Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from the Institution of Occupational Safety and Health

Introduction

1. The Institution of Occupational Safety and Health (IOSH) is the largest membership body for OSH professionals worldwide, with more than 44,000 members in 120 different countries. A Chartered body, we have charitable and international NGO status and our current President-Elect is a Scottish-based member. With over 4,000 members based in Scotland, of whom around 33% are Chartered members, we have four Branches and one District that meet regularly in Aberdeen, Edinburgh, Glasgow, Inverness and Tayside. IOSH volunteers also meet regularly with other OSH professional representatives and are active within the Health and Safety Executive-organised Partnership for Health and Safety in Scotland (PHASS).

2. IOSH welcomes the opportunity to comment on this important call for views from the Scottish Parliament’s Justice Committee on Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. In the submission that follows, based on contributions from members in Scotland, we provide some general comments, followed by more detailed ones in which we address the Committee’s specific questions. We close with references and further information about IOSH. We have confined our responses to fatal accident inquiries (FAIs) for work-related accidents and exposures, as this is the aspect in which we have experience.

3. IOSH members’ primary competences and activities are advising on work-related health and safety hazards and effective methods to manage the associated risks. However, when things go wrong, they are typically also involved in assisting duty holders to investigate, identify and record what happened, including both the immediate and the underlying or ‘root causes’ of the failures to effectively manage risks, and to ensure that relevant lessons to prevent similar tragedies are communicated and understood by those who need to know. They therefore have experience of the aftermath of work-related accidents, including some fatal accidents – though of course relatively few now have much personal experience of these as, for most organisations and for most of the time, fatalities are prevented by the application of effective controls.

4. In terms of their types of deployment; most of our members work as in-house or contracted advisers, but some also work for local authorities and the Health and Safety Executive (HSE) in Scotland as regulators/enforcers and a few are specialist legal advisors.

General comments

5. IOSH very much welcomes the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill and the accompanying Policy Memorandum and indeed,
we regret that decisions on how to implement Lord Cullen’s 2009 recommendations have taken several years to be reached.

6. The minority of our members who have personal experience of more recent fatalities have noted some beneficial effects from establishing the Scottish Fatalities Investigation Unit (SFIU) in respect of work-related fatalities, with improved consistency of approach and generally good links established with bereaved families. Our members experience is consistent with the findings of internal and external reviews of the enforcement activities of HSE, in conjunction with the Crown Office and Procurator Fiscal Service (COPFS). We note that the HSE briefing paper on prosecution of health and safety offences by HSE in Scotland, discussed at a recent PHASS meeting (February 2015), identifies similar benefits.5

7. We judge that both the Bill and the supporting Policy Memorandum are sound, clear and logical, and support the suggested reforms in the areas where we have relevant experience (see Introduction above). In particular, we welcome the emphasis in both documents on explaining that FAIs are held in the public interest and are not intended to consider criminal or civil liabilities. We are aware of examples where a party that was dissatisfied with aspects of the relevant enforcement body/ies investigation into a work-related fatality has then attempted to use the FAI process as a second opportunity to raise issues of liability. In our members’ experience that is not helpful – if there are perceived deficiencies in the way an enforcing body has carried out an investigation there should be suitable processes to examine these, but it is confusing and time-consuming to raise such concerns in the context of a separate legal process, which has a different function, such as an FAI. We suggest that the much improved liaison arrangements with families that COPFS now have in place should go a long way to minimise situations where families feel that an enforcing body investigation has not met their needs or expectations.

Detailed comments – IOSH response to the ‘call for views’ questions

8. Whether the circumstances for mandatory FAIs provided for in the Bill are sufficient? IOSH believes the circumstances that are provided for mandatory FAIs are sufficient, but make further comment in our next answer.

