HSE
Health & Safety Executive

Public protection consultation study

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Dr Suzanne King
Mark Dyball
Leeanne Waller
People Science & Policy Ltd
Hamilton House
Mabledon Place
London
WC1H 9BB

This pilot study gauged views on public protection in advance of a wider consultation. Six focus groups used examples of health and safety related incidents to explore whether there should be an investigation, its purpose and the expertise investigators need.

'Health and safety' was perceived as a workplace issue with HSE's role that of overseer and inspector, setting rules and standards. Prompted, participants acknowledged wider relevance for health and safety although they realised that there are risks in all activities.

The main purpose of an investigation was to prevent the incident recurring. Outcomes do not necessarily have to be punitive; rather, bodies should accept responsibility, apologise and take preventative action. Vulnerable groups were said to need extra protection. Compensation payments were disliked, although for severe injuries, payments might cover care costs.

Participants conflated the decision-making process on whether to investigate with the reason for the incident. Incidents should be judged on: frequency; severity; scale; preventability; potential for harm; injured party's level of control; degree of personal responsibility circumstances imply; and the understanding society has of the hazard's impact. For the public, personal experience also played a role. Prioritising was to be thought very hard because individuals have different priorities.

Investigators must have relevant expertise and be independent. The first step should be an internal investigation with the results communicated to the 'injured' party. If this investigation was unsatisfactory, participants would look to outside bodies but participants were unclear which. Other professionals in the relevant field, a solicitor, the police or the media, were suggested.

Further research with a broader sample could explore: the opportunity cost of investigations; compensation; employees whose jobs put them in harms way; and personal risk taking. Quantitative research would more effectively gauge the public mood and subgroup differences.

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HSC's new strategy *"A strategy for workplace health and safety in Great Britain to 2010 and beyond"* commits HSE to:

> *"Consultation on our role regarding public safety issues by the end of 2004 to encourage wider debate across Government with the aim of greater clarity of responsibilities for agencies involved in public safety issues."*

HSE commissioned People Science & Policy Ltd (PSP) to undertake a public consultation in advance of consultation with other groups.

Objectives

The objective of this pilot study was to explore whether or not there are general principles that the public identifies in determining the nature of the response to public protection incidents. The intention was to explore the issues the public considers when deciding whether a response by government regulatory authorities is necessary and if so, what that response should be.

Method

PSP conducted six focus groups with between six and ten members of the public in three locations in the UK during October 2004. Using examples of health and safety related incidents developed by HSE, we explored whether participants thought that there should be an investigation, the purpose of the investigation and the expertise required to conduct any investigation. We have also drawn on three other studies published by HSE in 2003 and 2004.

HEALTH AND SAFETY

Health and safety

'Health and safety' is recognised as predominantly a workplace issue, with the emphasis on safety in manual work, rather than health or shop and office environments. However, once participants were encouraged to think more broadly they could see a wider relevance for health and safety and HSE involvement, although there was also a realisation that there are some risks inherent in day-to-day activities.

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HSE's role was perceived to be that of overseer and inspector, with a role in setting rules and standards. Participants saw HSE as mainly responsible for employees.

OBJECTIVES AND OUTCOMES OF INVESTIGATIONS

Prevention

Participants saw the main purpose of an investigation as being to prevent the incident from occurring again.

Responsibility

Participants wanted organisations to accept responsibility. They recognised a distinction between accidents and negligence and accepted that there may be different outcomes from investigations depending on the cause of an incident. Participants thought that there was a spectrum of sanctions that could be deployed against people who had made mistakes. For example, they could be removed from their positions, given extra training or limited in the range of work they are allowed to undertake. Faulty systems were seen to be the responsibility of individual managers rather than the organisation.

Participants talked about 'accepting responsibility', rather than about 'apportioning blame' but there was an acknowledgement that if they were the subject of an incident they would react differently. Vulnerable groups were said to need extra protection.

Punishment

Participants did not necessarily want individuals or organisations punished. Nevertheless, the threat of punishment was said to be needed to ensure compliance. It emerged that participants were not clear what 'prosecution' entailed or the 'punishment' to which prosecution could lead.

Compensation

Participants said that compensation claims had got out of hand and there was something of a reaction against compensation payments, although it was recognised that for severe injuries, payments might be needed to provide care or cover loss of earnings. Many participants believed that other people might be motivated to seek compensation.

Apologies

Participants were keen that those at fault acknowledged their mistakes and apologised. Often an apology was all that was required because participants understood that accidents happen and people can make mistakes in good faith. Although participants did not use the phrase restorative justice, the desire to see mistakes admitted and apologies offered could be seen as first steps towards this.

DECIDING WHETHER TO INVESTIGATE

Participants found it difficult to address the question of whether or not there should be an investigation. They tended to conflate the decision-making process on whether to investigate with the reason for the incident. Nevertheless, we identified some general principles.

Frequency

Frequency of occurrence was participants' first thought on whether an investigation was required.

Severity

A less severe incident would require more occurrences before an investigation was thought to be necessary.

Scale

The number of people affected should be taken into account.

Preventability

The extent to which an incident was preventable, and therefore possibly due to negligence, was an issue participants wanted to consider in deciding whether or not to investigate an incident.

Potential for harm

Participants considered 'near misses' worthy of investigation depending on the potential scale and severity of the incident.

Control

Willingness to accept risk was related to the amount of control participants felt they had over the situation.

Personal responsibility

Personal responsibility relates to the degree of risk society is willing to accept. Participants were aware that life involves risks that cannot be escaped.

Vulnerable groups (predominantly children and old people) were seen to require additional protection as children in particular, would be less able to take personal responsibility.

Incidents that affected employees in occupations where there was a degree of risk were given a lower priority. It was thought that employees should be trained to deal with likely scenarios and that they had actively decided to enter the occupation, presumably aware of the risks.

Understanding the issue

Issues which are less well understood, such as the impact of passive smoking, might be given a higher priority for investigation, in order to raise the level of understanding.

In addition, participants realised that personal experience of a situation was likely to play a role in their decision on whether or not to investigate an incident. Moreover, they acknowledged that deciding which incidents to investigate and what to prioritise was *"a very hard question"* because: *"What's important to one person might not be important to someone else."*

WHICH ORGANISATION?

The need for expertise

Participants agreed that investigations into incidents should be conducted by people or bodies with relevant expertise and independent of the 'responsible' organisation.

The stages of an investigation

Participants identified that the first step should be an internal investigation with the results communicated to the 'injured' party. If this investigation was felt to be unsatisfactory they would look to more senior bodies or organisations with expertise in the relevant activity or geographical area, to solicitors and lastly to the media to support their search for redress.

The need for independence

Concern was expressed about professional groups *"closing ranks"* and the need for independence was seen as paramount in any investigation.

The role of HSE

None of the participants spontaneously suggested that HSE might be the body that would investigate any of the example incidents. Indeed, HSE was not necessarily seen as the most appropriate choice of investigator for these types of incident.

HSE was seen as dealing with companies, not individuals. Its role was seen to be setting standards, overseeing and monitoring the health and safety systems of organisations.

CONCLUSIONS

Participants were unclear about where they might go for help if they needed advice following an incident. A body with expertise in the relevant field, perhaps overseen by HSE, applying HSE's regulations and standards, was mooted as desirable. Alternatively, perhaps another body or arm of HSE, is required to support those in need of redress following incidents such as those explored in this study.

Further research

This research has shown that attitudes and beliefs are complex and participants themselves have identified that ultimately the actions of people affected by incidents may differ from the way

that they would expect to behave when not emotionally involved. We found a high level of agreement in the objectives of investigations and the principles that should be applied in deciding whether or not to investigate a specific incident. However, our participants were fairly homogeneous, further work should therefore be undertaken with a broader sample.

We could not explore all the issues that arose from the discussions and inevitably a pilot study of this type raises as many questions as answers. In particular we think the following issues need more research.

Firstly: the opportunity cost of an investigation with respect to the potential reduction in services. In this study we found that many participants wanted even fairly minor incidents investigated even if it meant a reduction in services. We cannot determine whether this is the effect of 'hot housing' in the groups, a misunderstanding of the implications of an investigation, a fixation on the impact of the incident on themselves, an inability to empathise with those who might have their services reduced or something else.

Secondly: the question of compensation. We think there is a need to better understand the motivation behind compensation claims. We question the role of compensation.

Thirdly: the issue of employees putting themselves in harms way to do their job. In the time available we could not explore what might be expected of different occupations based on reasonable expectations of the conditions employees might expect to encounter.

