

Open Government Status: Fully Open



DOCUMENT G - MAJOR INCIDENT RESPONSE AND INVESTIGATION POLICY AND PROCEDURES

HSE Enforcement Statement/Quality Statement for Continuing Aim 2

This Document is issued and controlled by the Operations Unit (OU) on behalf of the HSE Executive/Board. Any enquiries should be addressed to Alison Mckenzie-Folan, OU Room 506, Daniel House (Ext 4778)

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INTRODUCTION

This Document (DOCUMENT G) sets out HSE's quality management arrangements for responding to and investigating major incidents. It is one of a series of documents which establish procedures designed to meet HSE's Enforcement Statement/Quality Statement for Continuing Aim 2 - To secure compliance with the law in line with the principles of proportionality, consistency, transparency and targeting on a risk-related basis.

The document is divided into 2 parts:

- Part 1 sets out HSE's policy and procedures for **responding** to major incidents in the sectors for which it has responsibility up to the time when an investigation begins.
- Part 2 sets out the organisation and arrangements for implementing and monitoring HSE's policy and procedures on major incident **investigation**, including investigations directed by the Health and Safety Commission under Section 14(2)(a) of the Health and Safety at Work etc Act 1974.

For the purpose of this document HSE defines a major incident as follows:

A major incident is a significant event which demands a response beyond the routine. Significance is determined by the severity of the incident, the degree of public concern and the nature and extent of HSE's previous involvement with the duty holder(s); though the nature of previous involvement would not alone trigger a major incident investigation.

For incidents which are not subject to HSWA 14 (2)(a) investigation, the decision to designate an incident as major rests with the Executive and the Executive decides whether to invoke all or part of the investigation arrangements in Part 2 of this document.

Appendix 1 illustrates the process.

PART 1

HSE MAJOR INCIDENT RESPONSE PROCEDURES

1 SCOPE

Part 1 of this document sets out HSE's policy and procedures for responding to major incidents in the sectors for which it has responsibility, up to the time when an investigation begins. This section also covers the arrangements for testing, monitoring, auditing and reviewing the implementation of the response policy. Major incidents known or suspected to be the result of terrorist activity are not covered by this policy.

2 PRINCIPLES

The Executive's policy is to have an effective system for responding to major incidents, which is proportionate to the circumstances and cost effective. The underlying principles are:

- to provide an effective system to enable employers, employees, the public or emergency services to contact HSE in the event of a major incident;
- to provide an effective communication system within HSE to enable quick and appropriate response and begin to investigate promptly;
- that the responsibility for the control or mitigation of the effects of the incident rests with the emergency services in association with dutyholders in charge at the site of a major incident. If required, advice on matters of health and safety is given to the emergency services, other persons making rescue, or the public;
- that there are in place appropriate arrangements to ensure that major incidents are notified promptly to Ministers, including the Scottish and Welsh Executives if appropriate, the Commission and the Executive. The aim is to notify HSSD within one hour of HSE having sufficient information which may warrant classifying the incident as major;
- that there are in place appropriate arrangements to inform and liaise with other government departments, devolved administrations, the police and other enforcing authorities as appropriate;
- to maintain within each Directorate/Division written plans and procedures for responding to major incidents in accordance with this policy;
- to ensure major incident response plans include the roles of key personnel, arrangements for liaison with relevant parts of HSE, other government departments, the devolved administrations, the police and other enforcing authorities as appropriate;
- to test regularly major incident response plans and procedures;

- to audit and review periodically major incident response plans and procedures;

3 KEY RESPONSIBILITIES

Holders of the following posts have specific responsibilities for implementing this policy as outlined below.

The Executive

- Ensure that a member of the Executive is available for out-of-hours notifications of major incidents.
- Ensure that contact with the Secretariat and other members of the Executive is maintained during response to the major incident.
- Determine, after consultation with relevant Directors and the Heads of Division, HSE's initial response to the major incident.
- Oversee HSE's response to a major incident.
- Ensure that the Chair of the Commission is contacted as soon as possible, is made aware of the Executive's initial response and has the opportunity of consulting colleagues and Ministers before formal announcements are made.
- Monitor and approve briefing for the Commission Chair, Commission and Ministers.
- Periodically review the operation of this policy.

Directors or Heads of Free Standing Division

- Ensure that the Directorate/Division has effective plans and procedures for responding to major incidents in accordance with the requirements of this policy.
- Ensure the Directorate/Division has an effective communication system for out-of-hours contacts.
- Ensure that the major incident response plan includes arrangements to secure the site at an early stage and that prior to any site visit, instructions are given to those in control to prevent injury and to preserve essential evidence, using formal legal powers where necessary.
- Ensure that HSE Secretariat, the Executive, Press Office and, as appropriate, HSE Directors (Scotland) or (Wales) are notified and kept informed of any developments following a major incident.