9. Whether the circumstances provided for in the Bill in respect of discretionary inquiries are appropriate? We note that a mandatory FAI is required only when the person(s) who died was “...acting in the course of the person’s employment or occupation.” [Bill, section 2(3)(b)]1 However, there can also be fatalities to members of the public from work-related accidents and illnesses e.g. 4 deaths from Legionnaires’ disease in Edinburgh, 2012 and 6 deaths in the Glasgow bin lorry accident, 2015.6, 7 Where there is no resulting prosecution, as in the examples cited, we suggest it should be normal practice (i.e. covered by the ‘rules’, Bill, section 34)1 to hold a discretionary FAI, unless there are very strong reasons not to do so. This could enable valuable health and safety lessons to be gathered in the public interest, if these have not already been learned.

10. We agree with the reasoning in the Policy Memorandum about FAIs for work-related fatal diseases (paragraphs 75-77)4 and suggest a further reason for not
making these mandatory could be the difficulty in certain cases of determining whether a specific health condition that resulted in death was in fact wholly or partially work-related. However, where there is a strong likelihood that it was work-related and where there is no associated prosecution, again, we suggest that a discretionary FAI should be normal practice, unless there are very strong reasons not to hold one.

11. **Whether there are alternative approaches that should be considered?** IOSH does not advocate alternative approaches. Evidence from our members’ experience, the HSE paper referenced above, and the background information detailed in the Policy Memorandum, suggests that the non-regulatory recommendations already implemented are making a positive difference. Also most alternatives of which we are aware seem to originate from parties who wish to see an alternative means of assessing blame or fault where they believe the existing enforcement processes have been unsatisfactory. As we note in paragraph 7 above, advocating an FAI as a possible remedy does nothing to change the enforcement processes, if they do indeed need improvements.

12. **Whether the provisions in relation to FAIs into deaths abroad are appropriate?** IOSH has no comment on this at this time.

13. **Whether the provisions in relation to the pre-inquiry procedure are appropriate?** IOSH has no comment on this at this time.

14. **What are the practical implications of the provisions of the Bill?** As outlined in our introduction, we are solely focused on work-related aspects, so in most respects we are not in a position to comment on the practical implications overall. For work-related deaths, to the extent that the different purposes of enforcement activities and FAIs are made even clearer, we believe there will be improved clarity for both duty holders and all parties directly affected by deaths, including families and co-workers. In practice, this will aid resolution of resulting issues, rather than allowing them to become potentially alienating, due to lack of clarity in the legal processes of which very few persons will have had any previous experience.

**References**


3. IOSH. *Learning the lessons: How to respond to deaths at work and other serious accidents.* Wigston: IOSH, 2010. [www.iosh.co.uk/resources](http://www.iosh.co.uk/resources)


About IOSH
Founded in 1945, IOSH now has over 44,000 members, with around 13,000 Chartered Safety and Health Practitioners worldwide and our vision is:

“A world of work which is safe, healthy and sustainable”

The Institution steers the occupational safety and health profession, providing impartial, authoritative, free guidance. Regularly consulted by government and other bodies, IOSH is the founding member to UK, European and International professional body networks. IOSH has an active research and development fund and programme, helping develop the evidence-base for health and safety policy and practice. Summary and full reports are freely accessible from our website. IOSH publishes an international peer-reviewed journal of academic papers twice a year titled Policy and practice in health and safety. We have also developed a unique UK resource providing free access to a health and safety research database, as well other free on-line tools and guides, including basic information for business start-ups; an occupational health toolkit; and a risk management tool for small firms.

IOSH has 35 Branches in the UK and worldwide including the Caribbean, Hong Kong, Isle of Man, Oman, Qatar, the Republic of Ireland, Singapore and UAE, 16 special interest groups covering aviation and aerospace; communications and media; construction; consultancy; education; environment; fire risk management; food and drink; hazardous industries; healthcare; offshore; public services; railways; retail and distribution; rural industries; and sports grounds and events. IOSH members work at both strategic and operational levels across all employment sectors. IOSH accredited trainers deliver health and safety awareness training to all levels of the workforce from shop floor to managers and directors, through a professional training network of almost 1,900 organisations. We issue around 160,000 certificates per year.

For more about IOSH, our members and our work please visit our website at www.iosh.co.uk

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