

OVERVIEW

This Procedure describes how we carry out investigations into work-related incidents that have resulted in death, physical injury, occupational disease or dangerous occurrences. The purpose of an investigation is to find out what happened in an incident, and why, and to take enforcement action, where appropriate, that accords with the principles of HSE's Enforcement Policy Statement.

Operational directors expect that investigations will be actively managed so that they are conducted and completed within the shortest practicable timescales, taking into account scale and complexity and the need to achieve the right outcomes. Our policy is to continue an investigation solely to the extent of meeting our regulatory functions and the legal requirements for criminal investigations. Therefore, managers and inspectors will justifiably decide to stop an investigation at the point where those objectives have been achieved.

The emphasis is on prompt and positive decision-making during initial planning and subsequent reviews as the key to making timely progress and avoiding delay.

The Procedure provides the framework, generic objectives and performance standards for incident investigations. The material is arranged in a logical flow, but some flexibility is necessary in practice because the pathway through an investigation can vary according to circumstances.

COMAH Competent Authority (CA) Inspectors should also refer to the COMAH Remodelling Investigation Procedure that provides a common framework for CA investigations at COMAH establishments and supplements this procedure.

This can be found at <http://intranet/comah/docs/guidance/investigation-procedure.pdf>

Some activities that are related to investigation are not covered under this Procedure. Please refer to the relevant instructions and guidance on the following:

- [Receipt and handling of incoming reports, mainly under RIDDOR](#)
- [Cost recovery](#)
- [Investigation reports and work recording, including IMPACT and MEMT.](#)

The Procedure is in three sections, summarised below:

<u>All incidents</u> Applies to fatal incidents, following on from the initial and specific action for work-related deaths	<ul style="list-style-type: none">• Decision to investigate• Initial planning• Conduct and management – including reviews• Conclusion
<u>Fatal incidents</u>	<ul style="list-style-type: none">• Initial response• Management of joint investigation
<u>Potential major incidents</u>	<ul style="list-style-type: none">• Major incident or civil contingency event• Relevant to other serious/high profile events.

The content of each section is arranged under:

Headlines	<ul style="list-style-type: none">• Summary of the section's scope and content
Responsibilities and actions	<ul style="list-style-type: none">• The headlines expanded into "who" and "what" (with flexibility between roles to maintain pace)
Performance standards and criteria	<ul style="list-style-type: none">• Our policies in terms of quality, criteria, timescales and factors to take into account

ALL INCIDENTS

This section covers:

- decisions whether to investigate reported incidents (except where already actioned for fatal and major incidents)
- initial planning
- conducting and managing, including reviews
- concluding investigations, including when to curtail.

DECISION WHETHER TO INVESTIGATE

HEADLINES

Apply the Incident Selection Criteria (ISC) to decision-making

Identify incidents mandatory for investigation

Arrange for initial enquiries to be made where necessary

Re-direct incidents that are not within HSE's enforcement responsibility

Justify decisions not to investigate incidents that meet the ISC with reasons

Re-allocate investigations where local workload pressures would lead to delay

RESPONSIBILITIES & ACTIONS

<i>Band 2</i>	<ul style="list-style-type: none">• Select incidents that meet the ISC as mandatory for investigation where there is enough available information to decide without further enquiry• Re-direct any incidents that are not for HSE in accordance with the relevant Memorandum of Understanding, Protocol or other guidance• Arrange for initial enquiries* into incidents that fit the Criteria: Initial enquiries in order to reach a decision whether investigation is mandatory (* by administrative support team, VO/RCO or inspector as appropriate)• Decide whether any incidents meeting the ISC should not be investigated• Record a decision not to investigate directly on COIN, selecting one of the reasons given in the Criteria: Factors weighing against investigation• Inform the Band 1 if the team does not have the capacity to take on an incident that should be investigated.
Band 1	<ul style="list-style-type: none">• Re-allocate investigations across teams, Units and Divisions when resourcing issues arise.