Fourthly: personal risk taking was not considered in great depth.

An obvious starting point would be more focus groups. Some thought should also be given to a quantitative study that would enable HSE to gauge the public mood more effectively and to understand subgroups in more depth. The need for respondents to be given some information may mean that a quantitative methodology is impractical.

1 INTRODUCTION

1.1 BACKGROUND

The Health and Safety at Work etc Act can be construed very broadly. This has resulted in HSE frequently being asked to do more than it is able in respect of public protection, an area which is regulated by many other bodies, varying in the extent of their powers and levels of expertise. Often, the division of responsibility between HSE and other bodies is unclear.

HSC's new strategy *"A strategy for workplace health and safety in Great Britain to 2010 and beyond"* commits HSE to:

> *"Consultation on our role regarding public safety issues by the end of 2004 to encourage wider debate across Government with the aim of greater clarity of responsibilities for agencies involved in public safety issues."*

However, it was not clear to HSE what the public expects in terms of public protection and its enforcement. HSE believed that it needed a better understanding of public expectations before it could consult more widely and ensure that any ensuing debate is properly informed. Hence HSE commissioned People Science & Policy Ltd (PSP) to undertake this pilot public consultation in advance of consultation with other groups.

1.2 OBJECTIVES

The objective of this pilot study was to explore whether or not there are general principles that the public identifies in determining the nature of the response to public protection incidents. The intention was to explore the issues the public considers when deciding whether a response by government regulatory authorities is necessary and if so, what that response should be.

HSE was also keen to develop a methodology by which this potentially nebulous subject could be discussed and considered further by the lay public.

1.3 METHOD

PSP conducted six groups with between six and ten members of the public in three locations in the UK, see appendices A1-A5 for full details. The groups were divided on gender and social grade, all participants were aged 30-55 and most were working either full or part-time. Each group lasted for 1½ hours. Using examples of health and safety related incidents developed by HSE, PSP explored whether participants thought that there should be an investigation, the purpose of the investigation and the expertise required to conduct any investigation. This was done mainly by comparing the examples.

We have also drawn on three other studies commissioned by HSE: *"Strategy consultation with hard to reach groups"*, People Science & Policy Ltd, January 2004, *Attitudes towards health and safety: a quantitative survey of stakeholder opinion"*, Jessica Elgood, Nicholas Gilby and Hannah Pearson, MORI Social Research Institute, January – February 2004 and *"Public dialogue on train protection"*, People Science & Policy Ltd, January 2003.

1.4 THE REPORT

The next chapter sets the background for the remainder of the report by exploring participants' understanding of the phrase 'health and safety' and of the HSE. Chapter 3 looks at why participants thought there should be an investigation – the objectives of an investigation and their expectations of the outcomes of investigations. Chapter 4 draws out the principles that participants would use to decide whether or not an investigation should be conducted. Chapter 5 discusses the expertise required by investigating bodies and the role of HSE. It also highlights

the absence of a clear route for those seeking an investigation. Chapter 6 draws the findings together into cross-cutting conclusions.

2 HEALTH AND SAFETY

2.1 INTRODUCTION

We began the focus groups with a brain storming on first thoughts about 'health and safety'. This was followed by a similar exercise about awareness of HSE and for those who had heard of HSE, we asked about their image of the organisation and their understanding of the organisation's role. This chapter briefly sets out the findings from these ice-breaking sessions. In general they are as we would expect from earlier work we conducted (PSP, 2004) and the MORI (2004) study.

2.2 HEALTH AND SAFETY

Without exception, the words 'health and safety' as a phrase were spontaneously understood in a work context, with the emphasis on safety, rather than health and with a strong industrial and manufacturing emphasis. Typical responses were:

> *"Hard hats"*
> *"Protective equipment"*
> Women, C2D

> *"Construction"*
> *"Preventative measures"*
> Men, BC1

> *"Documents to read"*
> *"Chemical substances"*
> Women, C2D

Two of the three groups of men saw 'health and safety' as restrictive, for example:

> *"It takes the fun out of work."*
> *"Lots of protective gear you don't want to wear."*
> *"Nightmare"*
> Male, C2D

> *"Red tape"*
> *"Expense"*
> Male, BC1

Some manual workers saw 'health and safety' as something companies employ to ensure that they are protected against litigation, nevertheless, it was thought to be important. As we have found in other work for HSE (PSP, 2004), participants tended to assume that inspections occur more frequently than they do and there was talk of:

> *"annual checks…like auditors coming to see the books."*
> Woman, C2D

Where health was raised the two main topics were repetitive strain injury and stress.

Only after this first reaction did some participants in the focus groups begin to think more widely of issues in the home, shops and the wider public environment. Indeed, some groups needed active prompting as to whether health and safety applied outside the workplace. One man said:

"You do tend to associate health and safety, the phrase, with work rather than with home."
Man, BC1

Outside of the workplace participants thought of locations such as the home. A few people were aware that most accidents happen within the home and safety rather than 'health and safety' was more likely to be associated with the home. One man recognised that there is a need to be more aware of safety at home than at work because of the dangers to children and one woman said:

"At home you just do things automatically, when you are thinking of safety, especially when you have children around."
Female, C2D

Other environments where health and safety was said to be important included hospitals, especially in the context of MRSA and poor cleaning, schools, work canteens, shops with 'wet floor' signs, pavements and the potential dangers of walking past building sites. For example:

"That's why they have markings on clear glass [in shopping centres] *so you don't walk through it."*
Man, C2D

As one woman said:

"It's [health and safety] *everywhere."*
Woman, C2D

Food safety and environmental health issues were also mentioned in these brainstorming sessions.

For some the phrase 'health and safety' carried negative connotations, even outside of work. Words such as *"liability"*, *"lawyers"* and *"compensation"* were also mentioned. Some participants were involved in supervising sporting activities for children and with others were concerned that 'health and safety' is:

"restricting what children can do. Teachers are less likely to take things on."
Man, BC1

Importantly, generally participants perceived a difference between health and safety at work and elsewhere. The quote below highlights the belief that employers have responsibilities towards their staff and staff have some obligation to behave responsibly, something we also found in our earlier work for HSE (PSP, 2004). However, this participant articulated what many others felt, namely that customers (that is, members of the public) have to accept some risks in their day-to-day lives.

"I think there is a distinction between the rights of an employee from an employer and the general public. As an employee…. you know, you're doing a job, so …you should be able to work in a safe, hazard fee environment. But as an employee, for myself, I've got a certain amount of personal responsibility. But as a customer, you know, there's a certain amount of risk in everyday activity. You've got to accept that, I would say."
Man, BC1

2.3 HEALTH AND SAFETY EXECUTIVE (HSE)

The majority of participants were aware of the HSE, although several were not. Those in manual occupations had all heard of HSE.

Across the groups participants mentioned HSE as setting standards, laying down procedures and acting in an overseeing and inspection role. Interestingly, some participants saw HSE as having, in particular, the ability to look at systems. HSE was thought to be "*powerful"* because it *"acts like a policeman"* and "*can close workplaces down"*. The job of an HSE inspector was thought to be highly skilled. These findings accord with the MORI (2004) survey, which found that 69% of employees said that HSE's role was to enforce and/or to lay down the rules and regulations on health and safety.

There appeared to be some confusion between in-house health and safety officers, consultants and HSE inspectors, among participants. At least one participant felt that HSE did not do a very good job because health and safety was not taken seriously by employers. Some participants only felt that HSE came into play when something had gone wrong *"after something's happened"* rather than playing an advisory role, and they felt this was wrong. Another man said that:

> *"They* [HSE] *are the threat. When things go wrong people say: 'look out or the HSE will be down'."*
> Man, BC1

Participants did not think that HSE had a role in inspecting private homes but there was a possible role in providing information and the idea of a helpline on safety in the home was mooted. It was also felt that local Councils could play a role in non-work health and safety.

It is important for this study to note that participants were unaware of the potential breadth of HSE's remit. Participants saw HSE as mainly responsible for employees.

2.4 CONCLUSIONS

'Health and safety' is recognised as predominantly a workplace issue, with the emphasis on safety in manual work, rather than health or shop and office environments. However, once participants were encouraged to think more broadly, they could see a wider relevance for health and safety and HSE involvement. HSE's role was perceived to be that of overseer and inspector, with a role in setting rules and standards. These are perceptions that we have found in other work we have conducted for HSE over the last two years.

