Witness Name: Louis Burns
Statement No: WITN7670001
Exhibits: NIL
Dated: 15 June 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF LOUIS BURNS ON BEHALF OF HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND

I provide this statement in response to a request under Rule 9(1) and (2) of the Inquiry Rules 2006 dated 3 March 2022.

I, Louis Burns, will say as follows: -

Please provide a brief outline of the role and responsibilities of the Health and Safety Executive Northern Ireland.

1. Health and Safety Executive for Northern Ireland (HSENI) is a Non-Departmental Public Body with Crown Status under the remit of the Department for the Economy. Our work is focused on helping ensure that everyone stays safe and well 'at work' [as defined in Health and Safety at Work (Northern Ireland) Order 1978].

2. HSENI is the regulatory body for health and safety at work legislation in a range of sectors including manufacturing; schools and universities; chemical plants; hospitals and nursing homes; construction; disciplined services; transport; district councils; gas supply and distribution; government departments; agriculture; fairgrounds; market compliance in respect of

chemicals and products used at work; mines and quarries. Given our limited resources, the breadth of our remit, the premises and industry sectors we cover, we have to prioritise our activities. This has always meant that we concentrate our efforts more in the high-risk industries and activities known to be associated with serious injuries and fatalities.

3. As a regulator, a significant proportion of our resources are directed towards ensuring compliance with the relevant statutory provisions. This is achieved through a combination of workplace inspection and investigation activities which are underpinned by inspectors' enforcement powers.

4. HSENI also plays a role in educating, informing, communicating with and supporting businesses to comply with the duties of health and safety at work legislation in Northern Ireland.

5. HSENI employs inspectorate staff with backgrounds in scientific disciplines. The training of inspectors includes industrial experience and study to achieve a postgraduate regulatory diploma.

You will see that Mr Bragg proposes that there should be a statutory responsibility for all employees in the NHS to make a report when serious injury or death has occurred which might have been preventable, and that there should be a new, single organisation with responsibility to collect such information, to investigate incidents and to make sure that effective action has been taken. Please set out your response, from the perspective of the Health and Safety Executive Northern Ireland, to this proposal. Please provide any further comments regarding Mr. Bragg's proposals that you wish to provide set out your response, from the perspective of the Health and Safety Executive Northern Ireland, to this proposal. Please provide any further comments regarding Mr. Bragg's proposals that you wish to provide.

6. Mr Bragg proposed that, "*a statutory responsibility be created to require all employees within the NHS to make a report when serious injury or death has occurred which might have been preventable, and that there should be a new, single organisation with responsibility to collect such information, to investigate incidents and to make sure that effective action has been taken*". Mr Bragg stated that, "*This responsibility will drive the reporting of adverse events and drive the investigation and review of such cases such that effective actions are implemented to remove or reduce the possibility that this could be repeated. It would also remove the ability of management or those with authority to prevent or limit reporting*".

7. Although not in his statement, Mr Bragg in his evidence to the Inquiry mentioned the Reporting of Injuries and dangerous Occurrences Regulations (RIDDOR) as a possible vehicle for this reporting.

8. In respect of the 'single organisation proposal' Mr Bragg further stated in his evidence, "*Well, if we use RIDDOR, the Health and Safety Executive (HSE) automatically is that organisation, it is already existing. It does it across the UK as a matter of fact anyway. So it is just an extension of existing responsibilities*".

9. In sub-paragraphs 10 to 13 of this Part, I address the reporting / RIDDOR proposal. In sub-paragraphs 9 to 16 of this Part, I address the issue of a 'single organisation' and the proposed role of HSE but my response is on behalf of HSENI, not HSE.

10. The purpose of the RIDDOR regulations is primarily to provide HSENI with specified information from either the 'employer' or 'person having control of the premises'.