CRITERIA FOR DECISION-MAKING

Initial enquiries	<p>Enquiries should be made when there is not enough information to decide whether:</p> <ul style="list-style-type: none">• one of the factors weighing against a decision to pursue an investigation might apply, even though the incident meets the ISC• a serious incident to a non-employee falls within HSE's priorities for enforcement on Section 3. <p>Enquiries should not continue beyond the point when the Band 2 has enough information to decide whether to investigate or not.</p>
Factors weighing against investigation	<p>The grounds for not investigating incidents that meet the selection criteria are where:</p> <ul style="list-style-type: none">• it is impractical to do so, for example where key witnesses or other evidence is unavailable• it is clear that all reasonably practicable precautions were in place at the time of the incident to reduce the risk of it occurring

PERFORMANCE STANDARD

Timescales for selection decisions	<p>The decision whether to investigate should be made within 5 working days from when the Band 2 receives notification, or as soon as the information essential to making a decision becomes available.</p>
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INITIAL PLANNING

HEADLINES

Assess the incident and resource the investigation

Gather relevant information about the dutyholder(s) where their identity is known

Set initial objectives and identify any fast-track actions

Consider any necessary support required from specialists or the Sector at the outset

Involve and communicate with other enforcement agencies where appropriate

Identify any foreseeable health and safety issues and site conditions that may affect the investigators

Produce a fit-for-purpose plan

RESPONSIBILITIES & ACTIONS

Band 2	<ul style="list-style-type: none"> • Take account of the following factors when allocating resources to the investigation: <ul style="list-style-type: none"> ○ its likely scale and complexity ○ the type and volume of material to be collected while fresh and available ○ the urgency for first attendance at the site ○ the most appropriate mix of inspector and VO/RCO deployment • Ensure that the lead inspector's initial objectives and actions are appropriate and geared to making timely and effective progress • Set the timing of the first review.
Lead inspector	<p>Consider, in liaison with the B2, how best to deploy staff resources to achieve the following actions, delegating to other team members - VO/RCO, B3 or B4 colleagues - where appropriate:</p> <ul style="list-style-type: none"> • Arrange for information held about the dutyholder(s) to be supplied • Consider the running order for collecting the early material that is likely to be most productive and efficient • Assess whether any relevant material is at risk of being lost, destroyed or disturbed, and needs to be secured without delay to avoid detriment to the investigation • Set the initial objectives and timescales on that basis • Check the benchmarks or standards for the risk control measures that are likely to be relevant • Determine whether specialist assistance is likely to be required and for what purpose; and if so, arrange in accordance with the Specialist Assistance Procedure: http://intranet/strategy/cost-recovery/docs/specialist-assistance.pdf • Make any specific provision for the health and safety of investigating staff, including a check on a Violence and Aggression marker for the site • Capture the key actions in a fit-for-purpose plan in IMPACT.

CONDUCT AND MANAGEMENT

HEADLINES

Start the investigation within acceptable timescales

Ensure the health and safety of visiting staff attending the site

Take immediate enforcement action in the event of serious risk of personal injury

Establish the facts and the immediate causes of the incident

Identify the health and safety management failures directly related to the incident

Review to determine whether to curtail or continue, and if so, agreeing next priority actions
Secure compliance as soon as there is sufficient information or evidence to do so

Focus on the points to prove if considering formal enforcement action
 Review at further intervals to plan next actions and to maintain the pace