The remainder of this report explores the role of HSE and other bodies in public protection for those who are not at work using the various examples developed by HSE.

3 OBJECTIVES AND OUTCOMES OF INVESTIGATIONS

3.1 INTRODUCTION

Using the examples of 'incidents' set out in appendix 4, we explored whether there should be an investigation of the incident and if so why, that is, 'what would the participants expect to be the outcome of any investigation?' The aim was to identify the principles underlying people's expectations.

HSE had some preliminary ideas on why members of the public might call for an investigation. These were to:

1. hold to account any 'guilty parties';
2. ensure that the specific incident does not occur again; and
3. seek wider improvements in this particular area of public safety generally.

In this chapter we explore the main objectives participants identified for investigations and the outcomes they sought. They are set out below in order of priority.

3.2 PREVENTION

The most important reason for undertaking an investigation was said to be to prevent the incident from occurring again. This was not only participants' first thought, it was sustained throughout the discussions as highly important and there was consensus on this from all the participants. Indeed, participants had observed that in high profile incidents that are covered by the media, those involved often appeared in public after the case had concluded saying they want to ensure that the incident does not recur.

Implicit in the importance given to prevention was that the organisation and/or individuals involved would learn the wider lessons and implement changes to procedures and make other necessary changes to ensure that a similar situation could not arise again. Participants did not distinguish between points two and three above.

> *"Investigate to find out what's happened, who's accountable…primarily to stop it happening again – that must be the primary purpose."*
> Man, BC1

> *"…prevent accidents, not just reactive."*
> Man, BC1

> *"Prevention is better than cure."*
> Woman, BC1

In the summing up at the end of one group the participants included as principles:

> *"The likelihood of it happening again."*
> *"Whether something could have been done to stop it happening in the first place."*
> *"If circumstances exist that make it likely to happen again."*
> Women, C2D

We did not cover explicitly prospective investigation or pro-activity in preventing incidents, as we used the examples to stimulate discussions on what would happen if the example incident

had occurred. However, once participants had gained a better understanding of HSE one woman referred to HSE as:

> *"The prevention department."*
> Woman, BC1

3.3 RESPONSIBILITY

Identifying whether an individual or organisation was responsible for an incident was seen as an important part of the process of prevention. A clear distinction was made between accidents and negligence. Participants unanimously agreed that *"everyone makes mistakes"* and were prepared to give even medical staff whose actions resulted in death, some leeway on this.

> *"There's always going to be accidents, no matter how well trained you are."*
> *"Every person in this room has made mistakes…..Makes a difference if it's a repeat of a problem rather than a first time, with the best will in the world."*
> Men, BC1

Hence participants were aware that the desirable outcome would depend on the individual circumstances of an incident.

> *"It's down to circumstances."*
> Man, C2D

and whether it could be foreseen, and therefore prevented. However, if *'negligence'* is proved, then the individual and/or the organisation should be held responsible.

Participants wanted people who had made mistakes removed from positions where they could make the same mistake again, at least in the short term, even if this meant a reduced level of service to the public.

> *"I'd rather have fewer, good operations."*
> Man, BC1

They were, however, willing to believe that people could be retrained or given further training to improve their performance and return to their job safely. Importantly, there was a focus on systems and procedures and a desire that management be held accountable when equipment or procedures were found wanting.

> *"Even if the system is wrong, someone is to blame."*
> Man, BC1

Even if the incident was an accident, participants expected there to be some action.

> *"There's no point in investigating and finding they are at fault if all you say is 'don't do it again'."*
> Man, C2D

Indeed:

> *"I think it's the threat of being prosecuted that makes people do things properly."*
> Woman, BC1

so blame needs to be apportioned. Interestingly, while a few participants talked about blame, most used the word *"responsibility"*, which is much more constructive terminology. Moreover, it puts an emphasis on people taking responsibility and making changes to address problems rather than just apportioning blame and meting out punishment.

While participants were able to make allowances for human error in principle, they recognised that this was much more difficult if they were personally involved.

> *"I think a doctor is a human being in the end, but I would hate it* [the victim] *to be my son, daughter or mother."*
> Woman, C2D

Many of the examples we used involved public services and participants pointed out that under-funding and subcontracting could play a role in causing incidents. Subcontracting was not a mitigating circumstance. Participants saw managers as having a responsibility to ensure that subcontractors delivered the appropriate quality of service and believed that management systems should be in place to ensure delivery.

3.4 PUNISHMENT

Punishment was rarely mentioned spontaneously. Participants stressed that investigations that identified cause and allocated blame were part of the process of identifying the required remedial action. A spectrum of 'punishment' for individuals was called for from retraining or additional training, through restricting the range of work an individual could take on, to disqualification, the sack and fines, depending on the incident. However, one participant acknowledged:

> *"If a relative of mine died from MRSA I'd want to see someone hung drawn and quartered to be quite honest."*
> Man, BC1

Moreover, as mentioned above, there was a sense that senior managers should take personal responsibility, not the organisation.

> *"It's an individual's responsibility, not hospital funds."*
> Man, BC1

Interestingly, one man said that fining organisations was a perverse incentive and that fining individual hospitals would be *"a paper exercise"* because *"the money goes back to central government"*. Rather than fining those who got things wrong, organisations that *"get it right"* should be given more money next year. Nevertheless, some participants felt that prosecution was an important deterrent:

> *"Prosecute one or two, just to get the message across."*
> Man, BC1

In general, participants could see both sides of the argument until someone said something such as: 'but what if it was your child' and then they could agree that they would feel differently. This is an important point in understanding media involvement and the emotions and reactions of those involved in individual incidents.

3.4.1 Opportunity cost

We put to participants that if organisations offering public services, such as local authorities and churches were fined as the result of an investigation leading to prosecution they would have less

money to spend on other areas or good works. We asked if this was what they wanted and found that it was, *"if it prevents accidents"* (woman, BC1). Some participants felt that punishing organisations was the only way to deal with organisations and force them to take action.

It appeared that there could be greater sympathy for the impact of opportunity costs where the service to be affected was more familiar. In one group the preferred option shifted from the prosecution of organisations to the identification and punishment of responsible individuals.

> HSE Representative: *"if standards are being met, and advice is being given and standards are still not being met, is that what should happen, should we be able to prosecute hospitals?"*
> First Man: *"Absolutely"*
> HSE Representative: *"Schools?"*
> First Man: *"Absolutely"*
> HSE Representative: *"What if they are taken to court and they are fined, which is pretty much the only penalty available to the courts, and then the hospital says 'that money comes off patient care, so we can afford to employ three less nurses next year, or can't afford to buy this bit of kit', what do you think about that"*
> First Man: *"but where is the incentive for them to get it right?"*
> Second Man: *"... should dismiss the manager and get another manager in place, or get a new cleaning company in because these people aren't complying"*
> Third Man: *"Dismiss them but actually bar them as well from working in other companies"*
> HSE Representative: *"so it's an individual thing..."*
> First Man: *"and not hospital funds"*
> Men, BC1

However, we feel that this needs further investigation. It is not clear from the data we have gathered whether participants were only concerned about incidents that could happen to them, whether they cannot relate to some areas of public spending (such as children's homes) because they are outside their experiences, or whether the focus group environment meant that our examples gained more importance in the minds of participants than they might otherwise have done.

Moreover, it also emerged that some participants were not clear what was meant by 'prosecuting' or 'taking to court' an organisation or an individual as the result of an investigation.

> *"What does prosecute actually mean?"*
> Woman, BC1

They did not realise that a successful prosecution almost inevitably resulted in fines for organisations.

> *"...if you take them to court do you actually have to fine them?"*
> Woman, BC1

We did not explore the issue of legal costs. The implications of an investigation for organisations (especially those providing public services) is worthy of further investigation.

3.5 COMPENSATION

When it came to the issue of paying compensation to individuals there was the same reaction we have encountered in other work for the HSE (PSP, 2004) and MORI (2004) has obtained similar results. Many participants felt that the UK had developed a compensation culture and become *"too much like America"* (a phrase that was heard in every group).

> *"It's all coming like America, isn't it. ...Its' all on the telly, no win, no fee."*
> Woman, BC1

Some participants cited experiences where perhaps they might have made a claim for compensation but had not done so. Interestingly, none had made a claim for compensation, although many cases were mentioned from the press. Participants claimed to believe that compensation claims had got out of hand.

