HSE

Health and Safety Executive

Internal Audit of

Regulatory Decision Making (RDM)

Incident Investigation

July 2006

Internal Audit and Assurance Unit

Internal Audit of Regulatory Decision Making – Incident Investigation

Content **Page**

Annexes

1. Background and Scope

1.1 The main aim of the audit was to provide information and assurance on the quality of regulatory decisions made during the investigation of incidents by HSE and Local Authorities (LAs). A further aim was to provide baseline data and information on enforcement behaviour for the HSE Enforcement Strategic Enabling Programme (StEP).

1.2 This was a collaborative exercise undertaken by Internal Audit and Assurance (IAA), in conjunction with OPSD's Operations Policy Unit (OPU). A team drawn from IAA, Directorate auditors, LAU and regulatory specialists (inspectors) carried out the fieldwork. The audit built on a previous exercise carried out in 2004, which looked at a small sample of investigations, and this time covered a much larger sample, including greater involvement with LAs.

2. Audit Approach

2.1. The sample was designed with the help of CoSAS, to get maximum validity within available resources. It focused on a narrow range of types of incident, including manual handling investigations in FOD, HID and LAs, falls from height in FOD and LAs, losses of containment in HID, and breaches of licence condition in NSD.

2.2. We examined 126 incident investigations in total, with the sample being skewed towards where most of the investigations are carried out:

- FOD (2 Divisions) 69 Investigations
- LAs (4 LAs) 38 Investigations
- HID 15 Investigations
- NSD 4 Investigations

2.3 64 HSE inspectors and 19 LA S/EHOs were interviewed as part of the exercise to ascertain all the relevant information about each incident and the investigation. A case summary was prepared for each investigation, maintaining anonymity of the inspector concerned. The summaries were quality reviewed and referred back to the inspectors to ensure that all relevant facts had been correctly recorded.

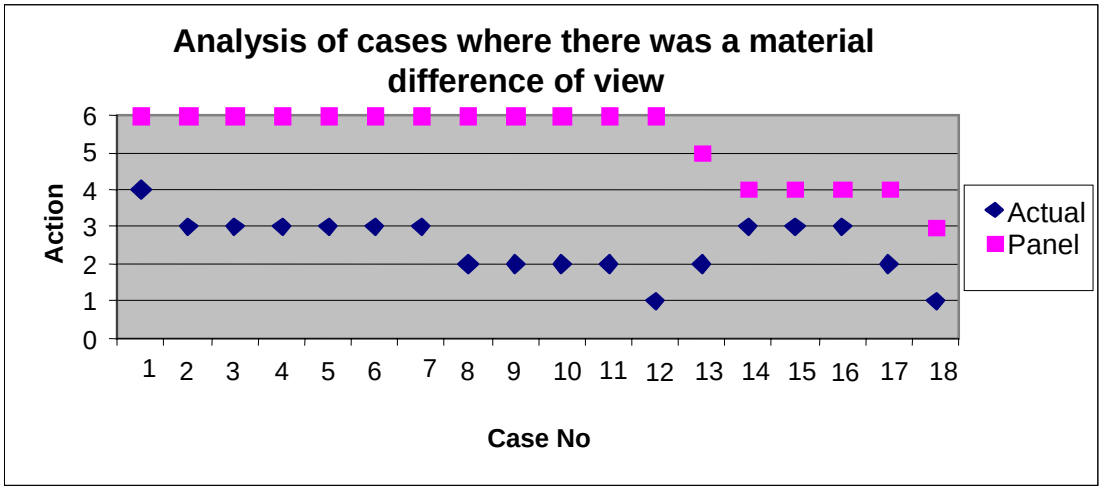
2.4 A Peer Review Panel (PRP) consisting of experienced Band 2 and Band 3 inspectors from FOD and HID, and 2 Senior EHOs from LAs examined each case and agreed the action (or a range of possible actions) they believe should have been taken. The case summaries provided to PRP members did not include the actual final action taken by the investigating inspector. This was only revealed after the PRP had decided on the action for each case. An experienced Band 2 from FOD HQ chaired the PRP, and IAA and OPU provided secretarial support and guidance.

2.5 To provide information for the Enforcement StEP, as mentioned in paragraph 1.1 above, we also took the opportunity to obtain inspectors (anonymous) views on a number of enforcement issues. Separate summaries have been prepared for this aspect of the audit and they have been forwarded to the Enforcement StEP team for information and analysis.

3. Main Findings

3.1 Our overall finding was that the PRP agreed with the investigating inspector's decision in 108 of the 126 cases. There were no cases where the PRP felt that the inspector had been over-zealous.

3.2 There were 18 cases where the PRP felt they would have taken significantly stronger action, including 12 instances where they thought a prosecution was probably appropriate. The chart below shows the variance between the PRP and the actual decision for these 18 'material differences'.



Note: The enforcement action range is: 1= No further action, 2= Verbal advice, 3= Letter, 4= Improvement Notice, 5= Prohibition Notice, 6= Prosecution.

3.3 It should be recognised that the team approach of the PRP, combined with the somewhat artificial setting, tends to lead to decisions for bolder regulatory action.

3.4 The PRP also accept that some of the HID investigations were rather complex and it was difficult to reach a conclusive decision in at least one of the cases where a possible prosecution was proposed. Also, some of the HID cases were relevant to Scotland, where a different legislative system is in place, and the decision to prosecute is outside of HSE's remit. The PRP agreed with the action taken in all 4 of the NSD cases.

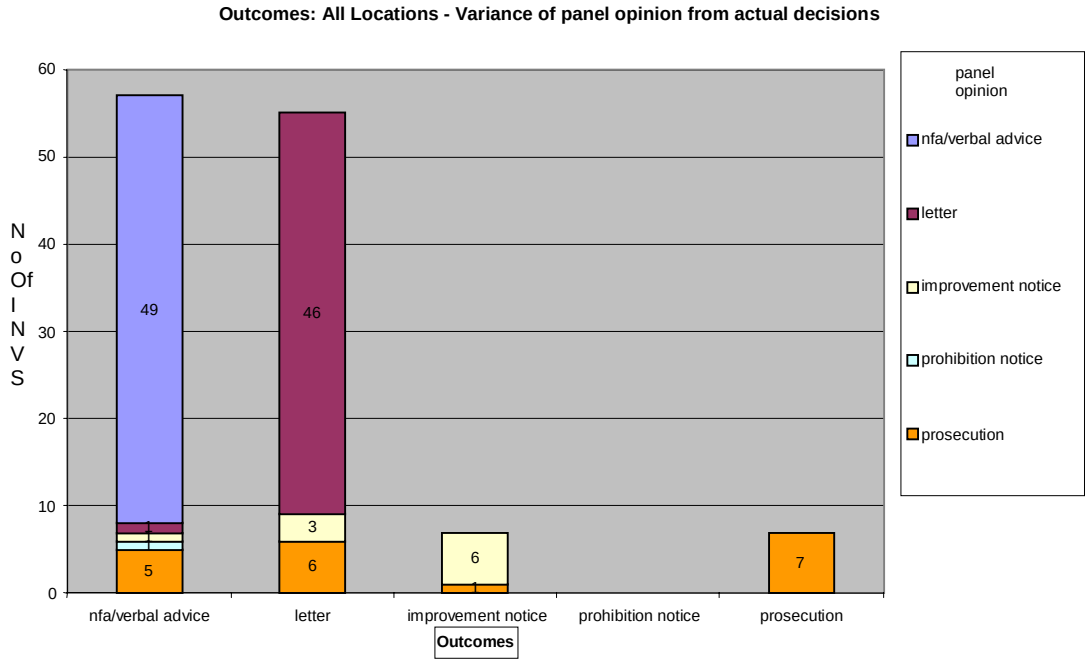
3.5 We have analysed the geographical split of these cases and there is no obvious trend pointing towards any 'hotspots'. Likewise, when looking

at the length of service of the HSE inspectors involved, there is a wide range of inspector experience. In general, the FOD sample was made up of more serious incidents than the sample for LAs, giving scope for wider enforcement action.

3.6 In terms of actual enforcement action taken, of the 126 incidents in our sample, 7 resulted in prosecutions (all FOD) and 8 resulted in Notices (7 FOD and 1 HID). The PRP agreed with all of these decisions, apart from the 1 Notice in HID, where they suggested a prosecution was appropriate (recorded as a material difference above). There was no actual formal (i.e. Notice or above) enforcement action taken for any of the cases in our LA sample.

3.7 The PRP raised a number of general observations during their discussions and these have been passed on to the Enforcement StEP team for information.

3.8 The chart below provides a breakdown of the PRP's opinion for all actual actions. It shows the number of cases where the PRP agreed as well as the actions they believe should have been taken where they did not agree.