- Ensure that where a major incident occurs in Scotland or Wales, the Directorate/Division receiving the information informs Press Office and HSE Secretariat who make arrangements to notify the devolved administrations.
- Ensure that where an incident occurs which involves more than one Directorate/Division there is effective co-operation and communication which is reflected in their plans.
- Ensure that the Directorate/Division plans cover the liaison arrangements with other Government Departments, regulatory bodies and the Scottish and Welsh Executives as appropriate.
- Ensure that in the event of a major incident involving a fatality the Directorate/Division has effective liaison arrangements with the relevant police force (in England and Wales) in line with the protocol “Work-related deaths - a protocol for liaison”.
- Provide industry/sector specific guidance to the Head of DIAS for inclusion in the Duty Officer Manual in accordance with the requirements of GAP 64.
- Ensure that the Directorate/Division tests, monitors and reviews its plan and procedures for responding to major incidents in accordance with the requirements of Section 4 of this part of the document.
- Ensure that the Directorate's/Division's Major Incident plans and procedures are included within a controlled document procedure.
- Within one month of a major incident occurring provide a report to the Deputy Director General (Operations) on HSE's response to the incident incorporating the information specified in Appendix 3. The report is prepared by the Director/Head of the Operating Division/Directorate with the prime responsibility for the operational response to the incident, incorporating information provided by the other Directorates/Divisions involved.

Head of HSE Secretariat

- Ensures that the Secretariat has an effective plan for responding to major incidents in accordance with the requirements of this policy.
- Ensures that the Secretariat has an effective communication system for out- of-hours contacts.
- Ensures that the Secretariat has an effective communication system to establish and maintain links with the relevant Directorate(s)/Division(s) and policy directorates following a major incident.

- Ensures that an efficient communication system is established and maintained to provide regular briefings to the Executive , Commission, HSE Press Office, Department of the Environment, Transport and the Regions (DETR), Ministers via the Health and Safety Sponsorship Division (HSSD), or other government departments (including that of the lead department if appointed by the Cabinet Office) and devolved administrations if appropriate, HSE Press Office (and if necessary the Central Office of Information (COI)).
- Prepares, in consultation with the Press Office, statements to the media, for senior management, members of the Executive or Ministers etc.
- Ensures that the Secretariat tests, monitors and reviews its plan for dealing with a major incident in accordance with the requirements of Section 4, of this part of the document.
- Ensures that the Secretariat's Major Incident Plan is part of a controlled document procedure.

Chief Press Officer

- Ensures that the Press Office has an effective plan for responding to major incidents in accordance with the requirements of this policy.
- Ensures that the Press Office has a communication system for out-of-hours contacts.
- Ensures the availability of a Duty Press Officer (deputy Duty Officer) to receive out-of-hours notifications and monitor reports from the media about major incidents.
- Ensures that there are effective communication links between the Press Office, Directorate/Division responding to the incident, and HSE Secretariat.
- Ensures that a press officer attends the major incident site if requested by the Directorate/Division.
- Organises where necessary, any HSE press conference(s) regarding the incident and HSE's role.
- In consultation with the Directorate/Division and HSE Secretariat, deals with requests for information from the media.
- Ensures that the Press Office tests, monitors and reviews its plan for dealing with a major incident in accordance with the requirements of Section 4, of this part of the document.

- Ensures that the Press Office's Major Incident Plan is part of a controlled document procedure.

Major Incident Office

- Provides day to day support to the Executive in co-ordinating HSE's ongoing response to a major incident .

Head of Information Services

- Ensures that an effective telephone contact system is in place to enable duty holders, members of the public and emergency services to contact HSE in the event of a major incident. This includes the publication of contact information for the emergency services.
- Ensures that sufficient trained Duty Officers are available to receive out-of-hours notification of major incidents in line with General Administrative Procedures (GAP) 64 'HSE Duty Officer System'.
- Provides and maintains the Duty Officer Manual which contains the Directorate/Divisional contacts for major incident notifications.
- Incorporates sector specific guidance provided by Directorates/Divisions into the Duty Officer Manual.
- Ensures that the out-of-hours telephone contact system and the operation of the Duty Officer system are tested, monitored and reviewed in accordance with Section 4, of this part of the document.
- Maintains the Senior Officers List.

Directors of Policy Directorates

- Provide policy guidance, as appropriate, to the HSC Chair, Executive, and Directorates/Divisions for major incidents occurring both within and outside the HSE enforced industry sectors.
- Considers the potential for cross Government departmental involvement, or cross border involvement in the case of incidents in Scotland or Wales.

- Provide guidance, as appropriate, to the Executive and Commission in cases where neither the HSE nor Local Authority are the enforcing authority and there is no agency agreement. Co-ordinates HSE action ensuring HSE Secretariat and Press Office are kept informed of developments.
- Provides Divisional contacts for out-of-hours notifications to the Duty Officer.

Head of Local Authority Unit (LAU)

- Ensures that the LAU has an effective plan for responding to major incidents in accordance with the requirements of this policy.
- Issues and maintains a Local Authority Circular for Local Authorities describing HSE's policy and arrangements for major incident response and ensures that Local Authorities are issued with the current version.
- Produces a policy for dealing with major incidents in Local Authority premises.
- Provides briefing for the Commission, the Executive, Secretariat, HSSD, Ministers and, if appropriate, the Scottish or Welsh Executives about major incidents in Local Authority enforced premises.
- Provides LAU contacts for out-of-hours notifications to the Duty Officer.
- Ensures that the LAU tests, monitors and reviews its plan for dealing with a major incident in accordance with the requirements of Section 4, of this part of the document.
- Ensures that the LAU's Major Incident Plan is part of a controlled document procedure.