RESPONSIBILITIES & ACTIONS

Band 2	<ul style="list-style-type: none"> • Conduct reviews in accordance with the Performance Standard: Management reviews • Monitor the effect of the investigation on the health and safety of staff where exposed to potentially traumatic situations, following HSE's health and safety policy.
Lead inspector	<ul style="list-style-type: none"> • Begin the investigation within agreed timescales • Take immediate enforcement action where appropriate to ensure the dutyholder controls or eliminates any evident risks of serious personal injury • Secure relevant parts of the scene or other material where identified as fast-track actions • Pursue lines of enquiry to establish what happened and why • Focus the investigation on the most significant and serious failures that emerge • Gather material selectively in relation to what needs to be proved in accordance with OG: Material and evidence management (collection, retention and disposal): http://www.hse.gov.uk/foi/internalops/og/og-00061.htm taking into account the strengths as well as the weaknesses of the dutyholder(s)' control and management of the risks associated with the incident • Apply this guidance, together with OG: Management of material at HSL: http://www.hse.gov.uk/foi/internalops/og/og-00057.htm where relevant, when deciding whether to take physical items into possession, especially where bulky or hazardous • Take appropriate and timely enforcement action during the course of the investigation when inadequately controlled risks are found • Judge whether the circumstances present the potential for a prosecution, and what the most relevant contraventions might be • Decide on that basis whether to gather material in forms that can be used in evidence • Hold the first and subsequent reviews with the Band 2 in accordance with the Performance Standard: Management reviews • Carry out the investigation process to meet the Performance Standard: Mandatory actions, subject to the stated exceptions • Record the key decisions and their supporting reasons • Identify and pursue any other sources of information directly relevant to the investigation, for example the supply chain • Inform the Band 2 if the investigation becomes more complex and/or requires more resources than foreseen.
Band 1	<ul style="list-style-type: none"> • Review the investigation regularly.

PERFORMANCE STANDARDS

VERSION 5.0	October 2015
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<p>Investigation reviews</p>	<p>The lead inspector should drive the review, providing information and material in advance where this will aid efficiency, especially for investigations tending towards prosecution, or away from it in cases where prosecution might otherwise be expected.</p> <p>The Band 2 should evaluate the action taken and proposed, then agree, advise on, or re-direct the course and pace of the investigation.</p>
<p>Key actions and decisions</p>	<p>As applicable to the stage of the investigation:</p> <ul style="list-style-type: none"> • present findings from the initial lines of enquiry • identify any potential contraventions: what, by whom and their significance • indicate whether enough material has been obtained to secure compliance, where contraventions have been found • justify further investigation where appropriate to: <ul style="list-style-type: none"> ○ establish any remaining facts necessary to secure compliance ○ achieve other agreed outcomes of value to HSE, or ○ collect the relevant material to support a prosecution • identify any evidence essential to a prospective prosecution that will, or is likely to be difficult or impossible to obtain • assess whether the joint management of a fatal incident investigation is working effectively • propose the lines of enquiry and timescales for the next stage of the investigation, where continuing, including any revised priorities • identify any factors that may delay the investigation, and plan to avoid or mitigate them • agree decisions not to pursue certain lines of enquiry, or to discontinue them, where appropriate • consider whether any further action is required in respect of specialist or Sector support, for example: <ul style="list-style-type: none"> ○ discussion and review with the specialist to keep existing work on track ○ new or additional support needs to be commissioned • decide whether an AIM should be applied to any aspect of the investigation in accordance with the criteria for: Use of AIMS • decide whether the dutyholder or other parties need to be updated on progress.
<p>Outcomes</p>	<p>Reviews result in:</p> <ul style="list-style-type: none"> • clear and accountable reasons for curtailing, concluding or continuing the investigation • plans for further investigation focused on priority lines of enquiry and points to prove, with timescales • resourcing of the investigation considered and adjusted if necessary • any action required to keep a fatal incident investigation on track in accordance with the WRDP and the Practical Guide is identified and taken • reviews done at the right time to ensure progress at the right pace • decisions reached as to what satisfies all reasonable lines of enquiry in the context of the investigation.

Timescales	<p>First review</p> <ul style="list-style-type: none"> • set to coincide with completion of the initially agreed actions • at the latest, within three weeks of the decision to investigate <p>Subsequent reviews</p> <ul style="list-style-type: none"> • set to coincide with completion of the next set of agreed actions, or whenever otherwise appropriate, for example, an unexpected turn of events or before a review meeting with the police or CPS • at the latest, within two months of the previous review.
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Investigation: mandatory actions	<p>Investigatory activities must include the following to qualify as a completed investigation:</p> <ul style="list-style-type: none"> • a visit to the scene unless: <ul style="list-style-type: none"> ○ it is unsafe to do so, or ○ it no longer exists or has no material bearing on the incident • an explanation to the dutyholder(s) about the purpose of the investigation and how it will be conducted • communication with the relevant employee representative(s) or workers in accordance with OG: Contact with employee representatives by HSE field staff (this link will be added when new OG published) • an interview with the injured or affected person unless it is not possible to do so • the facts about the circumstances of the incident, and any other information of value to HSE • IMPACT and MEMT completed in proportion to the investigation • an enforcement decision targeted and made by applying the principles of the Enforcement Management Model and recorded on EMM1.
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CONCLUSION