The bars show the total number of investigations by the actual decision taken. The bars are then broken down to show the actions that the PRP believe should have been taken.

3.9 The results have been further broken down by location and type of incident in a series of charts provided at Annexes A – O.

4. Conclusion

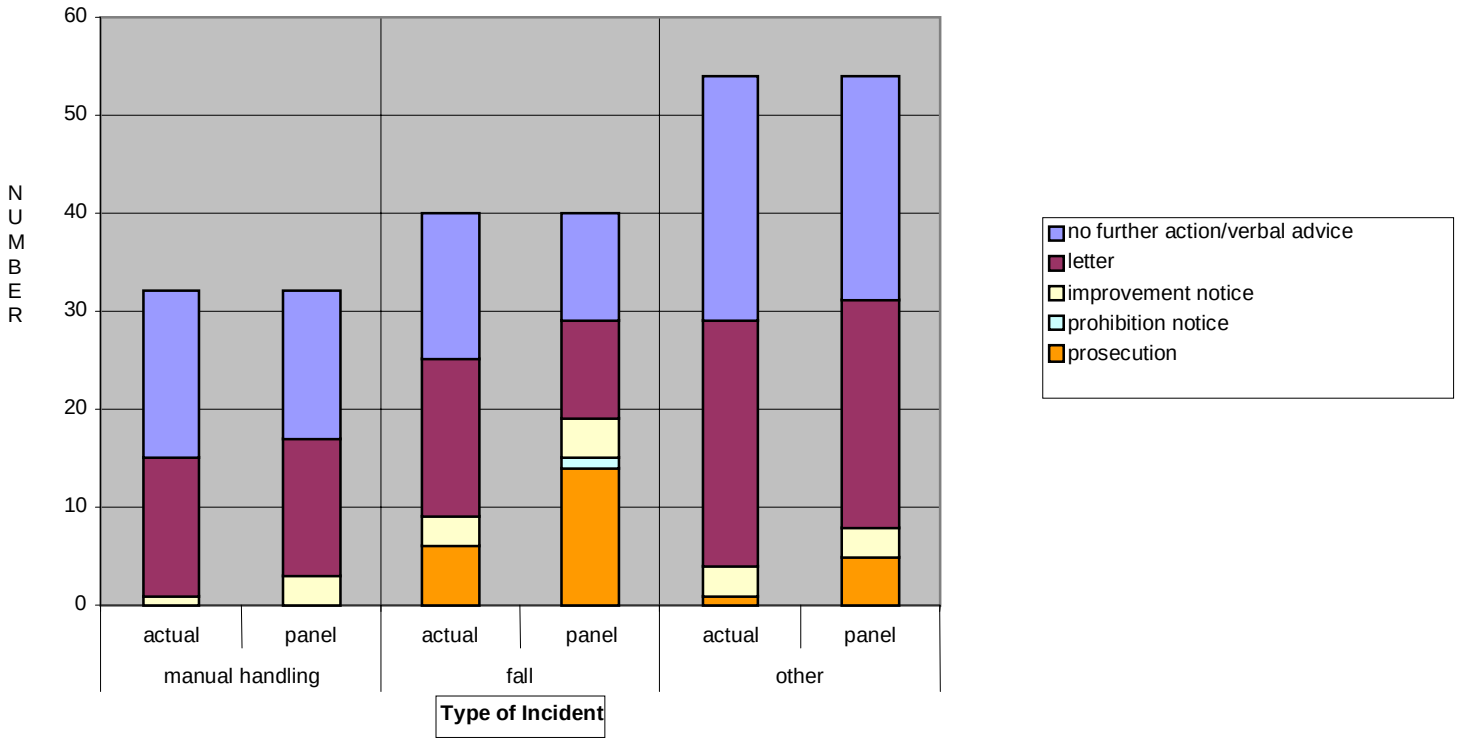
4.1 The results of this exercise suggest that there is a significant gap in following policies and that incident investigations should be resulting in somewhat more consistent enforcement activity than is currently the case. Therefore, we can give a **limited assurance** that the system provides an adequate basis for effective control and is properly operated in practice. See Annex Q for a definition of our levels of assurance. We recognise that there is considerable effort through the Enforcement Programme to improve consistency in this area.