Chief Executive of Health & Safety Laboratory (HSL)

- Ensures that HSL has a plan to respond to requests for assistance from Divisions/Directorates in the event of a major incident.
- Ensures that HSL has an effective communication system for out-of-hours contacts.
- Ensures that HSL tests, monitors and reviews its plan for responding to requests for assistance in the event of a major incident in accordance with the requirements of Section 4, of this part of the document.
- Ensures that the plan is part of a controlled document.

Head of Resources and Planning Division - Internal Audit Unit

- Includes within the internal audit programme, audits of the HSE's Major Incident Response Policy and Procedures and the Directorates/Divisions arrangements.

Head of Operations Unit (OU)

- Organises and chairs the Major Incident Progress Group meetings.
- Issues HSE Major Incident Response Policy and Procedures as a controlled document on behalf of the HSE Executive/Board .
- Supports the Major Incident Progress Group in the testing, monitoring and reviewing of HSE's Major Incident Response Policy and Procedures as detailed in Section 4 of this part of the document.

Major Incident Progress Group (MIPG)

- Comprises representatives from HSE Operational Divisions/ Directorates which are likely to be involved in HSE's response to a major incident as well as the Press Office, the Secretariat, DIAS, HSL, LAU, Operations Unit, Policy Directorates and Policy Unit, HSSD and DETR.
- Meets at least once a year to monitor and review HSE's Major Incident Response Policy and Procedures.
- Considers the experiences and lessons learnt from any monitoring, tests and audits of HSE's Major Incident Response Policy and Procedures and from real incidents, ensuring they are disseminated.
- Reports to the Deputy Director General (Operations) annually on the operation and adequacy of HSE's Major Incident Response Policy and Procedures.

4 TESTING, MONITORING, AUDIT AND REVIEW

- The testing, monitoring and reviewing of Directorate/Division plans and arrangements to comply with the HSE Major Incident Response Policy is the responsibility of the Director/Head of the Division.
- Each Directorate/Division produces an annual programme for testing and monitoring its major incident response arrangements over the next work year and a record of the previous year's testing programme and send them to the Head of OU by 1 February of each year.

- The testing programme includes at least a six monthly data verification test and a scenario test at intervals of not more than 24 months.
- Criteria are established to enable the success or otherwise of a test to be determined. [Appendix 2]
- Real incidents may be used as alternatives to scenario tests providing performance is reviewed against established criteria.
- Where Directorates/Divisions have no major operational responsibilities then they may, with the agreement of the Directorate/Division concerned, link their scenario tests with another Directorate/Division rather than organising an independent programme of their own.
- The Head of OU, acting on behalf of the MIPG, organises a scenario test of the HSE Major Incident Response Procedures. The test is carried out annually or at intervals agreed by the Executive/Board. The test involves more than one Directorate/Division and may be incorporated within any Directorate/Division test as agreed with that Directorate/Division. A report of the results of the test is provided to the Deputy Director General (Operations).
- Directorates and Divisions provide feedback to the MIPG about real incidents and tests they have undertaken with a view to sharing experiences and learning from them.
- Audits of Directorates and Divisions major incident response plans and procedures are carried out at intervals agreed with the Executive, MIPG and RPD Internal Audit Unit.
- It is the responsibility of the relevant Director or Head of Division to implement the recommendations of the audit.
- The HSE Major Incident Response Policy and Procedures are reviewed by the Executive every 3 years.

PART 2

HSE MAJOR INCIDENT INVESTIGATION PROCEDURES

1. SCOPE

Part 2 of this document sets out the HSE's policy and procedures on major incident investigation and on investigation directed by the Health and Safety Commission under Section 14(2) of the Health and Safety at Work etc Act 1974. Appendix 1 provides a schematic overview of the arrangements.

2. PRINCIPLES

The Executive's policy on major incident investigation supplements its policy on investigation set out in Document F - Investigation under HSE Enforcement Statement/Quality Statement for Continuing Aim 2.

The main purposes of a major incident investigation are to establish what happened and why, to learn the lessons from such events, prevent recurrence and put appropriate breaches before the courts. HSE's Major Incident Investigation Policy recognises these essential purposes and that :

- investigations aim to improve the Executive's capacity to fulfil its Mission, and its obligation to deliver the HSC enforcement policy;
- information from incidents is gathered, analysed and disseminated, and appropriate action taken to the extent necessary for HSE to fulfil its Mission;
- the response to major incidents is proportionate to the circumstances and cost effective;
- conditions are made safe prior to investigation;
- major incident investigations are conducted in line with HSE's and Operational Directorates' health and safety policies;
- major incident investigations are conducted and reported to the extent necessary to:
 - identify the immediate and underlying causes,
 - ensure that appropriate remedial action is taken by duty holders,
 - inform duty holders, other relevant enforcing agencies and the public about the causes of incidents and any relevant finding from investigations,
 - identify any breaches of the law and the appropriate action to be taken in the circumstances,
 - contribute to HSE's knowledge of the causes of incidents,