HEADLINES

Complete the investigation as soon as is realistically achievable in relation to its scope and complexity

Meet the target timescales for completing investigations wherever possible

Inform the interested parties of the outcome

Close the investigation without delay when the actions that qualify it for completion have been taken

Draw a clear line between the investigation and any other follow-on action arising from it

Decide and schedule any follow-up action.

RESPONSIBILITIES & ACTIONS

Band 2	<ul style="list-style-type: none"> • Agree or override the lead inspector's proposals for concluding the investigation • Refer to the Band 1 any fatal incident investigation where prosecution is not recommended.
Lead inspector	<ul style="list-style-type: none"> • Determine when investigatory activities should stop with reference to the Criteria for closure • Fulfil the conditions for closing investigations in the above criteria • Pursue any significant underlying factors that give wider concern about compliance through inspection, not by extending the investigation • Inform all the interested parties of the outcome, including any bereaved family, injured person, employee/safety representative, and dutyholder (if there is no other concluding communication on enforcement action) • Take any remaining and relevant enforcement action, and follow up in accordance with Directorate policy appropriate.
Band 1	<ul style="list-style-type: none"> • Assess fatal incident investigations where prosecution is not proposed: • confirm the recommendation • request further enquiries are carried out; or • overturn decision and recommend prosecution

CRITERIA AND PERFORMANCE STANDARDS

Criteria for closure	The following criteria describe the circumstances in which investigatory activities should stop, and the action that should be taken before an investigation is closed.
Curtail	<p>Circumstances</p> <p>One of the following:</p> <ul style="list-style-type: none"> • sufficient evidence or information has been obtained to conclude that there has been no material breach • the time and effort required to prove a breach of law would be disproportionate to securing justice • an incident is found, after initial investigation, to fall outside HSE's priorities for enforcement under Section 3.
Close without prosecution	<p>Action</p> <ul style="list-style-type: none"> • complete the Mandatory actions as far as relevant, • in all cases, record the reasons for stopping as a key decision.
Proceed to prosecution	<p>Circumstances</p> <ul style="list-style-type: none"> • sufficient lines of enquiry have been pursued to support a decision that enforcement will not exceed Notices or Notification of Contravention. <p>Action</p>

<p>Awaiting coronial investigation or inquest</p>	<ul style="list-style-type: none"> • complete the Mandatory actions • submit the IMPACT report to the Band 2. <p>Circumstances</p> <ul style="list-style-type: none"> • all reasonable lines of enquiry have been completed and evidence prepared with a view to a potential prosecution. <p>Action</p> <ul style="list-style-type: none"> • submit the completed IMPACT report and MEMT to the Band 2 for the approval process, or send to COPFS. <p>Circumstances</p> <ul style="list-style-type: none"> • the investigation is effectively complete with report prepared including a provisional enforcement decision • awaiting the outcome of the Coroner's investigation or inquest before finalising enforcement decision or proceeding to prosecution. <p>Action</p> <ul style="list-style-type: none"> • determine whether the outcome of the Coroner's investigation or inquest requires a change to the provisional enforcement decision, and bring to a conclusion accordingly.
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FATAL INCIDENTS

This section is about:

- early communications
- decisions on enforcement responsibility
- the joint management of fatal incident investigations with the police.

Refer to the section All incidents for guidance on how HSE conducts its part in the investigation, or continues when the police have handed over the lead.

INITIAL RESPONSE

HEADLINES

Confirm whether the incident is a work-related death and within HSE's enforcement responsibility

Resolve cases of uncertainty as quickly as possible to enable an investigation decision to be made

Reach agreement with the police over the status of the incident and the initial action, in particular preserving and retaining the scene

Engage with other regulatory bodies where the incident is not for HSE, or collaboration is required

Determine how quickly HSE should visit the site of the incident, and the resources required for the first attendance

Notify HSE Secretariat of the incident for senior management briefing

Obtain details about the bereaved relatives to enable early contact to be made with them.