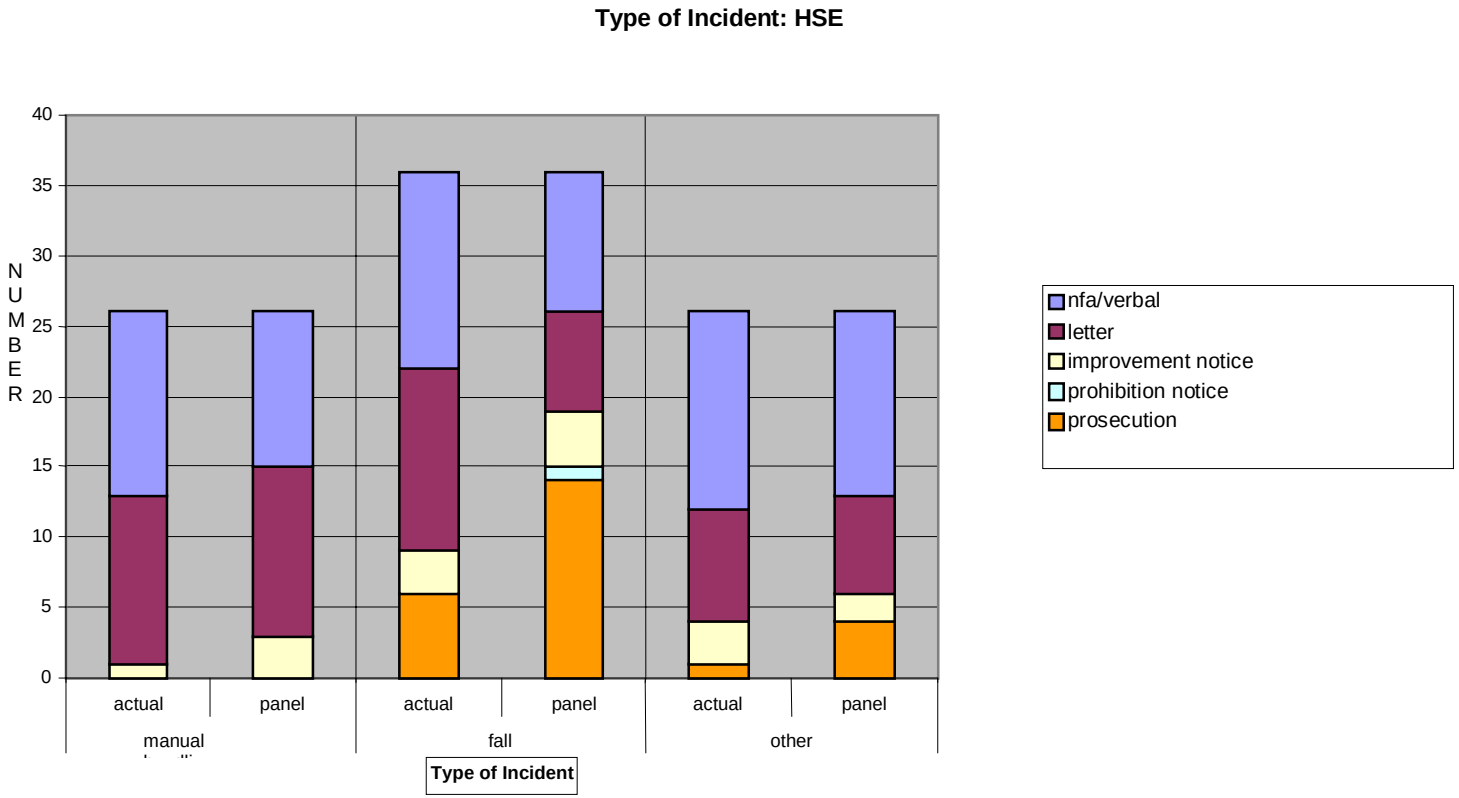
5. Recommendations

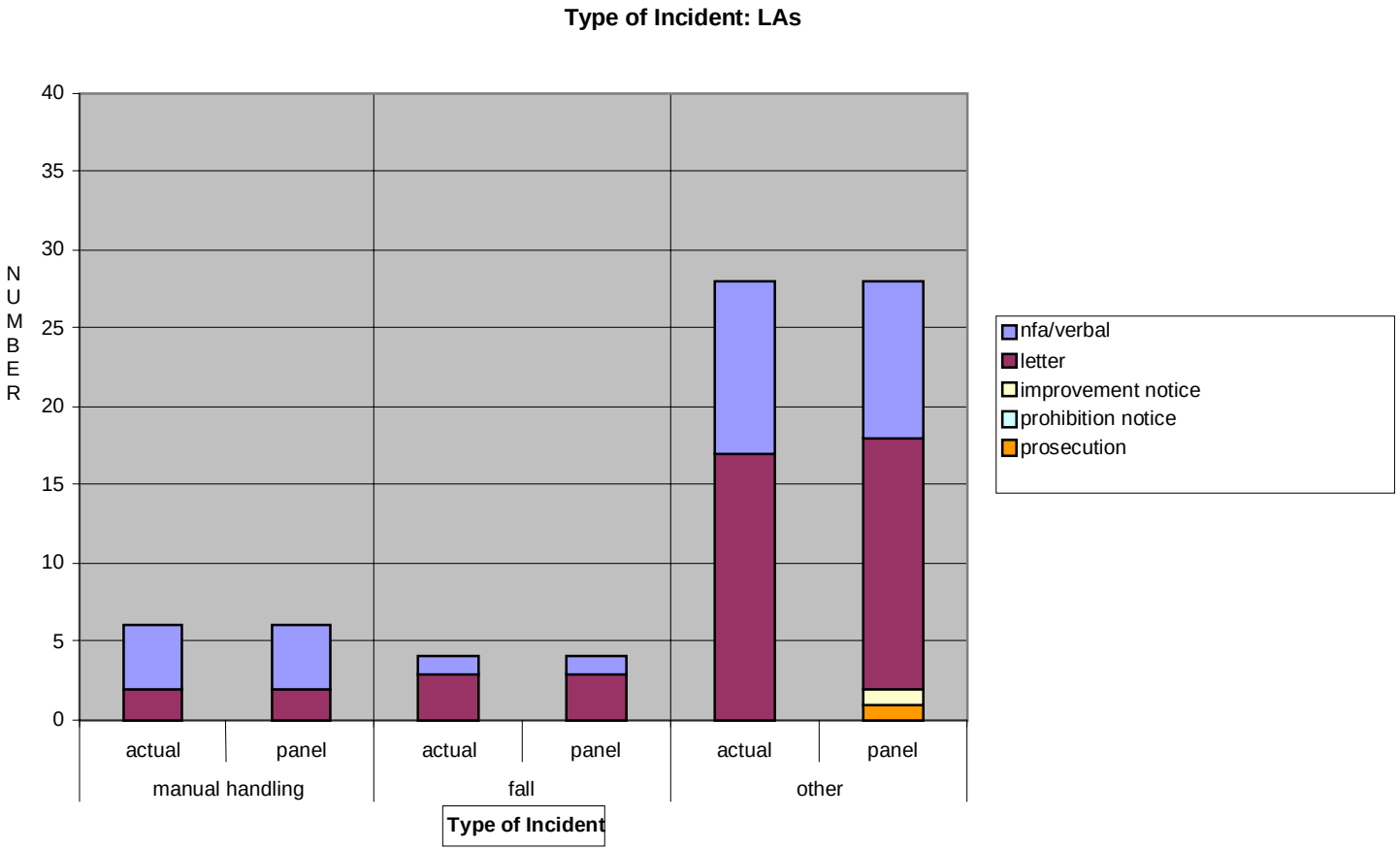
5.1 That the Strategic Enabling Programme on Enforcement takes into account the findings of the RDM audit in developing recommendations to improve the efficiency and effectiveness of HSE's (and LAs') investigation and prosecution activities.

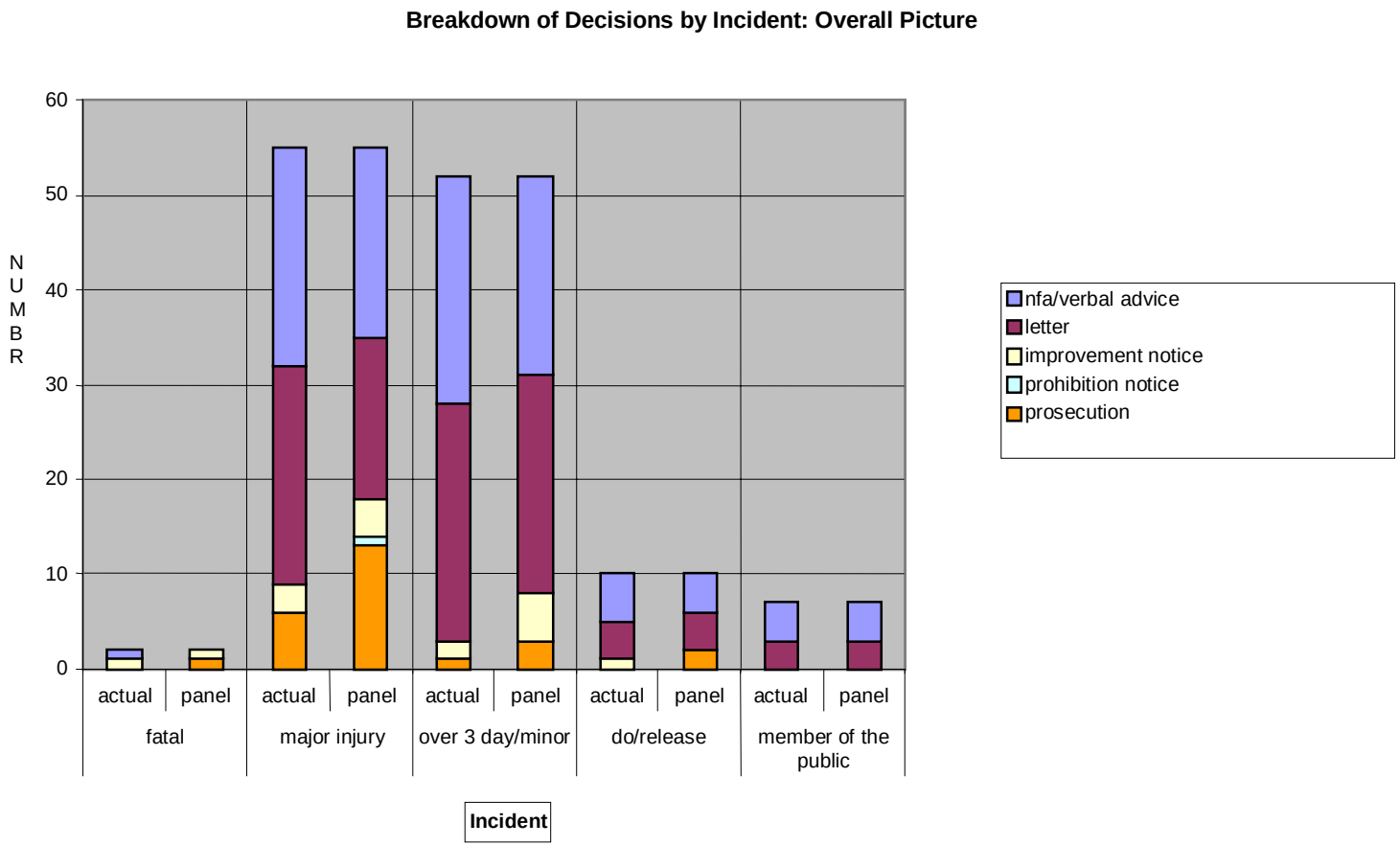
5.2 That this audit is repeated in 2007 to monitor progress.