- identify any shortcomings in policy, legislation or guidance and any consequential research,
 - help HSE evaluate the effectiveness of inspection activity, including liaison with other enforcing authorities,
 - use the intelligence gathered to inform and plan strategic enforcement decisions, and
 - meet the reasonable expectations of relevant stakeholders in line with Open Government commitments (but recognising that investigations are never solely made to assist with a civil claim or to provide Open Government information to third parties).
- Major incidents are investigated with the degree of independence in each case decided by the Executive to ensure appropriate examination of HSE's prior involvement with the duty holder(s). In those incidents subject to an HSWA Section 14(2)(a) investigation the Executive always appoints at least one person from outside HSE to provide such independence.
 - Directors, Heads of Operating Divisions and their staff co-operate fully in the examination of HSE's prior role.
 - It is HSC/E's policy to make information about major incidents available in so far as the interests of justice allow. Where the disclosure of information might prejudice enforcement action, including prosecutions, it will be necessary to balance the risk of such prejudice against the need for openness in deciding how much information can properly be disclosed and how soon.

3. KEY RESPONSIBILITIES

The Executive has overall responsibility for fulfilling this policy. Directors and Heads of Operating Divisions are responsible for advising the Executive on incidents which may warrant classification as major.

If the Executive decides to classify an incident as a major incident the Executive then assumed responsibility for the overall control and monitoring of the investigation.

4. ARRANGEMENTS

The Executive has instituted the following arrangements to ensure that this policy is applied:

- The allocation of resources to Directorates/Divisions each year takes due account of the need to provide for investigation work but may be varied in-year to cater flexibly for the demands of major incident investigations.
- Following receipt of initial information on the nature of the incident from Directors of Operating Directorates, the Executive decides if the incident should be categorised as 'major' by consulting with the Chair, Commission and Ministers as appropriate. The Commission may direct HSE to investigate the incident under HSWA Section 14(2)(a).
- Directors/Heads of Divisions advise the Executive on any developments of an incident not initially categorised as "major" which may subsequently warrant such classification in light of developments. They also alert the Executive to events which taken in isolation, may not warrant classification as major incidents but may do so when considered together.
- Directors/Head of Divisions advise the Executive about any specific legislation which creates particular obligations or gives powers to Ministers to direct the nature of investigations, or devolved administrations powers to use other legislation to hold investigations. They also brief the relevant policy branch, Secretariat and Press Office.
- For major incidents which are not subject to a HSWA Section 14(2)(a) investigation by HSE, the Executive decides on the application of the investigation arrangements detailed in Appendix 4.
- In agreeing to the form of the investigation the following points are considered:
 - the significance of the event,
 - any separate investigations by other regulatory bodies,
 - the involvement of other regulatory bodies in the investigation,
 - the effect of the investigation on HSE as a whole and the Directorate's/Division's programme of work,
 - the concerns of the Commission, Ministers, other Government Departments, devolved administrations and regulatory bodies.
- The Executive arrange for briefing and/or consultation with the HSC Chair, Ministers or others on the nature of the incident and the proposed action.

The detailed arrangements for investigation of the circumstances of the incident, the role of the dutyholder(s) and the inquiry into HSE's prior role are described in Appendix 4.

Where an incident is categorised as major the Executive activates HSE's Major Incident Group (MIG). The MIG comprises:

- the Executive;
- the Director(s) of the Operating Directorate(s) with responsibility for enforcement at the major incident site;
- the Director(s) of relevant Policy Directorate(s);
- the Major Incident Investigation Division (MIID). The MIID is under the direction of the Deputy Director General and includes HSE's Major Incident Office, the Major Incident Investigation and Inquiry Board, the Investigation Team and the Prior Role Inquiry team.

The report following a major incident investigation is published and consideration is given to the publication of interim technical reports if broader health and safety lessons emerge.

Any lessons learned from the inquiry into HSE's prior role are considered by the Executive and action is taken as appropriate to ensure that any improvements required to existing arrangements are implemented within a specified timescale.

The Executive has instituted the following common arrangements for quality assurance and control of investigations, as part of the Quality Policy, elaborated as necessary in individual Directorate/Divisional instructions:

- Inspectors are provided with such training, coaching, instruction and supervision as is necessary to ensure that investigations are conducted with due rigour.
- Resources are provided by the responsible Director to support each major incident investigation throughout its course. Any requirements over and above those available to the Director, either from the Directorate's allocated resources or by requisition from other Directorates under agreed arrangements, are reported to the Executive by the Deputy Director General for resolution.
- Directorates have arrangements in place as appropriate to inform and liaise with other government departments, devolved administrations, the police and other enforcing authorities in their investigation of a major incident.

- In a major incident involving a fatality, Directorates liaise with the relevant police force (in England and Wales) in line with the protocol 'Work-related deaths - a protocol for liaison'.
- The conduct of current major incident investigations is reported and discussed as a standing item at meetings of the Major Incident Progress Group (MIPG) as a means of sharing experiences and learning from them.
- The nature and number of major incident investigations undertaken by a Directorate/Division each year is provided to the MIPG and included in the annual report to the Board.