11. Regulation 10 of RIDDOR sets out the restrictions on the reporting requirements. Specifically regulation 10(1) states, "*The requirements of regulation 3 relating to the death or injury of a person as a result of an accident shall not apply to an accident causing death or injury to a person*

arising out of the conduct of any operation on, or any examination or other medical treatment of, that person which is administered by, or conducted under the supervision of, a registered medical practitioner or a registered dentist".

12. The restriction set out in 10(1) of RIDDOR is an important one. Where deaths and injuries occur under medical treatment etc. there is likely to have been a set of professional practices and standards in play. The consideration and evaluation of those practices and standards are outwith the spirit and scope of the Health and Safety at Work (NI) Order 1978 [1974 Act in GB]. I refer to the "Robens Report" Chapter 10 (paragraph 289) which states that the [HSE / HSENI] "*should be able to deal with any matter that falls naturally within its technical competence, whether or not employed persons are involved*". I believe the matters raised by Mr Bragg do not fall naturally within the technical competence of HSENI.

13. In summary, the exclusion set out in regulation 10(1) of RIDDOR is deliberate and correct and reflects the remit and limitations of HSENI.

14. As a general principle it occurs to me that the proposal to have a '*single organisation with responsibility to collect such information, to investigate incidents and to make sure that effective action has been taken*' is sound. It would allow for the development of uniform standards, shared learning, and consistency and transparency of enforcement etc. Importantly it would give an undiluted focus to this area of work.

15. The HSENI is a relatively small organisation with a complement of ten principal inspectors, twenty-four inspectors and sixteen trainee inspectors. We estimate we have some 80,000 premises which currently fall under the Health and Safety at Work (NI) Order in Northern Ireland.

16. One of the central aspects of HSENI's investigations is the assessment of risk. This is the assessment of health and safety risk. This is different and distinct from medical care where the basis of the system is the assessment of clinical risk. This is a clear and significant dividing line.

17. HSENI inspectors are trained on health and safety law and principles which can generally be applied to the "world of work". HSENI trainee inspectors must have a BSc at recruitment. HSENI has never recruited any investigator with a background which would be relevant to the matters raised by Mr Bragg. As such the organisation would have no competence in the investigation of related issues.

18. In addition, the range of 'medical practices' is large and the knowledge base held by medical professionals is so specialist that it would require significant levels of expertise to fully evaluate and understand reports of medical related incidents and related clinical systems. This expertise does not exist in HSENI. The resources required to set up a division within HSENI to service this area would be considerable and it would not fit into our existing structures. It is anticipated it would require medically qualified staff. Setting aside the obvious difficulties, it would require a significant investment and would essentially be a stand-alone division with limited crossover in HSENI.

19. I believe the addition of such a category of reportable accidents and the associated regulatory role with its many layers of complexity will move HSENI away from its core raison d'être. It would present HSENI with a body of information which it could not currently properly manage and act on. The danger would be that key issues would be missed, misinterpreted or misunderstood. It would also risk HSENI's normal work in construction, chemicals, farms etc. being reduced as we would try and resource the understanding and processing of healthcare issues.

20. There may be better placed agencies in the UK already operating in the regulation of medical practice who are / could be specifically empowered to oversee and investigate allegations in this area.

21. In summary, HSENI could not undertake the role proposed by Mr Bragg within current resources and competence. Any attempt to set up a new division in HSENI to do this work would be very challenging and for the reasons set out above would not deliver the necessary outcomes.

You will see from the statement of Ms Braithwaite that the Professional Standards Authority for Health and Social Care supports the establishment of a single body responsible for overseeing the safety system for health and social care. To the extent not already addressed above, please set out your response, from the perspective of the Health and Safety Executive Northern Ireland, to this suggestion

22. I refer to the statement of Ms Braithwaite where she proposes the Professional Standards Authority for Health and Social Care supports the establishment of a single body responsible for overseeing the safety system for health and social care.

23. I have set out my answer in sub-paragraphs 14 to 21 of this statement.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

LOUIS BURNS

Dated 15 June 2023