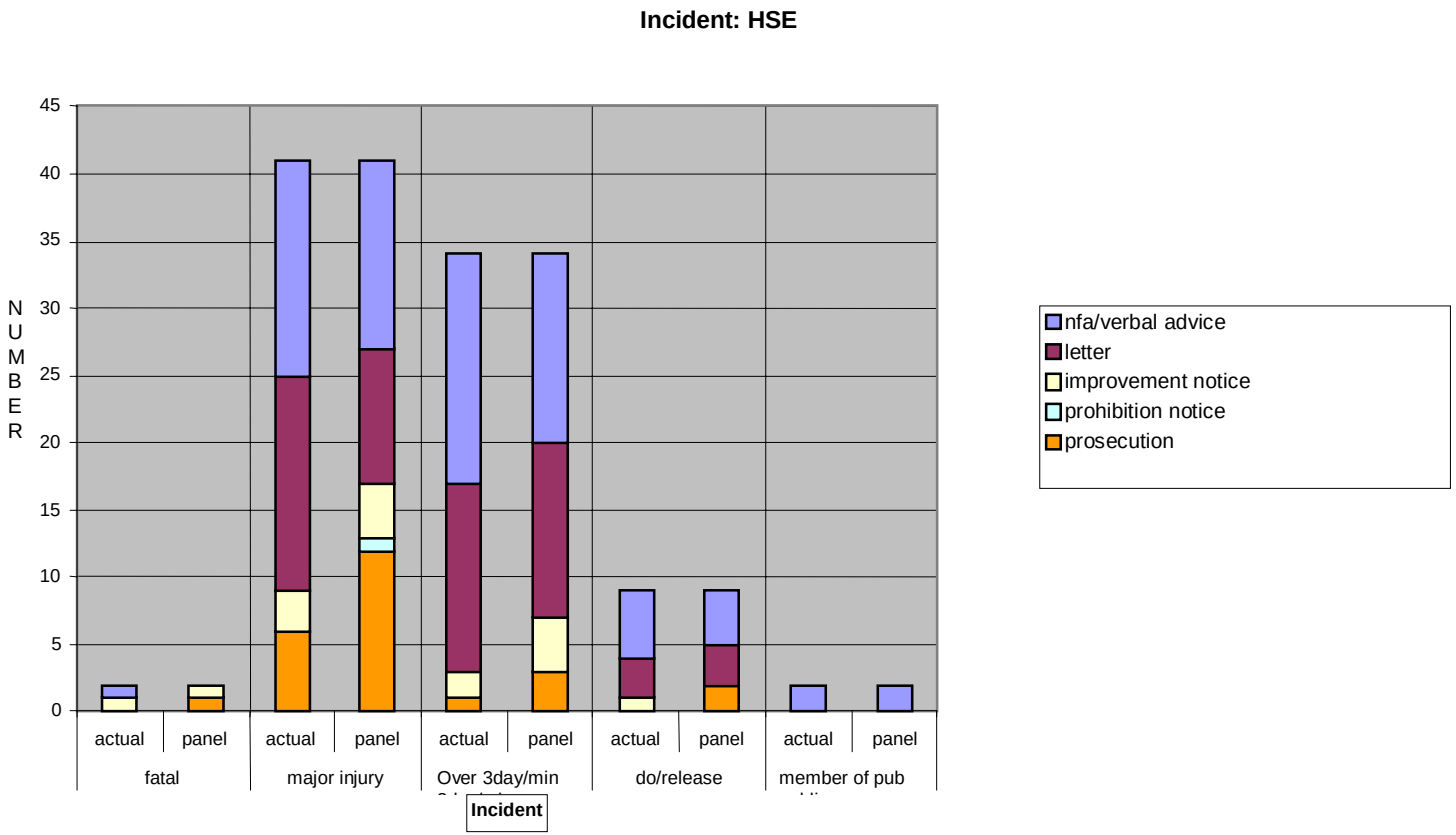
Breakdown of Decisions by Type of Incident: Overall Picture

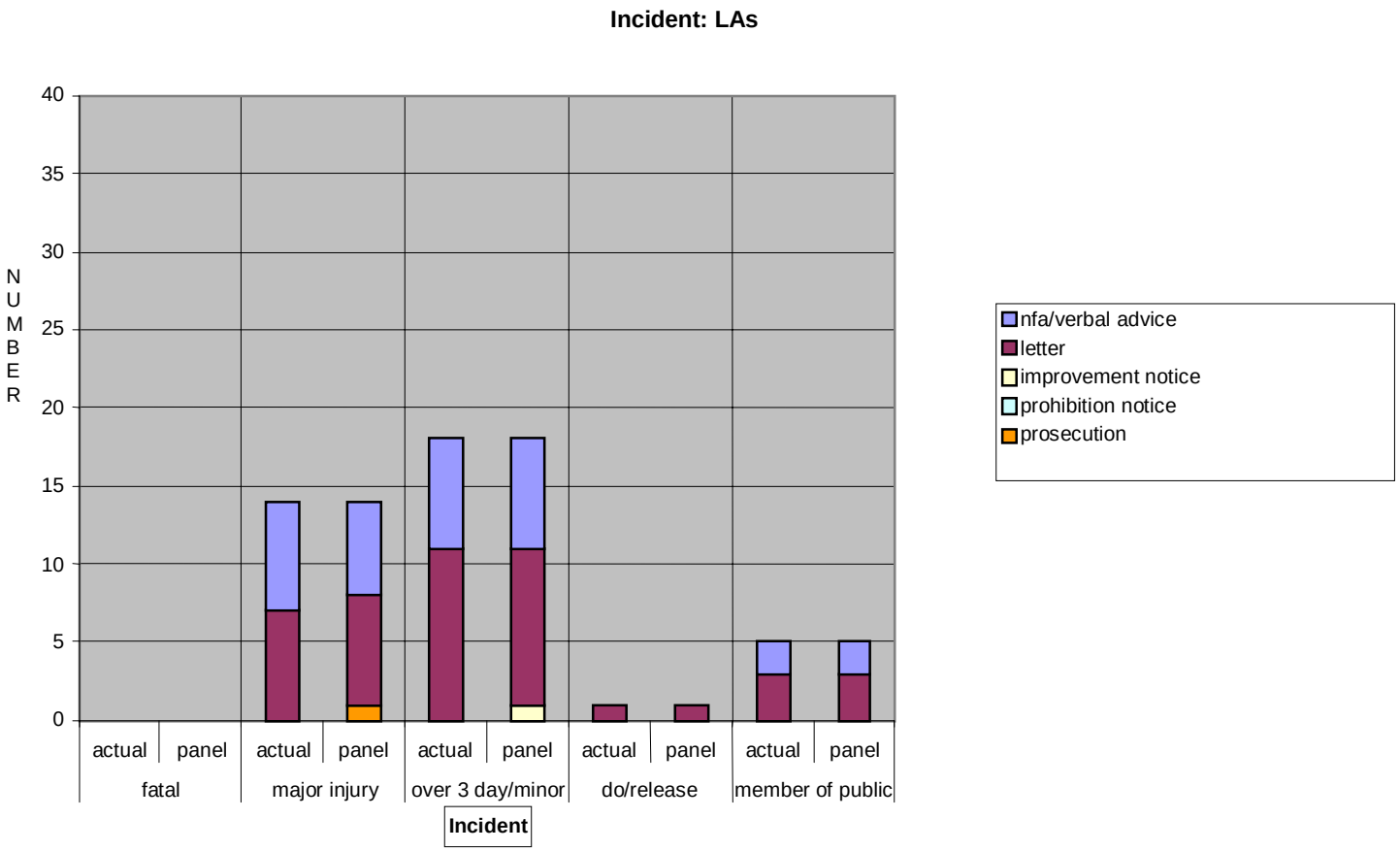



Type of Incident: HSE
NUMBER
40
35
30
25
20
15
10
5
0
actual
panel
actual
panel
actual
panel
manual
fall
other
Type of Incident
nfa/verbal
letter
improvement notice
prohibition notice
prosecution