5 MONITORING, AUDIT AND REVIEW

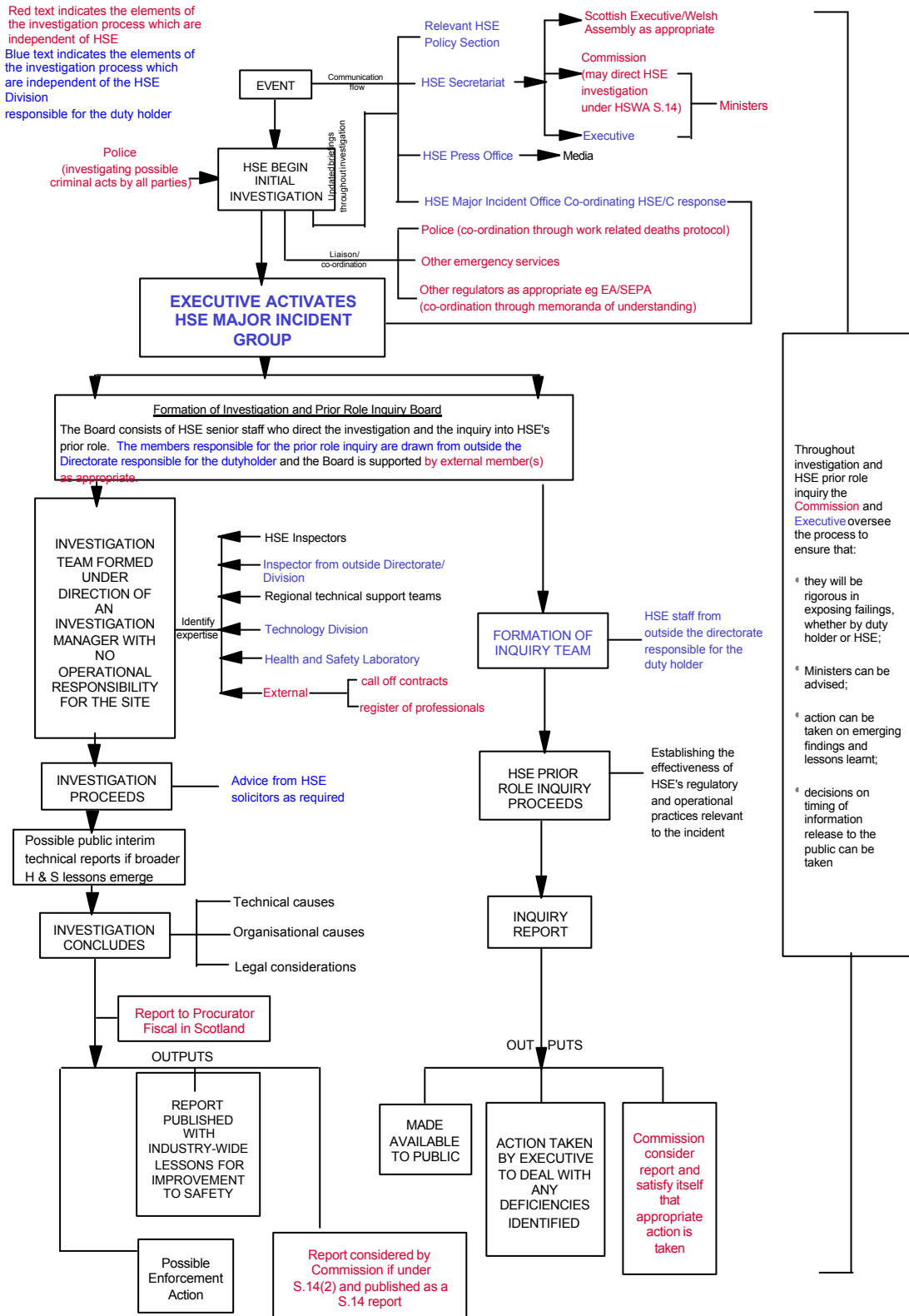
The Executive monitors the implementation and effectiveness of this policy annually through the receipt of a paper produced by the MIPG, and as appropriate in the circumstances of each major incident investigation. HSE's Internal Audit Unit includes within their programme the audit of the HSE Major Incident Investigation Procedures and Directorate/Division arrangements.

The policy is reviewed by the Executive every 3 years.

APPENDICES

APPENDIX 1 - SEE APPENDIX 4 FOR EXPLANATORY TEXT

REVISED HSC/E ARRANGEMENTS FOR ASSURING INDEPENDENCE IN MAJOR INCIDENT INVESTIGATION:



APPENDIX 2

CRITERIA TO BE INCLUDED IN MAJOR INCIDENT RESPONSE TESTS AND REVIEWS

Type of test	Content	Criteria for success	Carried out by:
1. Simple data verification	<p>1. Administrative check of the information contained in D/D emergency plans relating to the local information.</p> <p>2. Make amendments to the information as necessary.</p>	1. The information for all D/D's is accurate and up to date.	Relevant D/D staff.
2. Detailed incident scenario.	<p>1. Planned scenario exercise with predetermined objectives. (The scale of the exercise dependent on the Regulatory framework. It may include involvement of stakeholders.</p> <p>2. The exercise is reviewed and appropriate staff are informed of the results.</p>	<p>1. Demonstration that staff are available to respond promptly and the communications network is operational.</p> <p>2. Evidence that staff make decisions in accordance with the Major Incident Response Policy and D/Ds emergency plans.</p> <p>3. The objectives set are achieved and performance standards met.</p> <p>4. Any lessons learned are built into the system to improve future performance.</p>	<p>1. Exercise planned and conducted by D/Ds.</p> <p>2. Review of performance by D/D staff.</p>
3. Real incidents.	1. A review of the response to the incident by the investigating team.	<p>1. The incident results in a response that puts into practice the major incident arrangements.</p> <p>2. Demonstration that staff are available to respond promptly and the communications network is operational.</p> <p>3. Evidence that staff make decisions in accordance with the Major Incident Response Policy and D/Ds emergency plans.</p> <p>4. Any lessons learned are built into the system to improve future performance.</p>	1. The inspector managing the investigation or a person delegated for this function.

Type of test	Content	Criteria for success	Carried out by:
4. Corporate.	<p>A planned scenario exercise with the objective to test the corporate arrangements.</p> <p>The scenario involves more than one D/D.</p>	<ol style="list-style-type: none"> 1. The arrangements to communicate between D/Ds and to a wider network up to the ministerial office are in place and operating to performance standards. 2. Demonstration that staff are available to respond promptly and the communications network is operational. 3. Evidence that staff make decisions in accordance with the Major Incident Response and Investigations Policy. 4. The objectives set are achieved. 5. Any lessons learned are built into the system to improve future performance. 	Head of Operations Unit and Directors/Heads of D/Ds.

APPENDIX 3

RESPONSE TO A MAJOR INCIDENT - PAPER TO THE DEPUTY DIRECTOR GENERAL (OPERATIONS)

Within one month of a major incident occurring the Director of the OD which initially responded should prepare a report for the DDG (Operations).

The report should cover HSE's **immediate** response to the major incident including any lessons to be learnt. It should incorporate information from other Directorates/Divisions involved in the response and should include:

- a brief description of the incident with dates and times;
- details of the notification, by whom, how, to whom etc;
- who made the initial response and how;
- which HSE Directorate/Divisions and other enforcing authorities are involved;
- what communication links there were with the D/D, Press Office, Secretariat, Executive, HSC Chair, HSSD, HSE Directors of Wales and Scotland and the Welsh and Scottish Assemblies (where appropriate) and were they effective and appropriate;
- liaison arrangements with emergency services and other enforcing authorities and any difficulties encountered;
- lessons learned, for example what worked and what did not and what actions have been taken or need to be taken as a result;
- any other information relevant to how HSE responded.

The report should be copied to the Head of Operations Unit who will bring it to the attention of the MIPG to discuss lessons learned and to take forward any corporate actions required.

APPENDIX 4

MAJOR INCIDENT INVESTIGATION AND PRIOR ROLE INQUIRY ARRANGEMENTS (SEE ALSO FLOW CHART AT APPENDIX 1)

Following designation of the incident as major, the Executive activates the Major Incident Group and appoints from outside the home Directorate, an Investigation Manager at Band 0 or above to chair a Board responsible for the conduct of the investigation into the circumstances of the incident and the compliance of the dutyholder(s), as well as the inquiry into HSE's prior role. The Board members are bound by the Civil Service Code and carry out their responsibilities in accordance with its requirements.

The Investigation and Prior Role Inquiry Board

The Investigation Manager in consultation with the Executive appoints the HSE members of the Board. The Board Members are drawn from HSE senior staff from outside the home Directorate. With the agreement of the Executive, the Board may include a member from the home Directorate to advise on matters related to the investigation but that member is not involved in the conduct of the prior role inquiry.

The Board must include at least one person who is independent of HSE who is technically competent on matters relating to the incident. This person(s) is appointed by the Executive, and in the case of a Section 14(2)(a) investigation in consultation with the Chair of HSC.

The Incident Investigation Team

This team is composed of people with the necessary competence to undertake the investigation. They may be drawn from across HSE and from outside HSE as necessary depending on the nature of the incident and the range of skills and experience required to undertake a thorough investigation. The investigation team leader is a person usually at Band 1 level from the home Directorate but who is not responsible for the routine oversight of inspection of the site or dutyholders involved in the incident.

Prior Role Inquiry Team

The nature and extent of the Prior Role Inquiry depends upon the seriousness and complexity of the incident. In more serious or complex incidents it will be necessary to form an inquiry team. This team is composed of people from outside the home Directorate with the necessary competence to undertake the field work for the inquiry under the direction of an inquiry team leader at Band 1 level. In less complex incidents it may be appropriate for the Band 1 to undertake the inquiry alone.