> *"But don't you think it's gone too far?"*
> *"Oh, yes."*
> *"Everybody's going to be out of business with all these claims."*
> Women, BC1

> *"We seem to be in this culture where you just sue."*
> Man, BC1

> *"For me I would want to make sure someone doesn't suffer it again first, possibly then look for compensation, others would just dive straight in for compensation."*
> Man, C2D

The *"Better Routes to Redress"* report published by the Better Regulation Task Force in May 2004 shows that the number of accident claims (including personal injury claims) is going down year on year. Nevertheless, the Task Force argue that in general people believe there is a compensation culture in the UK and the Task Force argues that this perception is having an impact on the UK. More recently a report by Datamonitor reported similar findings. Indeed we found that participants said that a fear of paying compensation on the part of some was restricting what people were able to do, and that this was not necessarily desirable.

> *"It's what's reasonable or you spoil it for everyone."*
> Man, BC1

There was also a perception that people are more often required to sign indemnity forms.

There was concern though, that compensation was justified and required in some cases. A couple of participants, in different groups, identified that a very serious injury might result in the need for long term care that could be expensive or an inability to work. They believed that compensation payments in these circumstances were legitimate.

3.6 APOLOGIES

Participants said that they wanted those responsible to apologise, admit their mistake and put things right, rather than to claim compensation.

> *"You just want people to admit that they were wrong and apologise for it."*
> Woman, C2D

Although participants did not use the phrase restorative justice, the desire to see mistakes admitted and apologies offered could be seen as first steps towards this.

This desire for an apology was also a finding of the Better Regulation Task Force report *"Better Routes to Redress"*. This is related to the belief that those responsible should accept responsibility and take preventative action for the future.

3.7 CONCLUSIONS

Participants saw the main purpose of an investigation as being to prevent the incident from occurring again. They did not necessarily want individuals or organisations punished, rather they wanted them to accept responsibility and to take action to ensure that the incident did not recur. Hence, they were keen that those at fault acknowledged their mistakes and apologised. They talked about 'accepting responsibility', rather than about 'apportioning blame'. This said, there was an acknowledgement that if they were the subject of an incident they would react differently. Moreover, some vulnerable groups - identified as children and the elderly – were said to need extra protection. There was something of a reaction against compensation payments, although it was recognised that for severe injuries, payments might be needed to provide care. This begs the question of how to decide whether to investigate, we explore this in the next chapter.

4. DECIDING WHETHER TO INVESTIGATE

4.1 INTRODUCTION

This chapter looks at when our participants thought that there should be an investigation and how they would go about making the decision on whether or not to investigate a specific incident. It was our intention to identify some general principles for HSE that the public would expect to be followed when deciding whether or not to conduct an investigation.

Participants found it hard to distinguish between the outcome of an investigation and how they would decide whether to investigate. This was because their decision-making criteria for instigating an investigation were linked to the nature and cause of the incident. Regular monitoring could address some of their points and their perception of HSE's role as an overseer fits in with this.

4.2 FREQUENCY

Frequency of occurrence was participants' first thought on whether an investigation was required. If this was the first time that a specific type of incident had occurred to an individual or organisation it might be a 'one-off', in which case an investigation might not be required. If, however, the incident had happened several times before to a specific individual or in a particular organisation, then it should be investigated.

> *"The first thing you'd want to know is has it happened before? If they say no, it happened last week, it happens all the time, then you'd think hang on something's not right here."*
> Woman, BC1

Participants recognised that this requires records to be kept that allow judgements to be made on the frequency of incidents.

> *"There should be someone monitoring any incident that is serious enough to cause an incident* [accident]*."*
> Woman, C2D

4.3 SEVERITY

Severity of occurrence was the next thing participants thought should be taken into account. So, a less severe incident would require more occurrences than a more severe incident before an investigation should be launched.

> *"Severity of the incident, how badly anyone could be hurt."*
> Man, BC1

In comparing between the surgical death and the loss of children on a school trip, a hierarchy emerged such that a fatality was more important than an incident where everyone was alive but the death of a child was ranked above the death of an adult.

> Moderator: *"if you could only investigate one what would it be"*
> First Woman: *"Oh, that one"* (surgeon)
> Moderator: *"Even if one of the children died"*
> First Woman: *"Oh, no"*
> Moderator: *"if you had limited resources?"*
> Second Woman: *"Oh I'd say the child"*
> Women, C2D

In the context of the car brakes failing example (hence the use of the word 'claim'):

> *"If there is no one hurt then there isn't a claim, but if there is someone hurt then there is definitely a claim."*
> Man, C2D

4.4 SCALE

The number of people involved should also be taken into account, participants thought. An incident that has affected a number of people should take preference over one that only affects an individual.

> *"If there is a potential for infection with this situation*[flooded river] *it's going to affect a lot more people than in this situation* [Weil's disease] *so in theory you would have to set that a higher priority because more people could be affected by the outcome."*
> Man, BC1

4.5 PREVENTABILITY

We have already discussed how participants distinguished between accidents and negligence. Hence the extent to which an incident was preventable, and therefore due to negligence, was important in deciding whether to investigate.

> *"If they have these procedures and the boxes have been ticked, obviously they may not be taken to court because they've had the boxes ticked and they've tried to do the best they can and that's all we want, them to try to prevent things. We know accidents happen. We just don't want people to think, you know, it doesn't matter. Nothing's going to happen to us, you know."*
> Woman, BC1

And in a similar vein:

> *"I think major hazards should need investigating but me walking out of my front door and tripping, well that can just happen."*
> Woman, C2D

Importantly, in the context of some of the examples, organisations were thought to be negligent if they know about a situation that is potentially unsafe, such as a weak tree or unstable gravestones, perhaps because it has been reported to them, but have taken no remedial action. Participants were quite adamant that organisations should have people inspecting potential hazards such as these on a regular basis. In the case of the gravestones:

> *"Someone has to cut the grass. They could inspect the gravestones at the same time."*
> Woman, BC1

4.6 POTENTIAL FOR HARM

The potential for harm as the result of an incident was mentioned as a criteria in deciding whether or not to mount an investigation by some participants. However, this could not really be separated from the scale and severity of any potential harm.

> *"Did the responsible authority know about the potential problem and the level of risk?"*
> *"But it depends on the severity of incident or the likelihood of it happening again."*
> Women, C2D

Hence an incident that had the potential to cause harm took second place to one that had caused actual harm. As one man said when comparing the sewage spill example with the Weil's disease example:

> *"Potential is one thing but getting the disease makes it more urgent, important to be investigated."*
> Man, BC1

4.7 CONTROL

As we have seen, participants were well aware that accidents can happen. Willingness to accept risk was related to the amount of control participants felt they had in particular situations. For example, in the example of the surgeon who makes a fatal mistake, they believe this to be very serious and worthy of investigation. The level of training the surgeon has received and the fact that the patient has no control over the procedure as they are unconscious make this a priority investigation for participants.

> *"You're, like, in their hands."*
> Woman, C2D

Conversely, in a situation where people felt that they would be in total control, such as being a spectator at a cricket match, they did not feel that an incident where the ball injures a spectator merits investigation.

4.8 PERSONAL RESPONSIBILITY

Central to the concept of public protection is the degree of risk society is willing to allow individuals to be subjected to. We found that participants were well aware that life involves risks that cannot be escaped. One participant said:

> *"Some people are looking for a risk free environment but it doesn't exist."*
> Man, BC1

And another:

> *"There are risks in everything, and I think people are suing everyone for what they can get."*
> Man, C2D

With respect to children in particular:

> *"You can't wrap them up in cotton wool."*
> Woman, C2D

As indicated above, participants said that a fear of being sued was restricting what people, and children in particular, were able to do and this was not a situation they said they welcomed.

> *"I'd rather* [my sons] *took part in sport with the risks, than did nothing."*
> Man, BC1

In the work PSP undertook for HSE last year (PSP, 2004) we used the example of people taking part in adventure sports to explore the edges of personal responsibility and public protection. The first reaction of participants tended to be that those who take part in these types of activities should be aware of the risks. Further discussion revealed that such activities were expected to

be safe, in so far as equipment should be in proper order. Hence participants concluded that facilities should be inspected for safety.

