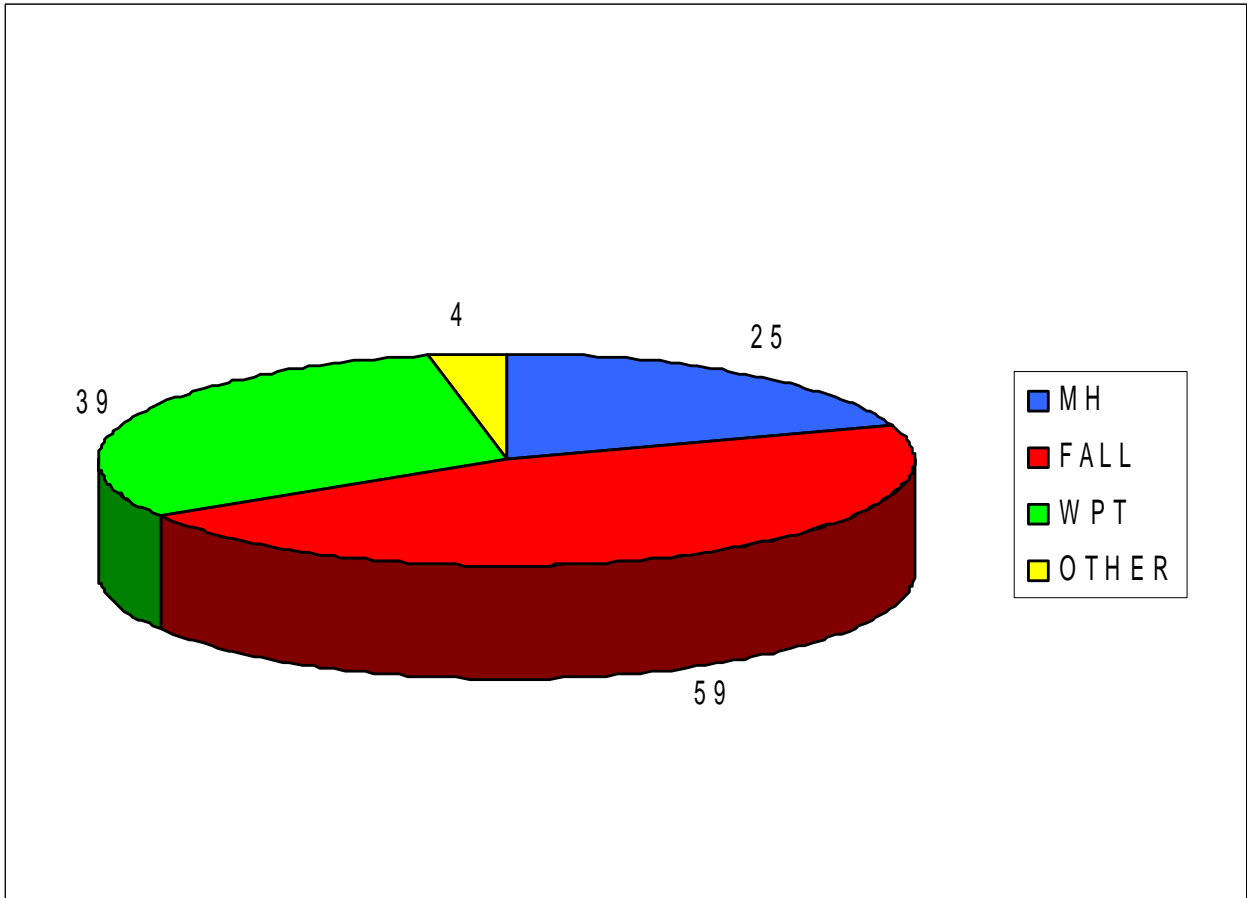
16. The results of this exercise compare favourably to the one undertaken in 2005/06 with the level of material differences recorded by the panel being significantly less.

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.