ROLES AND RESPONSIBILITIES

The Executive

The Executive

- designates the incident as major;
- decides on the extent to which the arrangements in this Appendix and Appendix 1 are invoked for major incidents which are not subject to an HSWA Section 14(2)(a) inquiry;
- appoints an Investigation Manager;
- agrees the HSE Membership of the Investigation and Prior Role Inquiry Board and appoints the external member(s).
- agrees the terms of reference for the investigation and the prior role inquiry (and in the case of an HSWA Section 14(2)(a) investigation with the HSC Chair);
- oversees the investigation and prior role inquiry process;
- briefs the HSC Chair, Commission and Ministers as appropriate;
- agrees decisions on the timing of release of information to the public;
- considers the report of the investigation and agrees the action to be taken;
- considers the report of the inquiry into HSE's prior role and ensures that action is taken as appropriate to ensure that any improvements required to existing arrangements are implemented within a specified timescale;

The Investigation Manager

The Investigation Manager is responsible for the overall conduct of the investigation and inquiry into HSE's prior role and is accountable to the Executive. In particular the Investigation Manager:

- with the agreement of the Executive appoints the HSE members to the Investigation and Prior Role Inquiry Board;
- agrees with the Executive (and the Chair of the HSC in the case of an HSWA Section 14(2)(a) investigation) terms of reference for the investigation and the inquiry into HSE's prior role;

- appoints an investigation team leader in consultation with the Director of the OD responsible for enforcement in the sector in which the incident occurred, and a prior role inquiry team leader in consultation with the Executive.
- co-ordinates the activities of the Investigation and Prior Role Inquiry Board;
- briefs the Director of the OD, the Executive and the Chair of HSC as appropriate on the progress of the investigation;
- briefs the Executive ,the Chair and HSC on the progress of the prior role inquiry;
- submits a report on the outcome of the investigation to the Executive and to the Chair of the HSC in the case of an HSWA Section 14(2)(a) investigation. The report is submitted within 3 months of the completion of the investigation (including that of other regulatory authorities).
- submits a report to the Executive and the Chair of HSC on the outcomes of the inquiry into HSE's prior role. The report is submitted within 6 months of the date of the incident occurring. Any extension to this time period must be agreed by the Executive.

The Investigation and Inquiry Board

The Board is accountable through the Investigation Manager to the Executive and is responsible for:

- identifying the immediate and underlying causes of the incident;
- examining the extent to which the dutyholder(s) have complied with the law;
- providing advice and support to the investigation team leader.
- monitoring the course of the investigation by receiving regular reports from the investigation team leader on progress and outcomes;
- directing the cause of the investigation as necessary;
- ensuring that the process of evidence collection and conclusions drawn from the evidence are robust and will withstand scrutiny;
- considering in consultation with Solicitor's Office, whether to publish interim technical reports if broader health and safety lessons emerge;

- ensuring that any issues emerging from the investigation which have implications with respect to HSE's prior role are examined by the prior role inquiry team;
- agreeing the action to be taken by HSE as a result of the investigation including enforcement action if appropriate in line with the HSC Enforcement Policy Statement. ***Note that the Board Member(s) independent of HSE are NOT involved in enforcement action considerations;***
- undertaking a thorough examination of HSE's prior role and, where relevant HSC's role, and making recommendations to improve effectiveness;
- providing advice and support to the prior role inquiry team leader;
- monitoring progress of the prior role inquiry by receiving regular reports from the inquiry team leader;
- directing the course of the inquiry as necessary;
- endorsing the reports on the outcome of the investigation and the prior role inquiry.

In addition to the above responsibilities the responsibility of the **Board Members independent of HSE** is to provide:

- independent advice to the investigation manager, investigation team leader and inquiry team leader;
- an independent view on the interpretation of the evidence collected and the conclusions drawn;
- assurance to the Executive on the adequacy of the investigation and inquiry processes in particular that:
 - the investigation and prior role inquiry have been properly conducted.
 - the performance of dutyholders has been thoroughly examined;
 - the immediate and underlying causes of the incident have been identified and remedial actions have been taken or are proposed;
 - the role of HSE and where relevant the HSC, before the incident has been properly considered.

The Investigation Team Leader

The investigation team leader is accountable to the investigation manager and is responsible for:

- assembling in consultation with the investigation manager, an investigation team with the range of competences necessary to undertake a thorough investigation;
- managing day-to-day investigation activity;
- liaison with other enforcing authorities;
- ensuring the health, safety and welfare of HSE staff involved in the investigation in accordance with the relevant HSE and OD health and safety policies;
- briefing the Investigation Board on the progress with the investigation;
- responding to the direction of the investigation manager;
- submitting a report on the outcome of the investigation to the Investigation Board;
- reviewing and preparing a report on the investigation process.

The Prior Role Inquiry Team Leader

The prior role inquiry team leader is accountable to the investigation manager and is responsible for:

- where appropriate assembling, in consultation with the investigation manager an inquiry team, with the range of competences necessary to undertake a thorough inquiry;
- managing day-to-day inquiry activity;
- briefing the Investigation and Inquiry Board on the progress with the inquiry;
- responding to the direction of the investigation and inquiry manager;
- submitting a report on the outcomes of the inquiry to the Investigation and Inquiry Board.

REPORTS

Main Investigation Report

The main investigation report is prepared for the Executive, or in the case of an HSWA Section 14(2)(a) investigation for the Health and Safety Commission. The report includes:

- The aims/objectives and any other terms of reference for the investigation.
- An executive summary of key conclusions and proposals for action by HSE and dutyholders.
- An explanation of the nature of the investigation and composition of the Investigation Board and the investigation team.
 - Major findings including:
 - When and where the event occurred.
 - The dutyholder(s) or other persons involved.
 - The sequence of events, how they occurred, the consequences and how injuries, ill health or damage arose. (This should include relevant results of any tests, reconstruction or specialist reports etc).
 - An assessment of the effectiveness of the dutyholders emergency procedures mitigating the consequences.