4.8.1 Vulnerable groups

It was quickly acknowledged in the consultation on HSE's strategy (PSP, 2004) that where children were concerned there need to be safeguards in place. HSE was interested in whether participants saw children and other more vulnerable groups as needing more protection than the majority adult population. In this work we found similar patterns of belief, with those less able to make informed decisions thought to be in need of special protection. For example, in the cemetery example, at first it was thought that the children were being naughty and were to blame for their own injuries. However, further discussion led some participants to believe that the Council or church authorities were at fault, especially if the children had a right to be there, for example because it was open to the public. Only if the Council could prove it was unaware that any of the gravestones were unsafe or the cemetery was securely locked might they be absolved from responsibility. Once again the issue of prevention – accident or negligence – arises.

It was felt that some incidents were not worthy of any investigation and that in some situations people just had to accept the risks. In the case of the cricket ball accident:

> *"Everyone has their own personal responsibility for health and safety."*
> *"It's down to you to do a personal risk assessment and understand the risk assessment."*
> *"There is a risk in everyday activity and you just have to accept that."*
> Men, BC1

4.8.2 Employees

As we have found in other work for HSE (PSP, 2003) participants had little sympathy for employees who might be endangered by their job. Some participants believed that this was part of doing some types of work and those in these occupations should be trained to deal with foreseeable incidents. It was thought that in some occupations this was a risk those employed should accept. There was even a feeling in one of the groups that protecting workers can be taken too far, they gave the example of cleaners not doing some cleaning tasks.

Other participants were less sure that people should put themselves at risk. The police were a group it was felt should be more prepared to put themselves' in harm's way than, for example medical staff. Participants said that medical staff, who might not have anticipated that their work would place them in danger, were less likely to be expected to put themselves at risk.

Hence the expectation of hazard that an employee in a particular occupation might reasonably be expected to face, coloured perceptions of how much of a risk employees should take (or danger they should put themselves in) when trying to fulfil their duties.

4.9 UNDERSTANDING OF THE ISSUE

It was suggested that the level of understanding that society has of a particular issue should be a reason for investigating an incident.

> Participant: *"There are not enough preventive measures for people who are passive smoking, work needs to be done on that."*
> Moderator: *"So you would chose that one because its not developed enough…."*
> Same Participant: *"Yeah, because preventative measures have been put into place for that one"* [meningitis example].
> Woman, BC1

This view implies that as new health and safety issues arise, such as stress, passive smoking or the use of new technology and machinery, investigations into any health and safety incidents should be given priority to enable a body of knowledge to be established. In this way better regulations and guidance could be given to prevent the incident being repeated.

4.10 CONCLUSION

Participants found it difficult to address the question of whether or not there should be an investigation. They tended to conflate the decision-making process on whether to investigate with the reason for the incident. Obviously, the reason for the incident is an outcome of the investigation and so cannot (usually) be used in the process of deciding whether an investigation should occur.

Nevertheless, by using several examples in each group discussion we were able to ask participants to prioritise which incident they would investigate and why. This helped us identify some general principles that could be applied given relatively simple record keeping by organisations. Namely, in order of priority:

- frequency;
- severity;
- scale;
- preventability;
- the potential for harm when none had occurred;
- the injured party's control over the situation;
- the degree of personal responsibility the circumstances dictate or imply; and
- the understanding society has of the hazard and its impact.

However, everyone realised that perceptions changed when someone is personally involved.

Basing the discussions around pairs of examples also enabled us to draw out from participants that personal experience of a situation is likely to play a role in their choices. It also helped participants to realise:

> *"That's a very hard question* [which incident to prioritise], *everything's important, it's prioritising the priorities."*
> *"What's important to one person might not be important to someone else."*
> Men, BC1

5. WHICH ORGANISATION?

5.1 INTRODUCTION

In this chapter we explore the question of which organisation(s) should undertake investigations. In the discussion we asked participants about the expertise, experience and skills they would expect an investigating organisation to possess for each of the specific examples. During this part of the discussions it emerged that participants were unaware of any potential role for HSE in these cases and they usually either identified another body as having more appropriate expertise or did not know where they might turn for help. This finding led us to explore how participants would expect an individual investigation to progress.

5.2 THE NEED FOR EXPERTISE

For each example we asked participants who they would expect to investigate the incident. Without exception they identified an organisation that would have expertise in the field. So, for example, in the case of the incidents in the health service, they would expect hospitals or ambulance services to conduct investigations. With respect to the car with faulty breaks they would look to the RAC, AA, their insurance company or, if the incident had resulted in harm to an individual, to the police. Where the 'expertise' was more general, they looked to the organisation that they felt would be responsible for the service, or location to which the incident referred. Hence in the example of the cemetery they looked to the Council and in the school trip example to the school or the local education authority.

> *"It's no good HSE coming and not knowing anything about it."*
> Woman, BC1

We can divide the incidents into two groups. Where public services were involved, it was expected that there would be an automatic investigation by the responsible authority – the hospital, ambulance service, Council, school, etc. Not only were these the responsible authorities, they were also seen as having relevant expertise in the field. Where the services were private, such as in the case of the car with faulty brakes, they looked to people with relevant technical knowledge such as the AA/RAC, gas board, electricity board or trained electrician, etc. but in these cases they felt that the individual concerned would actively need to seek help from these organisations.

However, there was a feeling that in at least some areas:

> *"You'd need an independent investigation, not by a doctor from the same hospital. They stick together."*
> Woman, C2D

However, there was still a strong view that investigators would need knowledge of the field to understand *"what went wrong"*.

5.3 THE STAGES OF AN INVESTIGATION

With the public services examples, so strong was the feeling that the first step should be the responsible authority, we asked participants who they might look to if the incident had occurred to them or a close relative and they were not satisfied with the outcome of the investigation.

The women in one group talked about *"taking it further if they were not satisfied"*. We pushed them on what they meant by *"satisfied"* and it became apparent that they meant if they had unanswered questions or there appeared to be inconsistencies in the account of what had occurred.

"You keep going if you feel that someone's trying to pull the wool over your eyes."
Woman, C2D

We found similar sentiments in other groups, which helped us clarify these concerns.

What they meant by *"taking it further"* was much easier to discern. In essence they would *"go up the hierarchy"*. So, if they were unhappy with the hospital's investigation, they would look to the health authority and as a last resort they said they would turn to the media to generate attention. It was acknowledged that media involvement can change the public's perception of priorities.

This discussion brought it home to participants, and made it clear to us, that they did not know where they would go for help.

"Where do people go?"
Woman, BC1

Someone mentioned that they would need *"a good solicitor"* and mention was also made of the small claims court. Hence they are perhaps open to the 'no win, no fee' advertisements.

When the HSE representative made it clear that HSE would not normally see any of the examples as priority areas it was suggested that:

"Then the Government needs to set up another body."
Woman, BC1

There was little appreciation of the roles that different parts of Government play

"I just see the Government as the Government... there's lots of little men running round."
Woman, BC1

There was also a request for more information on where to go for help and the role of HSE, if HSE is the organisation that can help.

5.4 THE NEED FOR INDEPENDENCE

Participants were concerned about professional groups *"closing ranks"*. They were clear that while the first stages of an investigation might take place within the professional or institutional structure of the organisation where the incident occurred, there should be recourse to independent bodies if they were not satisfied with an investigation.

"When it comes to the local authority investigating itself, you might need an outside body to ensure impartiality."
Man, BC1

Other bodies put forward as potential investigators included: Trading Standards; the police; insurance companies; and most commonly, the Council. For most incidents discussed in this study, it was not thought to be good use of police time.

"I think its bad use of police time."
Woman, BC1

5.5 THE ROLE OF HSE

None of the participants had spontaneously suggested that HSE might be the body that would investigate any of the example incidents. In keeping with the perceptions that some participants had of HSE at the beginning of the discussions as being work focused, it was felt that while those with expertise in the relevant area should undertake inspections and investigations, HSE should receive reports from those experts. This would ensure minimum standards and that all organisations had appropriate strategies in place to deal with foreseeable incidents. One woman summed up participants' views of HSE as:

> *"To deal with companies."*
> Woman, C2D

In the C2D men's group the participants introduced another example – that of a fork-lift truck accident. When asked which of the examples we had discussed during the session HSE would be most likely to investigate, their reply was:

> *"That's the only one* [example of fork-lift truck accident] *I thought would be done, all of these* [the examples used in this group, as set out in annex 5] *would have been done by different bodies."*
> Man, C2D

However, towards the end of one of the discussions, participants were considering where they might look for help if they needed it. It was suggested that HSE should have a helpline to deal with public protection incidents and that this number could be included on a list of local emergency numbers. The HSE representative interjected that HSE was not an emergency service but now that a better understanding of HSE's duties had been gained, the participants responded:

> *"I would see you* [HSE] *as an emergency service, if I want something done."*
> Woman, BC1

As we have seen in chapter 2, and we found in the consultation on HSE's new strategy (PSP, 2004) some participants saw HSE's role as setting standards, overseeing and monitoring the health and safety systems of organisations. It was said that this should include checking that all relevant health and safety procedures were in place in organisations, for all likely foreseeable scenarios. This would enable organisations to be in a position *"to be able to roll out a response quickly"*, Woman, BC1.