RESPONSIBILITIES & ACTIONS

Band 2	<ul style="list-style-type: none">• Make the investigation decision with reference to:<ul style="list-style-type: none">○ section 1 of the Incident Selection Criteria relating to fatalities○ the enforcement priorities for Section 3○ the criteria for investigating or following up deaths arising from domestic gas incidents• Request enquiries to be made where it is not clear whether HSE is the right enforcing authority• Secure the agreement of the appropriate enforcing authority to take on the incident if it is not for HSE• Make provision for early response, especially liaison with the police and arrangements for attending the scene• Ensure a completed Fatality 1 form is sent to HSE Secretariat for all reportable work-related deaths
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Lead inspector	<p>Consider how best to deploy staff resources to achieve the following actions, delegating to other team members - VO/RCO, B3 or B4 colleagues - where appropriate:</p> <ul style="list-style-type: none"> • Make enquiries where necessary to inform the investigation decision, or • Liaise with the police to discuss and agree initial action under the relevant Work-related deaths protocol and practical guide: <ul style="list-style-type: none"> ○ England and Wales: http://www.hse.gov.uk/pubns/wrdp1.pdf ○ Scotland: http://www.hse.gov.uk/scotland/workreldeaths.pdf ○ Practical Guide: http://www.hse.gov.uk/pubns/wrdp2.pdf ○ OC 165/10: http://www.hse.gov.uk/foi/internalops/ocs/100-199/165_10.htm • Ensure the Coroner (in England & Wales) is aware of the police/HSE response, and arrange for future communication and provision of factual report in accordance with the Enforcement Guide • In Scotland, inform the COPFS Health and Safety Division of the incident • Gather information to the extent available about the deceased, their next of kin and the family structure through the police and/or other contacts • Ensure the personal details about the deceased are correct • Record key decisions and their supporting reasons • Determine benchmarks and standards with relevant colleagues as early as possible.
Band 1	<ul style="list-style-type: none"> • Provide direction and a steer if experience and expertise adds value, especially in cases of difficulty over enforcement responsibility or collaboration between agencies • Oversee the flexible use of staff resources between teams where necessary to ensure an adequate initial response by HSE.

PERFORMANCE STANDARD

Timescales	<ul style="list-style-type: none"> • The Fatality 1 form should be sent to HSE Secretariat within 24 hours of receiving notification of the incident • The decision to investigate should be made within 24 hours of receiving notification or as soon as sufficient information becomes available.
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MANAGEMENT OF JOINT INVESTIGATION

HEADLINES

Begin a joint investigation with the police as soon as practicable, identifying their senior investigating officer

Follow the Work-related Deaths Protocol, and the Practical Guide (England & Wales)

Establish who will take primacy

Agree with the police and any other relevant authorities how the joint investigation is to be managed and kept under review

Make joint arrangements for the investigation, including:

- lines of enquiry
- resources required and use of powers
- gathering, processing and sharing relevant material
- specialist and expert advice
- interview strategy
- communications with bereaved relatives

Agree approach to HM Coroner (England and Wales) or the Procurator Fiscal (Scotland)

Assess whether the investigation calls for application of an analytical investigation method (AIM)

Comply with HSE’s health and safety policy on staff exposure to potentially traumatic situations.