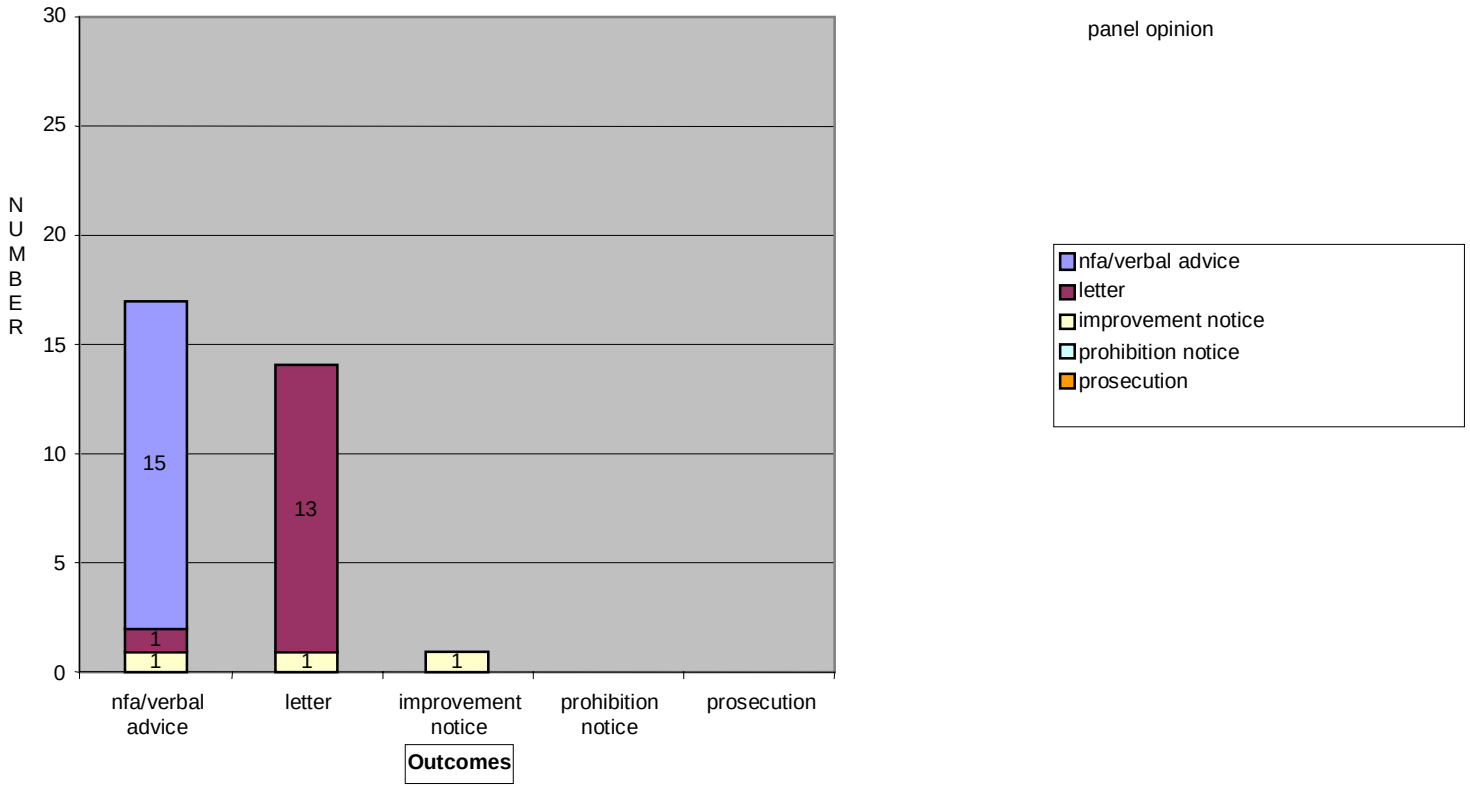

Type of Incident: LAs
NUMBER
40
35
30
25
20
15
10
5
0
actual
panel
actual
panel
actual
panel
manual handling
fall
other
Type of Incident
nfa/verbal
letter
improvement notice
prohibition notice
prosecution


Breakdown of Decisions by Incident: Overall Picture
NUMBR
60
50
40
30
20
10
0
actual
panel
fatal
major injury
over 3 day/minor
do/release
member of the public
Incident
nfa/verbal advice
letter
improvement notice
prohibition notice
prosecution

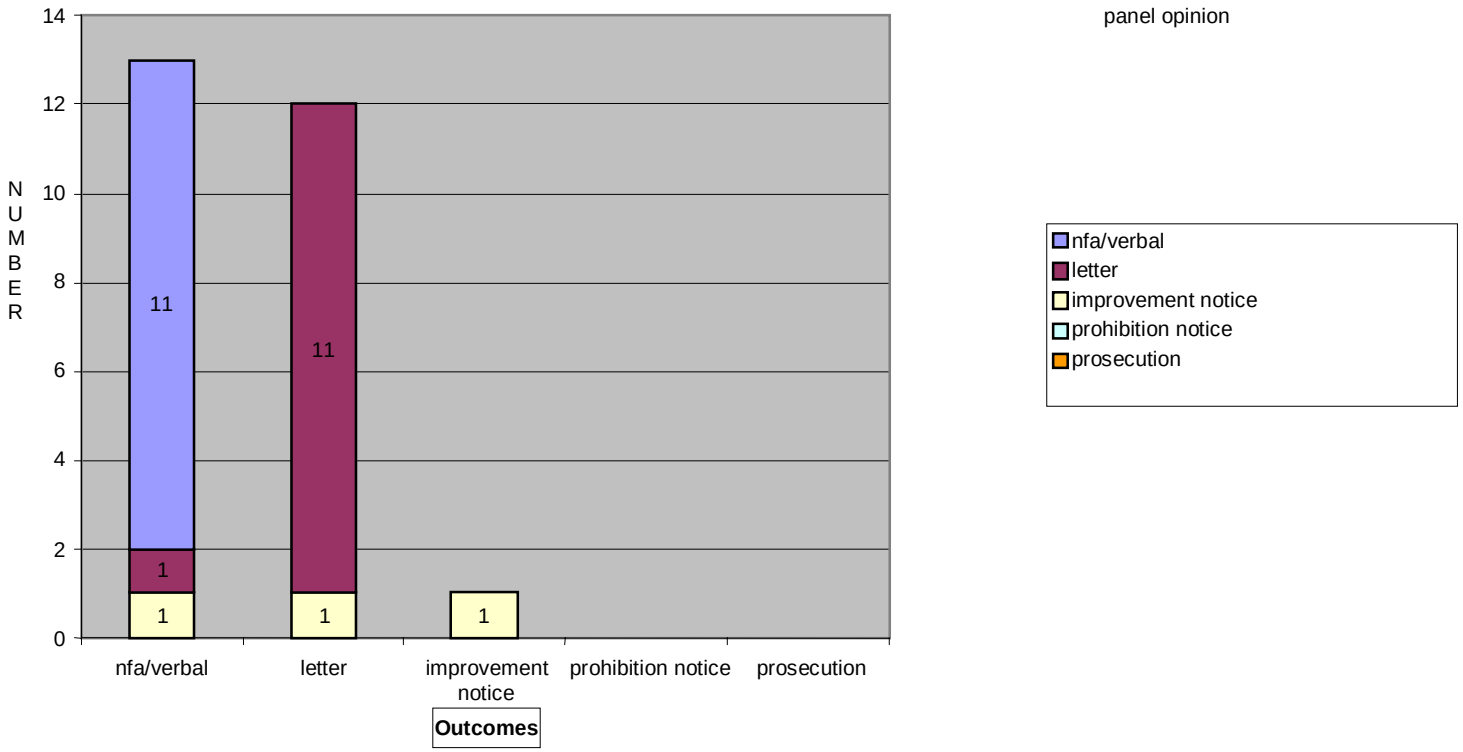

Incident: HSE
45
40
35
30
25
20
15
10
5
0
NUMBER
actual
panel
fatal
major injury
Over 3day/min
do/release
member of pub
Incident
nfa/verbal advice
letter
improvement notice
prohibition notice
prosecution