Lastly, some events were regarded as outside HSE's jurisdiction and it was recommended that they stay outside.

> *"If HSE get involved in this* [cricket ball example], *where does it stop?"*
> Man, BC1

5.6 CONCLUSION

Participants agreed that investigations into incidents should be conducted by people or bodies with relevant expertise and independent of the 'responsible' organisation. They also identified that the first step should be an internal investigation with the results communicated to the 'injured' party. If this investigation was felt to be unsatisfactory they would look to outside bodies.

However, during the discussions it became clear that participants were unclear about where they might go for such outside advice. The most obvious choices were other professionals in the

relevant field, a solicitor, the police or the media; the latter as a last resort to draw attention to their case. As participants did not know where to go for help in the event of an incident, we might deduce that some members of the public would respond to 'no win, no fee' advertisements. These findings lead us to suggest that a clearer strategy, perhaps involving another body or another arm of HSE, is required to support those in need of redress following incidents such as the examples explored in this study.

6. CONCLUSIONS

6.1 INTRODUCTION

In this chapter we draw together the findings to identify cross-cutting conclusions and to make recommendations for further work which will verify the findings set out in this report. In that context it is worth mentioning that, where the same issues arose, we found that opinions have not changed since we undertook the *"Strategy consultation with hard to reach groups"* in 2004.

6.2 THE PURPOSE OF AN INVESTIGATION

The main purpose of any investigation was seen to be prevention – ensuring that the incident did not happen again. Participants wanted those responsible to admit their mistakes and apologise and put in place systems and procedures that would prevent the incident from recurring. Punishment was seen as a necessary threat to ensure compliance but one to be used sparingly. Prosecution was not always seen as desirable and compensation was not participants' first objective.

6.3 TO INVESTIGATE OR NOT?

In deciding whether or not to investigate any individual incident participants identified the following principles that should be taken into account in the initial assessment:

- frequency;
- severity;
- scale;
- preventability;
- the potential for harm when none had occurred;
- the injured party's control over the situation;
- the degree of personal responsibility the circumstances dictate or imply; and
- the understanding society has of the hazard and its impact.

Within these general principles there were other conditions that should be taken into account. An incident that affected vulnerable groups, usually thought of as children and old people, but anyone who was less able to make their own informed decisions, was thought more deserving of an investigation. Included in vulnerable groups were people who were in hospital, particularly those undergoing operations under general anaesthetic because they were unable to make informed decisions themselves at the time of the incident.

In occupations where there was a degree of risk perceived by the participants, the need to investigate incidents that affected employees were given a lower priority. It was thought that they should be trained to deal with likely scenarios and they had actively decided to enter the occupation, presumably aware of the risks.

Participants were aware that personal involvement in an incident would radically alter their views. They also knew that media coverage could alter public perceptions of incidents. HSE needs to bear these points in mind. It may be that while those directly involved may be highly emotional and angry, the wider community may have a different perspective.

6.4 A BODY FOR PUBLIC PROTECTION

'Health and safety' is a phrase participants tended to associate with work and those who had heard of HSE thought that HSE only dealt with workplace incidents and the health and safety of employees.

If participants wanted or needed help as victims of non-work health and safety incidents they would look to organisations with expertise in the relevant activity or geographical area. Access to an independent investigator was desired but HSE was not necessarily seen as the most appropriate choice of investigator. A body with expertise in the relevant field, perhaps overseen by HSE, applying HSE's regulations and standards, was mooted as desirable.

The findings also highlight the need for greater clarity of responsibility among public bodies. It became increasingly clear to participants that they did not know where, or how, to seek help. In some instances they would expect to become part of a process, for example within an education or healthcare system or if the police became involved. If they were dissatisfied with the outcome of an internal investigation, or in cases where this was not available, they indicated that they would probably turn to the legal system for redress. In extreme cases, they might seek to draw in the media to raise awareness of their case. However, they tended to be thinking in terms of seeking an apology and assurance that action would be taken to prevent the incident occurring again.

6.5 FURTHER RESEARCH

This study was relatively small, comprising six focus groups, just 49 people in all, and aged 30-55. We found a high level of agreement in the objectives for investigations and the principles that should be applied in deciding whether or not to investigate a specific incident but our groups were fairly homogeneous. Further work should broaden the sample to include younger and older people, as well as those from a wider range of backgrounds and therefore in a wider range of locations.

In the context of 1½ hour discussions we could not explore all the issues that arose from our central discussions. This is to be expected of a pilot study and it is inevitable that as well as providing some insights to public attitudes, the work has also raised more questions. In particular we think the following issues need more research.

Firstly, there is the issue of the opportunity cost of an investigation with respect to the potential reduction in services. In this study we found that many participants wanted even fairly minor incidents investigated even if it meant a reduction in services. We cannot determine whether this is the effect of 'hot housing' in the groups, a misunderstanding of the implications of an investigation, a fixation on the impact of the incident on themselves, an inability to empathise with those who might have their services reduced or something else.

Secondly, we think that the question of compensation needs further work. Perhaps with those who have sought or been awarded compensation, if there is an easy way to identify such individuals and persuade them to co-operate. Another approach might be to work through those who deal with such individuals. We think there is a need to better understand the motivation behind compensation claims. Almost everyone in this study, in common with other work commissioned by HSE (PSP, 2003 and MORI, 2004) said that they believed that the 'compensation culture' had gone too far. We question whether claiming compensation, at least for some, is necessary to provide an income or access to expensive care. Or is it a form of recognition by the responsible body, perhaps a necessary route to an apology?

Thirdly, we consider that the issue of employees putting themselves in harms way to do their job was not sufficiently explored. We began to see some differentiation between what might be expected of different occupations based on reasonable expectations of the conditions employees might expect to encounter. This could be teased apart further.

Lastly, personal risk taking was another issue that was not considered in great depth.

An obvious starting point would be more focus groups, run using these, or perhaps a wider range of examples to draw out the topics listed above. Some thought should also be given to moving to a quantitative methodology that would enable HSE to gauge the public mood more effectively and to understand subgroups in more depth. We find that a narrower range of people tend to attend focus groups than is covered by in-home survey work. Development of a highly structured questioning system would be required for this to work effectively. We should state that this might not be possible as respondents might require too much information to be able to respond for a quantitative methodology to be practical.

APPENDIX 1 INTRODUCTION

These appendices provide technical information on how the project was carried out.

The next chapter, A2, provides an overview of the methodology. A3 is the recruitment questionnaire, A4 provides the issues and examples provided by HSE and A5 the topic guide as used in the last four of the six focus groups.

Recruitment of participants to the focus groups was sub-contracted to Synovate.

APPENDIX 2 METHODOLOGY

A2.1 INTRODUCTION

This project was to some extent experimental in so far as it was not clear to what extent members of the public would be able to discuss the general principles of public protection. Earlier work that PSP had conducted for the HSE (*"Strategy consultation with hard to reach groups"*, People Science & Policy Ltd, 2004) had suggested that in certain context it was possible. This project drew on that experience and the analysis provided in this report draws on that data as well as data specifically collected in this project.

A2.2 SAMPLE

This project comprised six focus groups structured as follows:

Glasgow	**Cardiff**	**Birmingham**
Women C2D	Women C2D	Women BC1
Men BC1	Men BC1	Men C2D

Each group lasted 1½ hours and consisted of between six and ten individuals aged between 30-55 recruited to the particular profile using a recruitment questionnaire (see Appendix 3) agreed with HSE. A member of the Enforcement Policy Group from HSE was present at each group. Fieldwork took place in October 2004.

A2.3 TOPICS

The first two groups (in Glasgow) were run more loosely than the other four groups. There we tried to explore the issues set out in appendix 4 by using the various examples provided by HSE, also set out in appendix 4, to build on participants' own views and experiences. However, we found that participants became hooked into personal hobby horses. Consequently, we redesigned the groups to be more focused around the examples, as described in appendix 5. The remaining four groups used this format and focused on the examples as set out in the topic guide in appendix 5.