RESPONSIBILITIES & ACTIONS

Band 2	<ul style="list-style-type: none"> • Appoint a lead inspector for the investigation • Secure any additional resources required at this stage, including the need for Sector or specialist assistance: refer to the Specialist Assistance Procedure: http://intranet/strategy/cost-recovery/docs/specialist-assistance.pdf • Check that the joint investigation arrangements are working effectively in accordance with the WRDP and Practical Guide (for England & Wales): http://www.hse.gov.uk/pubns/wrdp2.pdf , and intervene or escalate if not • Give guidance or direction on the lead inspector’s objectives and priorities for the investigation where appropriate • Ensure that early contact is made with bereaved relatives, overseeing the arrangements set out in OG: Contact with relatives of people killed through work activities: http://www.hse.gov.uk/foi/internalops/og/og-00064.htm • Monitor progress, especially: <ul style="list-style-type: none"> ○ the reasons for the police continuing to pursue potential negligent homicide, via liaison with the CPS ○ the timely production of HSE’s report to the Procurator Fiscal • Attend review meetings with the police, CPS or COPFS where a senior presence is required • Make a positive decision whether an AIM should be applied to any aspect of the investigation in accordance with the criteria for Use of AIMs • Apply HSE’s health and safety policy on exposure to potentially traumatic situations in respect of all staff connected with the investigation • Proceed with the investigation as set out in All incidents
Lead inspector	<ul style="list-style-type: none"> • Arrange for relevant background information on the dutyholder(s) to be assembled • Brief the police SIO, or delegated officer, on the health and safety aspects of the incident, and where HSE can contribute expertise • Follow the WRDP Practical Guide (England and Wales) in setting up and progressing the joint investigation • Arrange for any specialist assistance required at this stage

	<ul style="list-style-type: none"> • Take on any delegated role in engaging with bereaved relatives in accordance with OG: Contact with relatives of people killed through work activities: http://www.hse.gov.uk/foi/internalops/oq/oq-00064.htm • Continue the investigation in accordance with the section: <u>All incidents</u>
Band 1	<ul style="list-style-type: none"> • Intervene with the police and the CPS to resolve issues of investigation delay or stalling when necessary • Keep Head of Division informed about investigations of particular importance, sensitivity or reputational risk.

PERFORMANCE STANDARDS AND CRITERIA

Timescales	<ul style="list-style-type: none"> • Investigations into fatal incidents should be completed as soon as practicable, and in any event within 12 months of HSE taking primacy • An investigation review with the police and CPS should be carried out in cases where primacy remains with the police at 3 months post incident, for the purpose set out in the WRDP Practical Guide • The COPFS are responsible for investigation into fatal incidents in Scotland. Against that background, HSE will endeavour to submit their report within 12 months of the incident WRDPS
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Use of AIMS	<p>An analytical investigation method must be formally applied in consultation with an AIMS facilitator to:</p> <ul style="list-style-type: none"> • a declared or potential major incident • a work-related fatality of other serious incident where AIMS is likely to be of significant benefit in dealing with any complex aspects of the investigation. <p>The use of AIMS in other circumstances is discretionary, and should be considered at investigation reviews.</p> <p>The decision whether or not to use AIMS must be recorded on IMPACT.</p>
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POTENTIAL MAJOR INCIDENTS - IMMEDIATE ACTION

<p>This section concerns potential major incidents and politically sensitive events.</p> <p>The detailed response arrangements, including preparedness, are set out in the instructions and guidance relating to:</p> <ul style="list-style-type: none"> • the Divisional Major Incident Response Plan • HSE's Emergency Response Plan • HSE's duty as a responder under civil contingencies legislation. <p>The sole function of this section is to provide the link to the relevant information: HSE response to a major incident or civil contingency event</p>
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VERSION 5.0	October 2015
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The Investigation Procedure should be followed in parallel with the above.
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WRPD PRACTICAL GUIDE (England & Wales)

Purpose of 3 month review

Whilst all investigations will be managed differently, it is suggested that in cases where primacy remains with the police at 3 months post incident, a comprehensive review of the investigation is carried out by the police and the relevant enforcing authorities. The review should be jointly conducted and involve the police, CPS and relevant enforcing authority and should:-

- assess progress;
- review the evidence obtained to date and seek advice from the CPS, if not already obtained, on whether the investigation into potential negligent homicide⁽¹⁾ should continue;
- where the police are to retain primacy for the investigation, agree (unless there is a good reason) that the CPS seek suspension of the coronial investigation⁽²⁾, and the adjournment of any associated inquest; and,
- where there is no evidence of a negligent homicide offence, agree how and when primacy should be passed to the relevant enforcing authority.

(1) Negligent Homicide means 'Serious criminal offence other than a health and safety offence.

(2) Coroners powers to suspend an investigation under Schedule 1 (Section 11) of the Coroners and Justice Act 2009