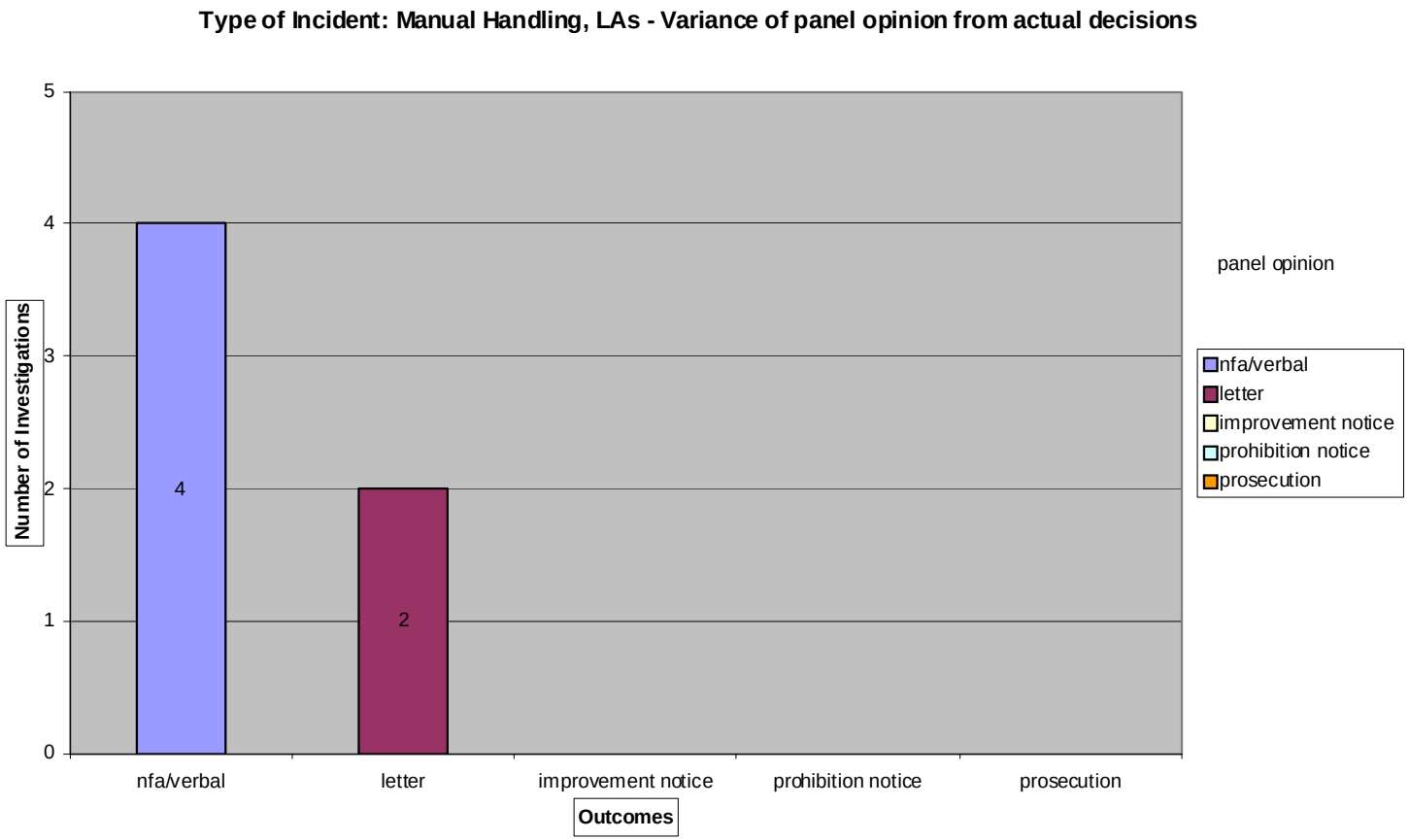

Incident: LAs
NUMBER
40
35
30
25
20
15
10
5
0
actual
panel
fatal
major injury
over 3 day/minor
do/release
member of public
Incident
nfa/verbal advice
letter
improvement notice
prohibition notice
prosecution

Type of Incident: Manual Handling, Overall Picture - Variance of panel opinion from actual decisions

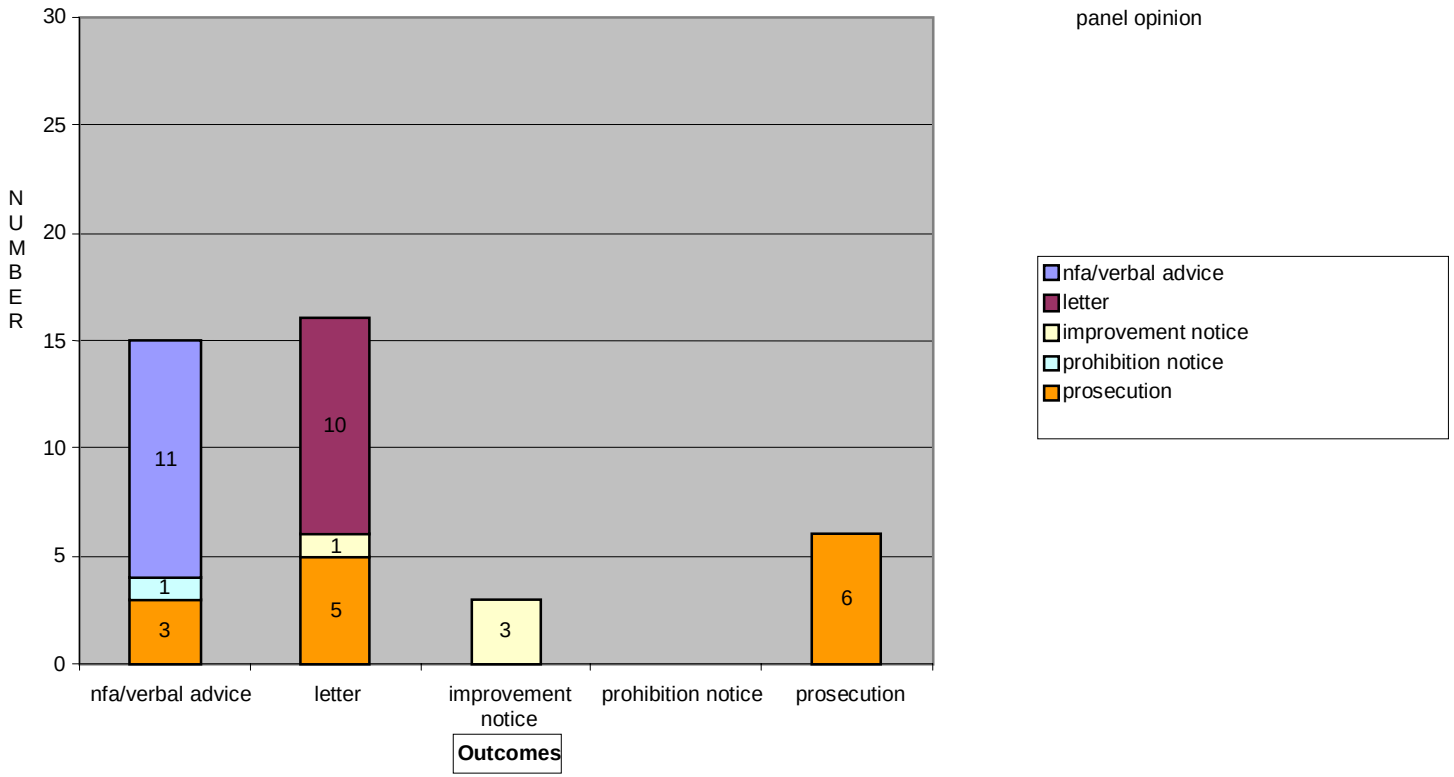


Type of Incident: Manual Handling, HSE - Variance of panel opinion from actual decision