A2.4 ANALYSIS

The discussions were all recorded and analysed by listening back to the recordings. Major issues were identified in each group, notes made and quotes identified. Analysis across the groups was then undertaken, looking for common themes, understandings and ideas.

APPENDIX 3 RECRUITMENT QUESTIONNAIRE:

Briefing We want to recruit 10 people for 8 to show to the quotas set out at the end of this recruitment questionnaire. Groups will last 1½ hours. The subject to be discussed is the health and safety of people as they go about their day-to-day business.			
Introduction Hello my name is… and I work for…... We are looking for a cross section of people to take part in discussions about the health and safety as they go about their day-to-day business. Could you spare me a few minutes to answer some questions please?			
Q1	**Do you or any of your close relatives work in any of the following occupations?**		
	Market research	1	CLOSE
	Journalism	2	CLOSE
	Public relations	3	CLOSE
	Marketing	4	CLOSE
Q2	**What was your age on your last birthday?**		
	<29	1	CLOSE
	30-55	2	CONTINUE
	>56	3	CLOSE
Q3a	**Are you…**		
	Working full time	1	CONTINUE
	Working full time	1	CONTINUE
	Working part-time	2	CONTINUE
	Retired/not working	3	CONTINUE
	Unemployed	4	CODE AS E
	Student	5	CODE AS C1
Q3b	**Job Title (WRITE IN)**		
Q3c	**Job Description (WRITE IN)**		
Q3d	**Size of Company (WRITE IN)**		
Q3e	**Qualifications (WRITE IN)**		
Q3f	**How many people are you responsible for? (WRITE IN)**		
Q3g	**CODE SOCIAL GRADE**		
	A	1	CLOSE
	B	2	CHECK QUOTAS
	C1	3	
	C2	4	
	D	5	
	E	6	CLOSE
Q4	**Gender**		
	Male	1	CHECK QUOTAS
	Female	2	
Q5a	**Have you attended a focus groups or in-depth interviews in:**		
	The last 6 months	1	CLOSE
	The last two years	2	GO TO Qb
	More than 2 years ago	3	Go to Qc
	Never attended any group discussions	4	RECRUIT
Qb	**How many focus groups/in-depth interviews have you been to in the last 2 years? (i.e. 6 months - 2**		

	years ago)		
	1 or 2	1	GO TO Qc
	More than 3	2	CLOSE
Qc	**What was the subject of the discussions/in-depth interviews you took part in? (WRITE IN SUBJECT MATTER AND APPROX - WHEN IT WAS FOR EACH OCCASION).**		
	IF ABOUT HEALTH AND SAFETY - CLOSE. THE RESPONDENT MUST NEVER HAVE PARTICIPATED IN A DISCUSSION ON THE SAME SUBJECT. OTHERWISE RECRUIT.		
	• At least half of each group/set of depths must be **brand new** recruits. • The remaining half can have attended up to a maximum of 2 groups/depths in the last 2 years (ie. 6 months -2 years ago) • **None** to have attended any group/depths in **last 6 months** • **None ever** to have attended a group/depths on the same subject If you have any queries, please call your Manager		

QUOTAS

Glasgow – 14 Oct	**Cardiff – 26 Oct**	**Birmingham – 28 Oct**
Women C2D	Women C2D	Men C2D
Men BC1	Men BC1	Women BC1

APPENDIX 4 KEY ISSUES AND EXAMPLES

Key Issues

There are a number of issues that the HSE wishes to explore, they are listed below.

1. What is the **reason for involvement of the regulatory authorities** in these matters – is it to hold to account any 'guilty parties'; or to ensure that that specific incident does not occur again; or to seek wider improvements in this particular area of public safety generally.
2. What is the impact of resource considerations? How much resource should be devoted to specific incidents and what criteria could be used to determine the extent of that resource? Also, what will be the wider benefit to society of tackling such matters?
3. To what extent should the imperative be considered – ie: the need for certain people to take certain actions that could put them at risk. How should we balance the risk to the public against the risk to employees? For example, emergency services employees putting themselves at risk during rescue attempts, etc. Or hospitals to be fined for public safety offences, thereby using resources that could otherwise be used for patient care?
4. How 'risk free' do we want society to be?
5. To what extent should people take personal responsibility for actions undertaken voluntarily that could put them at risk?
6. What emphasis should be placed upon those who are seen to be 'vulnerable' or at risk involuntarily in terms of public protection, over and above those who are not?
7. What emphasis should be placed on safety as opposed to other considerations? For example, what is the balance between safety in cemeteries from unstable memorials when weighed against any distress to the bereaved from fencing off or removing memorials deemed to be unstable?
8. The matter of time. For example, a building is closed and over time, falls into disrepair thereby becoming a hazard. Should there be a point whereby the safety of the building becomes a public responsibility, regardless of the duties of the owner?

Examples

1. Rubbish is fly-tipped in a small public park. Rats are soon attracted to the area. After several days, the LA arranges for the rubbish to be removed. A week later, two local teenagers who are frequent park users are diagnosed with Weils Disease. (1, 2, 4, 6, 8).
2. Following heavy rain, a river breaks its banks. Streets and houses are flooded and sewers overflow in a residential area along the riverside. Risk to public health clear but no cases of ill-health reported as a direct result. (1, 2, 4, 5, 6, 7).
3. There is an outbreak of food poisoning, affecting staff, visitors and patients, emanating from a canteen in a hospital (1, 3, 6). There are several admissions to the hospital as a result.

This was replaced by:

Two teachers take a twelve-strong party of 14 year old students on a walking trip in Snowdonia. Two children who have been lagging behind the main group become detached from the rest and get lost. They are found the next day.

4. Customers are subjected to passive smoking in an enclosed public place such as a restaurant or bar (1, 2, 4, 5, 6, 7).
5. A car is serviced, and the next day the brakes fail. The car crashes but no one is physically injured. The driver is treated for shock. It could have been much worse as the driver had to swerve to miss two elderly persons on a pedestrian crossing. (1, 2, 5, 6).
6. Children are playing among gravestones in a cemetery. A gravestone falls and a child is injured (1, 2, 4, 5, 6, 7, 8).
7. A new owner of a house suffers burns as a result of poor electrical work undertaken by the previous owner (1, 2, 4, 5, 6, 8).
8. There is an outbreak of meningitis among students at a hall of residence (1, 2, 3, 5, 6, 7).
9. A pedestrian is seriously injured by an ambulance responding to a 999 call (1, 2, 3, 4, 6, 7).
10. A spectator at a cricket match is seriously injured by a ball struck by a batsman (1, 3, 4, 5, 6)
11. A building is closed and over time, falls into disrepair and children gain access. When playing, part of the building collapses causing injury (1, 2, 4, 5, 6, 8).
12. A patient dies following surgery because correct operating procedures were not followed by the surgeon (1, 2, 3, 5, 6).
13. A tree falls on a car during a heavy storm and three persons are killed. The tree had been reported to the Council as being in poor condition. Subsequently, the council was found guilty under the Health and Safety at Work Act charges and fined £150,000. Costs to council were huge – as well as the fine and the legal costs, the Council checked all trees in its area for safety.
14. In a restaurant you go into a non-smoking area but smoke is drifting through from the smoking area and you child has an asthma attack.

NB The numbers in brackets refer to the issue number to which the example is relevant. Examples 13 and 14 were added during fieldwork.