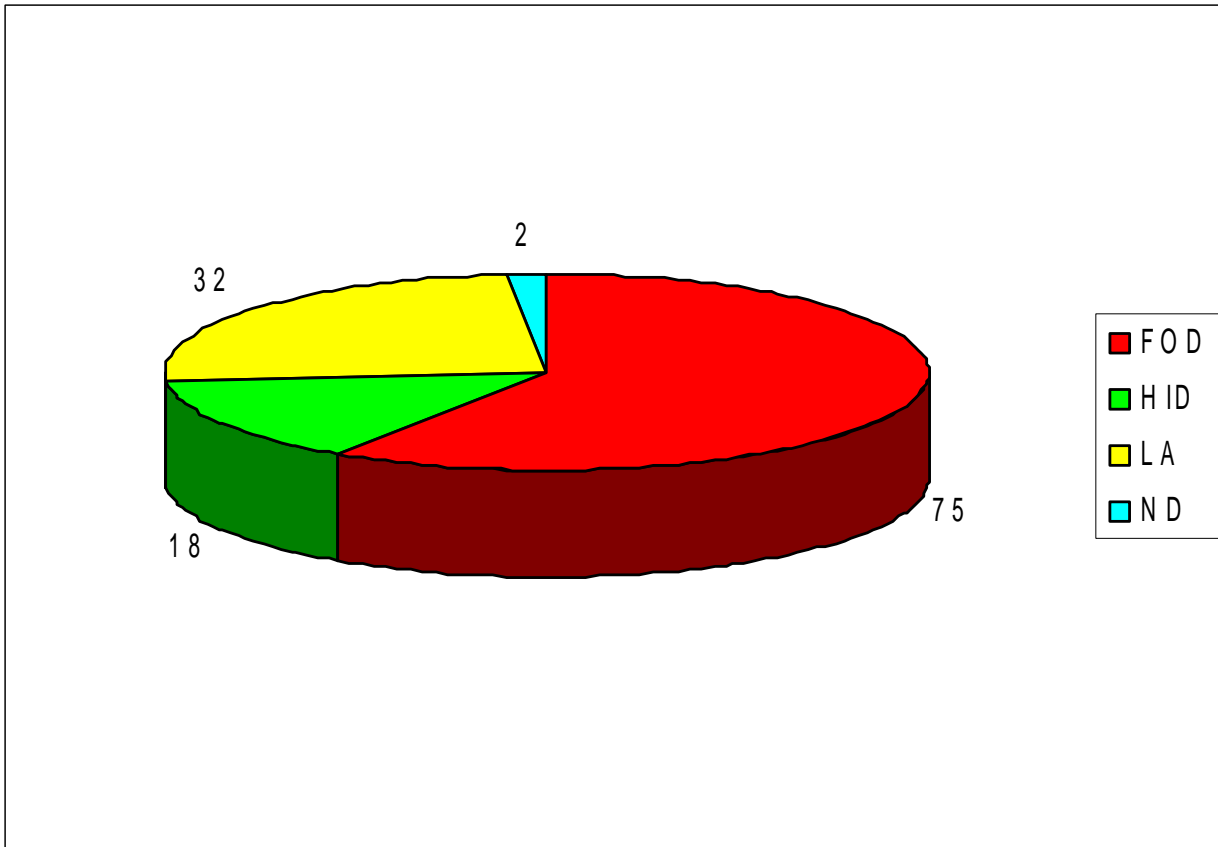
Next Steps

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

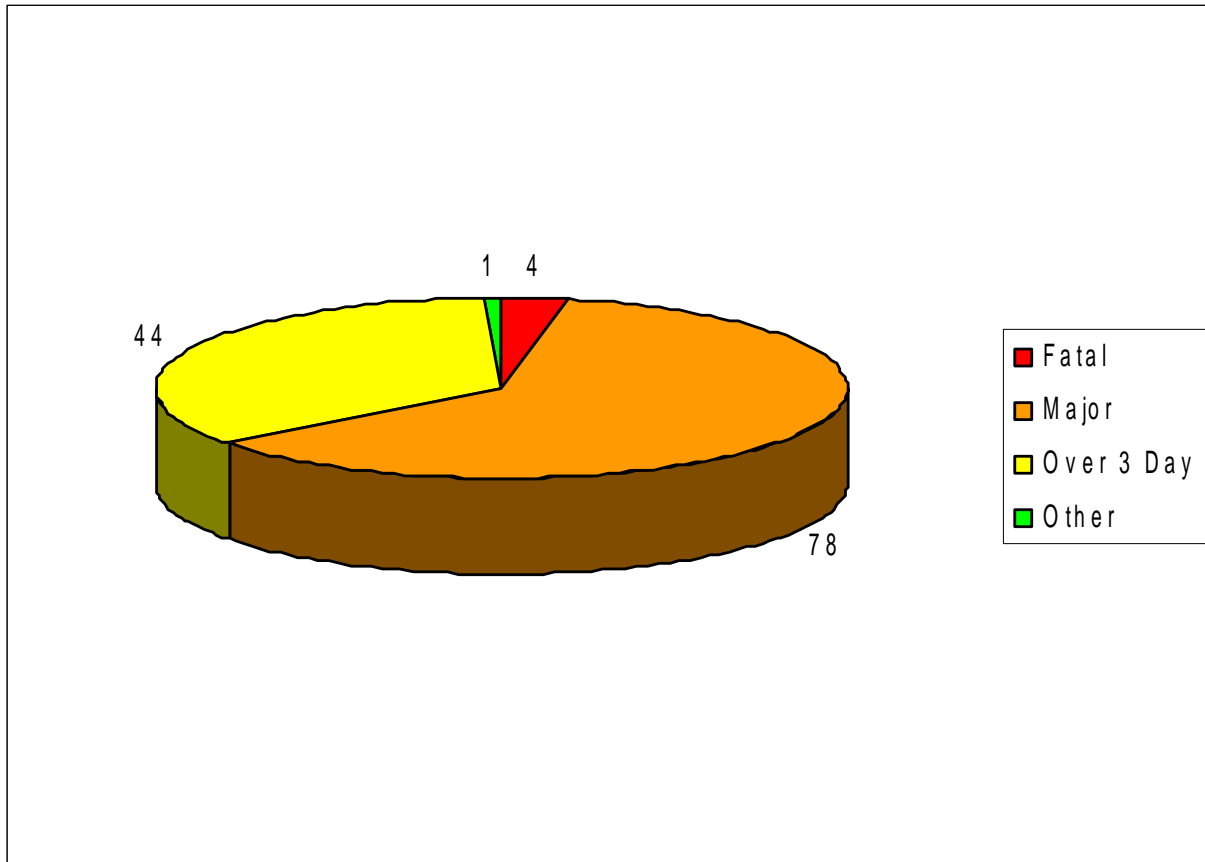
Breakdown of cases by accident type



Breakdown of cases by directorate