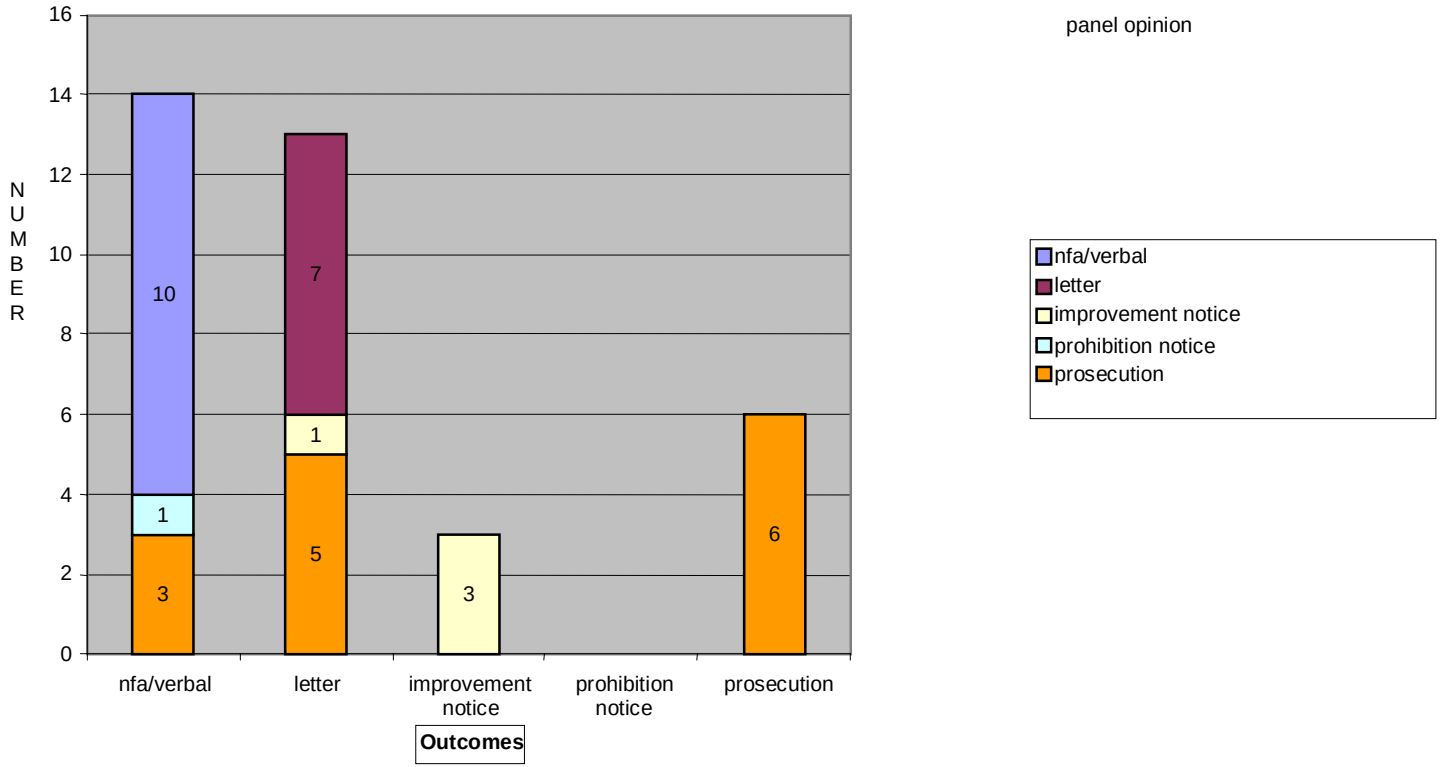


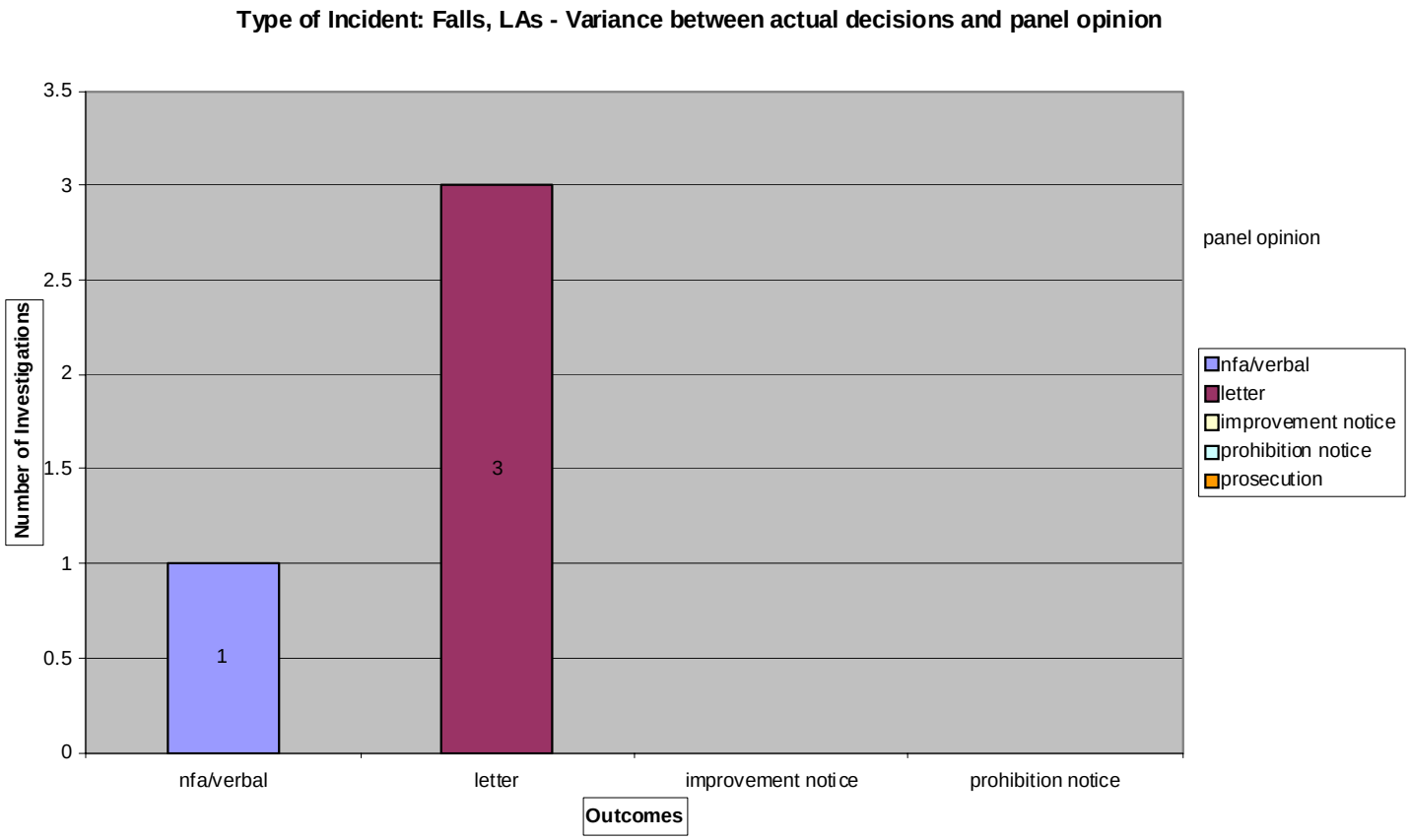

Type of Incident: Manual Handling, LAs - Variance of panel opinion from actual decisions
Number of Investigations
5
4
3
2
1
0
4
2
nfa/verbal
letter
improvement notice
prohibition notice
prosecution
Outcomes
panel opinion
nfa/verbal
letter
improvement notice
prohibition notice
prosecution

Type of Incident: Falls, Overall Picture - Variance between actual decisions and panel opinion

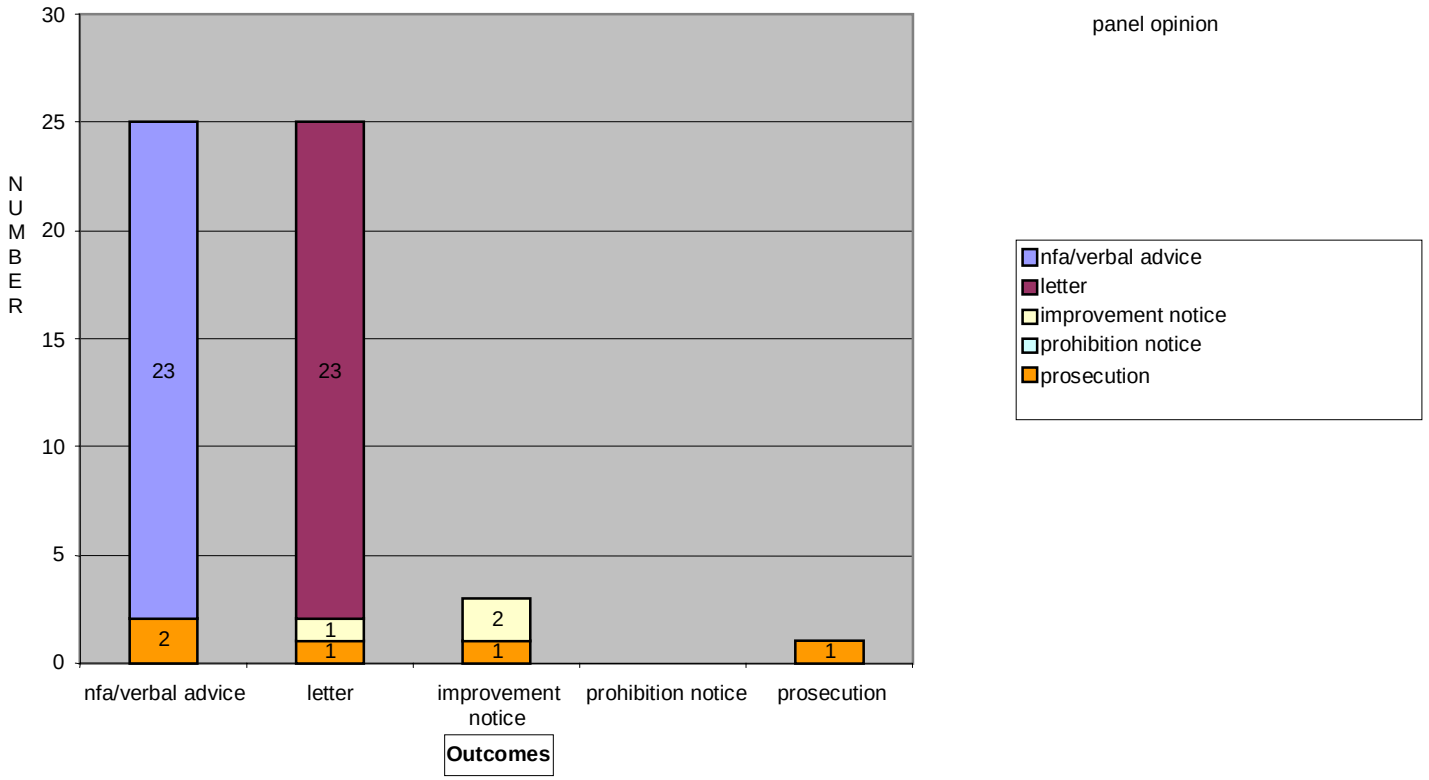


Type of Incident: Falls, HSE - Variance between actual decision and panel opinion