APPENDIX 5 TOPIC GUIDE GROUPS 3-6

INTRODUCTION

	Introduce self
	Introduce PSP and independence from the client
	Introduce anyone else who is observing or helping
	Has anyone been to anything like this before?
	I have here a list of things I'd like to cover but really want to hear your views on the issues we'll be introducing.
	There are no right or wrong answers. Everyone is entitled to their own view, so I'd like to hear from everyone because everyone's view is valid.
	You don't have to answer all of the questions.
	You are free to leave before the end of the session, if you wish.
	I would like to tape record the discussions, just to save me taking notes, so I can listen to what you're all saying.
	No one will be identified in the report. All the information will be collected together and anonymised.
	This is just one session of x number that we are running around the country on this project.
	Is everyone happy for me to record the session?
	SWITCH ON TAPE AND MIKE
	Introduce the project
	Give any information on publication of report and access to it
	Give information about the client if appropriate
	Make it clear PSP is independent of the client
	Standard warm up round the room of introductions

First impressions	
Explore what health and safety at work means to participants.	Word association brainstorming. RECORD ON FLIPCHARTS PROBE FOR REASONS BEHIND SUGGESTIONS

Explore what public protection means.	Is health and safety relevant to you outside of your workplace? Why? Why not? PROBE FOR EXAMPLES OF H&S THAT RELATE TO PUBLIC PROTECTION
Image of Health and Safety Executive, what it does	Brainstorm Health and Safety Executive RECORD ON FLIPCHARTS PROBE FOR REASONS BEHIND SUGGESTIONS Is HSE relevant to you outside of your workplace?
Introduce Client	INTRODUCTION FROM CLIENT Explain that HSE is responsible for enforcing health and safety at work legislation, but (as people have identified) this can relate to people who are not necessarily at work.
Explore issues in depth	
Use examples to explore issues	BREAK GROUP INTO 2. MAY NEED TO TAKE ACCOUNT OF INDIVIDUAL PERSONALITIES OR OCCUPATIONS, ETC. EXPLAIN: We're going to split you in to 2 groups to look at a couple of examples of incidents. GIVE OUT CARDS WITH EXAMPLES WRITTEN ON THEM SEE ROTATION LIST BELOW FOR SPECIFIC ALLOCATIONS We're going to give you about 10 minutes to consider 4 questions: REVEAL FLIP CHART WITH THESE QUESTIONS ON: What would you do if this happened to you or a close friend/relative? Who would you hold responsible? Would you want an independent investigation and if so why? Who would you expect to investigate?

	ONE MODERATOR TO SIT WITH EACH GROUP AND PROBE AS RELEVANT FROM THE FOLLOWING LIST OF QUESTIONS

1) What would be their first reaction?

Would they want to: do nothing?
Sue for compensation?
Send someone to prison?
Get someone fired?
Prevent the incident happening again?

What would be the purpose of an investigation?
to hold to account any 'guilty parties'?
to ensure that that specific incident does not occur again?
to seek wider improvements in this particular area of public safety generally?

2) How much resource should be devoted to specific incidents?

How would you decide how much to spend (financially or in terms of other resources)?

What would be the wider benefit to society of tackling such matters?

3) How should we balance the risk to the public against the risk to employees of providing a service? For example, emergency services employees putting themselves at risk during rescue attempts, etc.

What about fines for public safety offences which mean that an organisation has less money to spend on delivering a service.

4) How 'risk free' do we want society to be?

5) To what extent should people take personal responsibility for actions undertaken voluntarily that could put them at risk?

6) What emphasis should be placed upon those who are seen to be 'vulnerable' or at risk involuntarily in terms of public protection, over and above those who are not?

7) What emphasis should be placed on safety as opposed to other considerations? [For example, what is the balance between safety and inconvenience to others?]

8) The matter of time. Is there a point whereby the safety becomes a public responsibility, regardless of the duties of the owner?

9) Frequency. Does whether the incident has happened before matter when deciding whether an investigation is needed? How would the earlier incidents be dealt with if an investigation goes ahead? Does this relate to the purpose of the investigation? See 1 above. 10) Potential scale of harm. Does the number of people likely to be affected or the severity of the impact on individuals matter in deciding whether an investigation is needed?	
	AFTER ABOUT 10 MINUTES WHEN THE GROUPS HAVE GOT TO GRIPS WITH THE EXAMPLES AND THE ISSUES, BRING GROUP BACK TOGETHER AGAIN
Explore similarities and differences in views on the examples	Get each group to describe their example and their answers to the 4 questions on the flip chart. When both groups have spoken, explore similarities – points where people think the same and explore why 2 different examples have led to similar conclusions. PROBE USING QUESTIONS ABOVE Then explore differences and reasons for differences. IF NECESSARY, PSP TO PROMPT FROM CONVERSATIONS LISTENED TO
HSE representative to provide information	Provide a view on what might happen if HSE is asked to investigate the incident. Reasons that HSE might give for not being able to investigate at present. SEE HOW PARTICIPANTS REACT Focus on limited resources and trade-offs or should there be more resources and expertise? If participants had to choose to investigate one of the examples but not the other, which would they choose and why? Facts and figures to support discussions on numbers of people affected by e.g. hospital infection deaths, frequency of occurrence for other examples, scale of problem. PSP WILL ASK FOCUSED QUESTIONS ABOUT THE EXAMPLES AND PARTICIPANTS' VIEWS OF HSE. THIS WILL ENABLE US TO MOVE PARTICIPANTS ON FROM THEIR INITIAL REACTIONS TO SEE THE ISSUES FROM HSE'S PERSPECTIVE.

Key messages (15 MINUTES FROM THE END)	
This final stage is designed to allow the participants to focus back on to the key issues as they see them.	Revisit principles discussed and ask participants to prioritise issues. WORKING FROM THE EXAMPLES IDENTIFY WHAT SHOULD HAPPEN AND WHY USING FLIP CHART. When should things not be investigated? Why? When/why should there be an investigation? How would you decide? How would you identify who should investigate? Expertise? Legal powers? Absence of anyone else? Mechanisms for drawing other organisations in What is HSE's role in non-work accidents? Does it have a role? [Use example of brick falling off a building site on to a passer-by versus leisure pursuits, if necessary.] Is there a role for the private sector? Should people be able to buy an investigation to support civil prosecutions?
Recruitment to major hazards	
Invite people to take part in a further, more focused exercise relating to a priority area for HSE, major hazards.	Explain that there will be two further sessions, one in late 2004 and one in early 2005. Details will be sent in writing, take soundings on venue/time. The first session will last 1½ hours and the second session will take the form of a longer workshop. Need participant's permission for PSP to re-contact directly. Obtain this using signing-up sheet asking for full postal details, phone number and e-mail.
Thank and Close	

Rotation of examples

		Reason for involvement **1**	Resource consideration **2**	Balancing imperatives **3**	Risk free society **4**	Personal responsibility **5**	Vulnerability **6**	Consequences **7**	Time **8**
1	Rubbish in park	X	X		X		X		X
2	River floods	X	X		X	X	X	X	
3	School trip	X		X	X	X	X	X	
4	Passive smoking	X	X		X	X	X	X	
5	Car service	X	X			X	X		
6	Cemetery	X	X		X	X	X	X	X
7	Poor electrical work	X	X		X	X	X		X
8	Meningitis	X	X	X		X	X	X	
9	Ambulance injury	X	X	X	X		X	X	
10	Cricket ball accident	X		X	X	X	X		
11	Dilapidated building	X	X		X	X	X		X
12	Surgery death	X	X	X		X	X		
13	Tree falling on car	X	X		X		X	X	X

Pairs on the basis of similar incidents illustrating different principles: 1 and 2, 3 and 12, 4 and 8, 5 and 7, 6 and 11, 9 and 10. 13 and 11 are substitutes for each other.

Men, BC1, Cardiff

		Reason for involvement **1**	Resource consideration **2**	Balancing imperatives **3**	Risk free society **4**	Personal responsibility **5**	Vulnerability **6**	Consequences **7**	Time **8**
1	Rubbish in park	X	X		X		X		X
2	River floods	X	X		X	X	X	X	
9	Ambulance injury	X	X	X	X		X	X	
10	Cricket ball accident	X		X	X	X	X		

Women, C2DE, Cardiff

		Reason for involvement **1**	Resource consideration **2**	Balancing imperatives **3**	Risk free society **4**	Personal responsibility **5**	Vulnerability **6**	Consequences **7**	Time **8**
3	School trip	X		X	X	X	X	X	
12	Surgery death	X	X	X		X	X		
6	Cemetery	X	X		X	X	X	X	X
13	Tree falling on car	X	X		X		X	X	X

Men, C2DE, Birmingham

		Reason for involvement **1**	Resource consideration **2**	Balancing imperatives **3**	Risk free society **4**	Personal responsibility **5**	Vulnerability **6**	Consequences **7**	Time **8**
4	Passive smoking	X	X		X	X	X	X	
8	Meningitis	X	X	X		X	X	X	
5	Car service	X	X			X	X		
7	Poor electrical work	X	X		X	X	X		X

Women BC1, Birmingham

		Reason for involvement **1**	Resource consideration **2**	Balancing imperatives **3**	Risk free society **4**	Personal responsibility **5**	Vulnerability **6**	Consequences **7**	Time **8**
6	Cemetery	X	X		X	X	X	X	X
11	Dilapidated building	X	X		X	X	X		X
9	Ambulance injury	X	X	X	X		X	X	
14	Passive smoking	X		X	X	X	X		

APPENDIX 6 REFERENCES

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