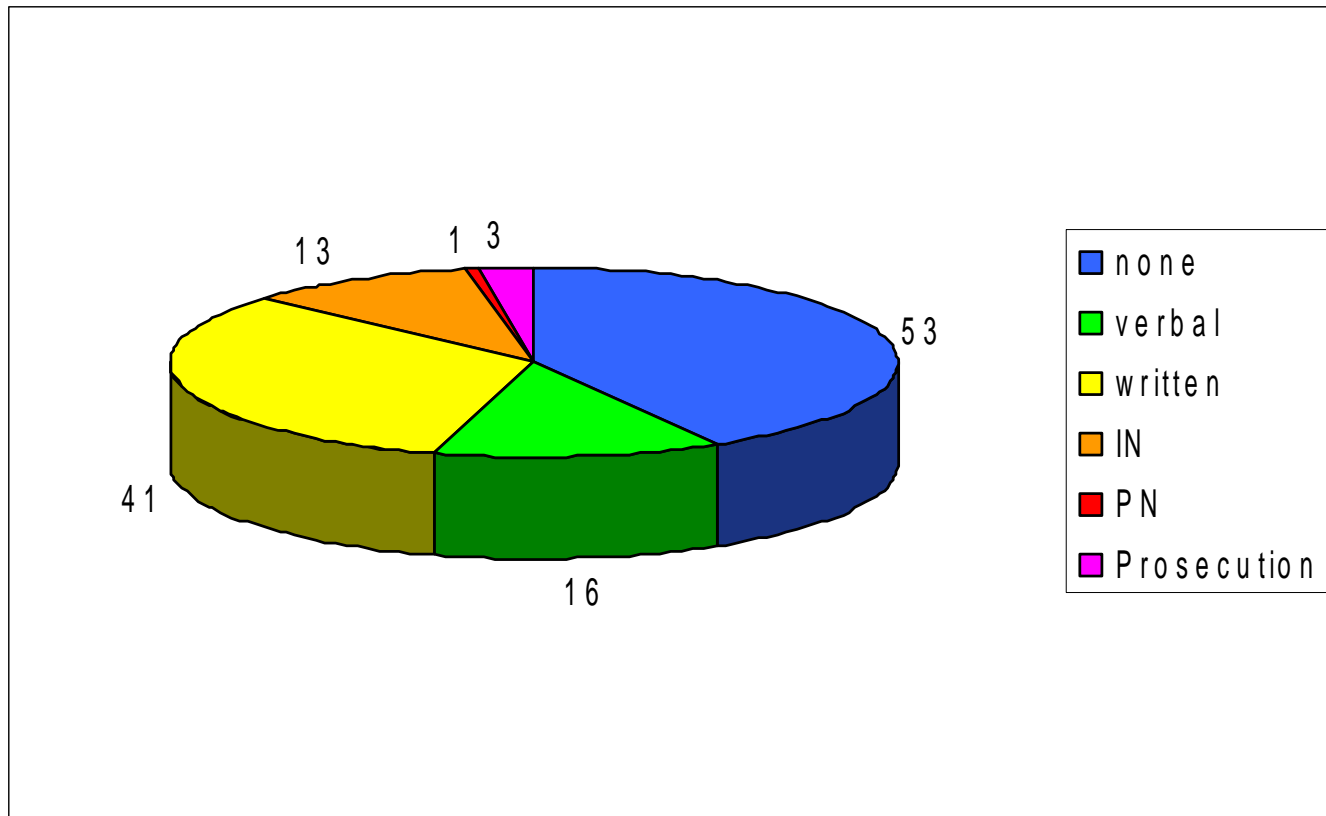


Severity of accidents investigated



Annex D

Break down of cases by actual enforcement action



Annex E

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