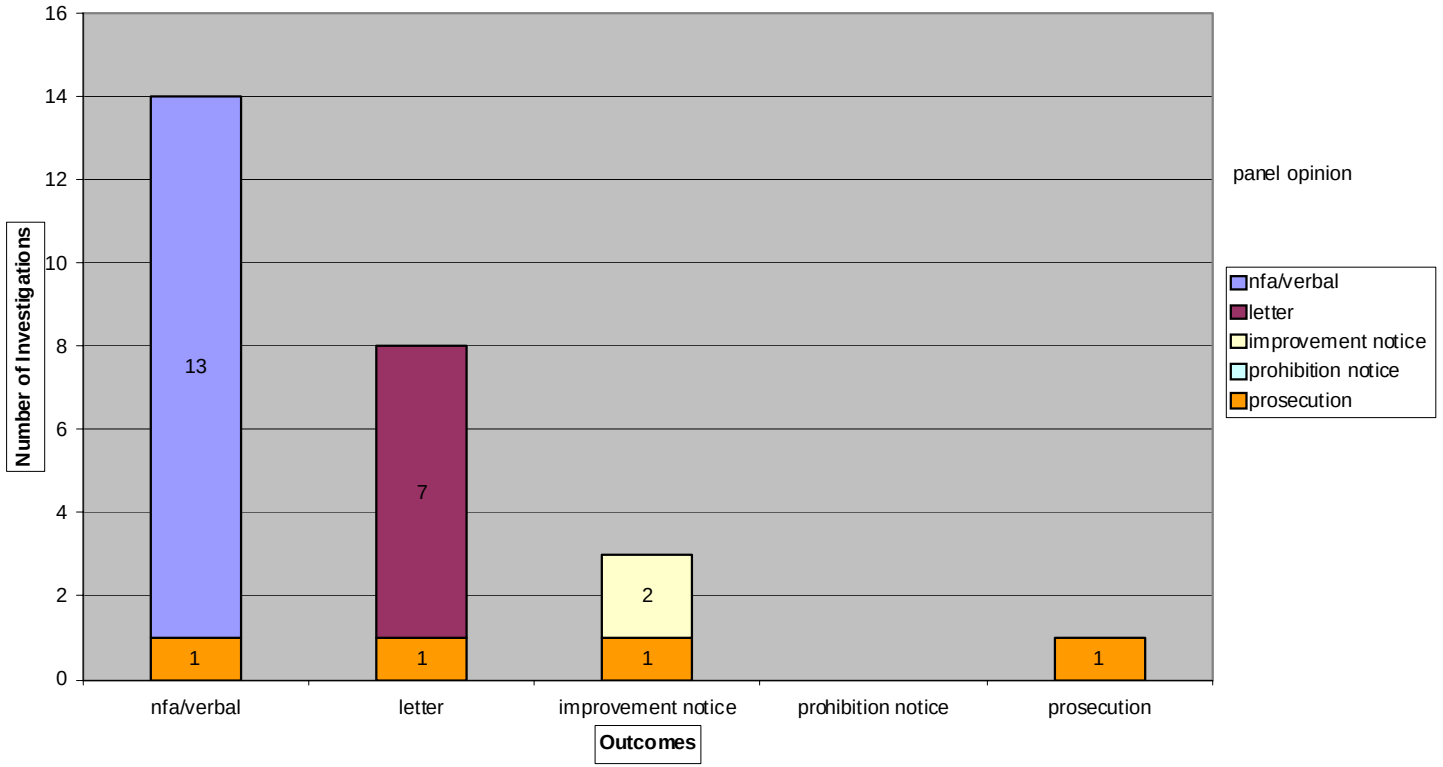



Type of Incident: Falls, LAs - Variance between actual decisions and panel opinion
Number of Investigations
3.5
3
2.5
2
1.5
1
0.5
0
1
3
nfa/verbal
letter
improvement notice
prohibition notice
Outcomes
panel opinion
nfa/verbal
letter
improvement notice
prohibition notice
prosecution

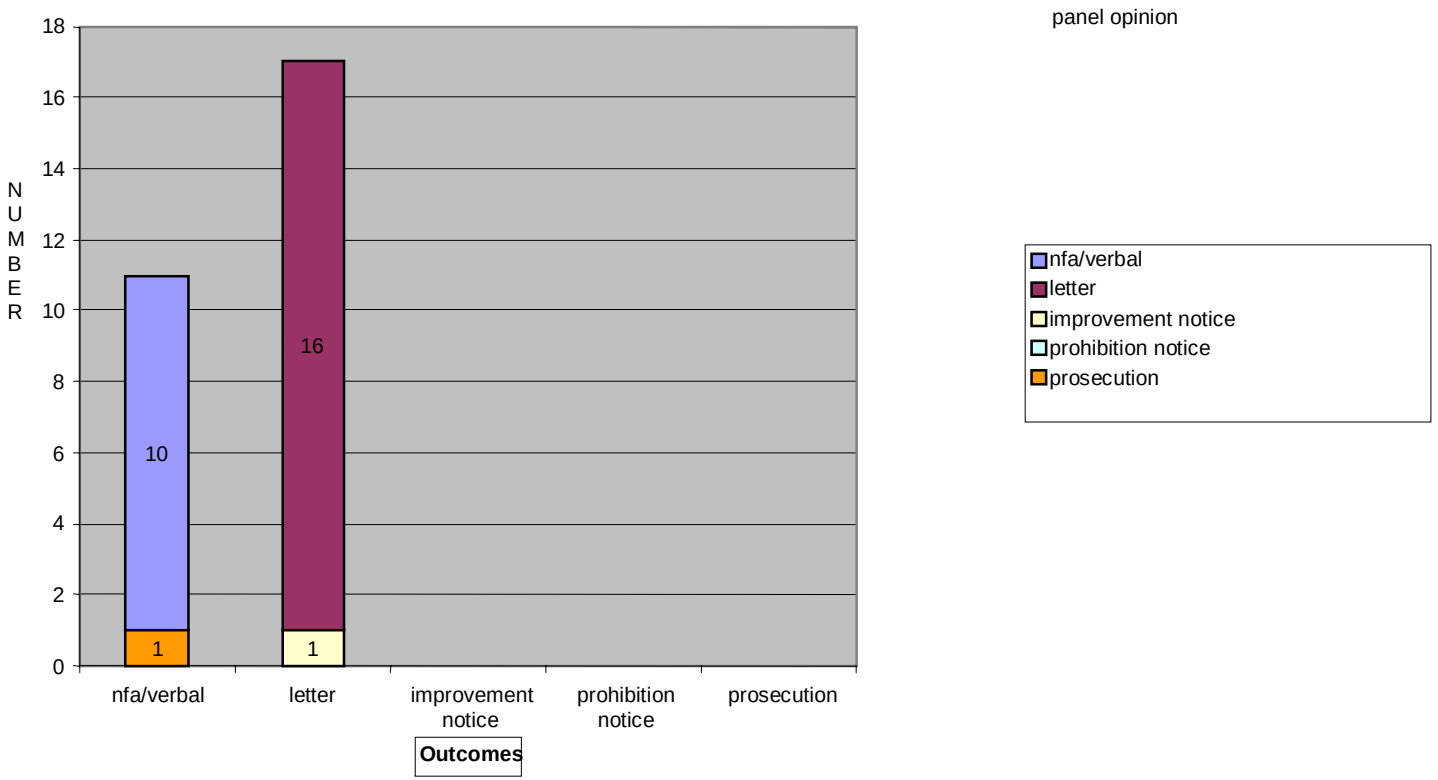
Type of Incident: Other, Overall Picture - Variance between actual decisions and panel opinion



Type of Incident: Other, HSE - Variance between actual decisions and panel opinion



Type of Incident: Other, LAs - Variance between actual decisions and panel opinion



Annex P

Enforcement Strategic Enabling Programme

Efficiency Workstream Aims

This Programme will examine HSE's and LAs' formal enforcement activities and make recommendations that will better enable HSE and Las' to:

- where appropriate, use these activities to support delivery of the targets to reduce occupational injury, ill health and days lost through work;
- undertake prosecutions and conduct the associated investigation work more effectively and efficiently;
- determine whether more should be done to target and enforce against those who deliberately flout the law and put others at risk for financial gain;
- optimise and sustain, through communications, the ripple and deterrent effect of these activities.

Annex Q

MEASUREMENT OF ASSURANCE

CATEGORY NUMBER	LEVEL	DEFINITION
1	**FULL ASSURANCE**	Sound risk management, governance arrangements, or control systems established and found to be operating effectively and consistently.
2	**SUBSTANTIAL ASSURANCE**	Basically sound risk management, governance arrangements, or control systems established, but they are not fully developed or consistently applied.
3	**LIMITED ASSURANCE**	Risk management, governance or control systems not sufficiently developed or significant levels of non-compliance identified.
4	**NIL ASSURANCE**	Risk management, governance or control systems poorly developed or non-existent, or major levels of non-compliance identified.

Annex R

CIRCULATION LIST

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Ian Baddeley	Local Authority
Jenny Fordham	Local Authority
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