Conclusions about immediate and underlying causes of the incident. This part

- Demonstrates that all underlying causes have been addressed eg by working back from each immediate cause to the underlying causes and demonstrating that all reasonable possibilities have been explored.
- Identifies the law and standards used to evaluate the evidence.
- Identifies where controls for risk were absent, provided but were inadequate, provided and adequate but were not properly implemented or provided adequate and properly implemented.
- Examines the evidence concerning compliance with legal and other relevant standards, identifies the law applicable

to each dutyholder and draws conclusions on where breaches have occurred and whether the evidence is sufficient to support prosecution and

- Prioritises actions necessary to prevent recurrence with timescales or details actions already taken by the dutyholders and HSE.

Review of the investigation process

With the aim of continual improvement in HSE's arrangements for investigation of major incidents, the investigation team leader is responsible for reviewing and preparing a report on the investigation process. The report should highlight issues and any lessons learned during the investigation which need to be addressed either at Directorate/Division level or for HSE corporately in order to improve the current arrangements. Such issues might include for example:

- health, safety or welfare, of HSE staff;
- liaison arrangements with other enforcing authorities;
- liaison with emergency services;
- administrative/IT support;
- accommodation/welfare arrangements;.
- site security;.
- continuity of evidence;
- resources available;

The report is submitted to the Director of the OD and the Chair of the Major Incident Progress Group (MIPG). The Director of the OD is responsible for considering and taking forward recommendations for improving the OD's existing investigation arrangements and the MIPG is responsible for considering and taking forward recommendations relating to HSE's corporate arrangements.

Prior Role Inquiry Report

The inquiry considers:

- prior contact and advice given to the dutyholder(s) involved in the incident generally, and in particular at the site of the incident. This includes information on:
 - planned routine inspections;

- reactive inspections;
- safety reports;
- the granting of licensing and exemptions;
- the extent and nature of contact and co-operation with other enforcing authorities etc in relation to the site or dutyholder(s) involved;.
- the time and resources spent on previous contacts with the dutyholder(s) and at the site, the topics addressed and the actions taken. How these activities were planned, monitored and closed out;
- what inspection policy and resources are generally applied to the dutyholders of the type in question and whether they were applied at the site prior to the incident. This takes account of not only written instructions but also the operational procedures and practices normally adopted by HSE;
- whether the previous enforcement activities were effective, the advice given was sufficient and the standards applied were adequate/ appropriate in the light of the resources available (where appropriate this includes an assessment of the effectiveness of the arrangements for liaison with other enforcing authorities);
- whether the existing inspection policy and resources, procedures and instructions applied to HSE contact with dutyholders of the type involved were adequate, absent or deficient;
- where there has been no previous contact with the site, whether such absence of contact was in line with OD inspection policies and procedures and if not how this situation arose;
- what could be done differently to improve effectiveness.

The report records the findings of the inquiry into HSE's prior role. In the main these arise directly from HSE's contacts with the dutyholder(s) concerned. However the report deals also with the broader examination of the adequacy of HSE's arrangements for dealing with dutyholders of the type in question. The report includes:

- The terms of reference for the inquiry.
- An executive summary of key conclusions and proposals for action.
- An account of the legal position at the site and with the dutyholder in question if their performance at other sites is relevant; for example any outstanding enforcement action, any relevant exemptions, licenses, safety cases, safety reports and contact with other enforcing authorities etc.

This largely concentrates on factual matters which are directly relevant to the incident but includes enough information about the site/dutyholder in general to set the specifics in context.

- A factual summary of HSE's previous contacts with the site/dutyholder/ other authorities, including visits, meetings, written and verbal advice given (were recorded on file). This should concentrate on the incident but set the information in context.
- Analysis of the issues covered in the previous paragraphs exploring whether HSE's approach is being coherent, based on sensible risk related priorities, reflecting any known strengths and weaknesses of that site/dutyholder, making reasonable use of the resources available to HSE, being technically sound and in accordance with HSE policy and procedures including the HSC Enforcement Policy Statement.
- An assessment of HSE's approach generally to dutyholders of the type involved, including inspection, policy and local and Directorate/ Divisional resourcing. Sources for this should include both written material (instructions to inspectors, technical guidance etc) and actual but undocumented practices.
- Where relevant the role of the Commission/Executive/Board in their exercise of leadership, direction and oversight of operational policy relevant to HSE's general approach to dutyholders of the type involved.
- Any lessons to be learned including:
 - Allocation of responsibilities within the Directorate and/or HSE
 - Resourcing and inspection priorities
 - Adequacy of existing relevant HSE/Directorate procedures or instructions or where the absence of such procedures/instructions was relevant.
 - Changes to methods for contacting and influencing such dutyholders.
 - Other relevant issues such as support training for inspectors, effectiveness of arrangements for liaison with other enforcing authorities etc.

The prior role inquiry report is made available to the public.

References

- GAP 64 - HSE Duty Officer System**
- MISC 114 - Work-Related Deaths - A protocol for liaison**
- C 80 - Leaflet For The Emergency Services**