CARLISLE CITY COUNCIL

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Audit of Public Health & Safety / Enforcement

Draft Report Issued: 13 November 2017
Director Draft Issued: 18 December 2017
Final Report Issued: 20 December 2017

Audit Report Distribution

Client Lead:	Regulatory Services Manager
Chief Officer:	Corporate Director of Governance and Regulatory Services Chief Executive
Others:	Principal Health & Housing Officer, Food & Public Protection Team
Audit Committee:	The Audit Committee, which is due to be held on 12 January 2018, will receive a copy of this report.

1.0 Background

1.1. This report summarises the findings from the audit of Public Health & Safety / Enforcement. This was an internal audit review included in the 2017/18 risk-based audit plan agreed by the Audit Committee on 16th March 2017.

1.2. Health and safety legislation is either enforced by the HSE (Health and Safety Executive) or local authorities, depending on the main activity carried out at any particular premises. Local authorities are the main enforcing authority for retail, wholesale distribution & warehousing, hotel & catering premises, offices and the leisure industries.

1.3. Each local authority is an enforcing authority in its own right and must make adequate provision for enforcement.

1.4. Local authority inspectors can use enforcement powers, including formal enforcement notices, to address occupational health and safety risks and secure compliance with the law. Prosecution action may be appropriate to hold duty-holders to account for failures to safeguard health and safety.

2.0 Audit Approach

Audit Objectives and Methodology

2.1 Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems.

2.2 A risk based audit approach has been applied which aligns to the five key audit control objectives (see section 4). Detailed findings and recommendations are reported within section 5 of this report.

Audit Scope and Limitations.

2.3 The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Lead for this review was the Regulatory Services Manager and the agreed scope was to provide independent assurance over management's arrangements for ensuring effective governance, risk management and internal controls of the following risks:

- Risk 1 - Danger to public health and safety due to limited arrangements in place in relation to health and safety / enforcement. (**Management**)
- Risk 2 - Reputational damage / sanctions arising from legislation / regulation associated with health and safety for new and existing business not wholly known / compiled with. (**Regulatory**)
- Risk 3 - Reputational damage / sanctions arising from failure to meet statutory health and safety legislation / regulations. (**Regulatory**)
- Risk 4 - Sanctions for non-return of information to organisations such as the Health and Safety Executive. (**Regulatory**)

- Risk 5 - Council fail to evidence they have achieved their statutory obligations by failing to properly document appropriate inspections / investigations have taken place. (**Information**)
- Risk 6 - Inaccurate information resulting in poor decision making process and outcomes (including court decisions) due to data input errors or inconsistencies occur in the way the information is input, updated and recorded in the system. (**Information**)
- Risk 7 - Poor decision making process and outcomes (including court decisions) due to management and performance data not up to date and / or incomplete. (**Information**)
- Risk 8 - Safeguarding of data is not effective because it is not held securely and can be accessed by unauthorised individuals. (**Security**)
- Risk 9 - Inspections / investigations are not administered in an efficient way. (**Value**)

2.4 There were no instances where the audit work was impaired by the availability of information.

3.0 Assurance Opinion

3.1 Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix B.**

3.2 From the areas examined and tested as part of this audit review, we consider the current controls operating within Public Health & Safety / Enforcement provide **reasonable assurance**. The Audit includes one high graded recommendation; however, this relates to a single, discreet control area. Overall the internal controls are generally suitable, however there are some areas where controls are not always effectively applied.

4.0 Summary of Recommendations, Audit Findings and Report Distribution

4.1 There are two levels of audit recommendation; the definition for each level is explained in **Appendix C**.

4.2 There are eight audit recommendations arising from this audit review and these can be summarised as follows:

Control Objective	High	Medium
1. **Management** - achievement of the organisation's strategic objectives achieved (see section 5.1)	1	3
2. **Regulatory** - compliance with laws, regulations, policies, procedures and contracts (see section 5.2)	-	1
3. **Information -** reliability and integrity of financial and operational information (see section 5.4)	-	2
4. **Security** - safeguarding of assets (see section 5.3)	-	1
5. **Value** – effectiveness and efficiency of operations and programmes (see section 5.5)	-	-
Total Number of Recommendations	**1**	**7**

4.3 Management response to the recommendations, including agreed actions, responsible manager and date of implementation are summarised in Appendix A.

4.4 **Findings Summary**

Good Practice:

- The Regulatory Services service plan 2017/18 includes public health and safety enforcement. The service plan aligns to the Council's plan and includes specific service objectives for health and safety / enforcement. This is reviewed and updated after 6 months and has been approved by the Corporate Director.
- There is a current enforcement policy.
- Risks have been identified for the service and detailed in the service plan and are regularly monitored by management.
- The team use various sources of reference for advice and guidance in their day-to-day roles.
- The Principal Health & Housing officer regularly attends the Health & Safety Technical Working Group, which is made up of officers from each Cumbria local authority plus a designated partnership officer from the HSE. Best practice is shared within the group.
- The statutory LAE1 2016/17 annual return which reports health and safety inspections and enforcement activity was completed and submitted prior to the deadline.
- The team are aware of RIDDOR (Reporting of injuries, Diseases and Dangerous Occurrences) and these procedures were last updated in August 2016.
- All flare users have their own individual user ID and password and the system regularly prompts users to change their password.

- A document retention schedule is in place and the team are working through all their documentation to bring the service up to date, this continues to be work in progress.
- Customer satisfaction questionnaires are sent out quarterly. However, there had been a delay in sending the last two quarters. These should be sent out as soon as possible.

Areas for improvement:

- Audit testing highlighted that the Accident Reporting procedures needs to be updated.
- Management checks are completed, but not on a regular basis. Audit testing highlighted errors and missing data for case files on Flare. Regular management checks need to be undertaken to ensure that the required data is accurately recorded.
- Team meetings and 1 to 1's are completed, but not on a regular basis.
- Audit testing identified that not all incidents have been passed on to the responsible authority to action, for example CQC (Care Quality Commission).
- There is currently no reminder on Flare to prompt officers to check the Primary Authority Register to see if the business has a primary authority. A Primary Authority gives companies the right to form a statutory partnership with a single local authority. The local authority can provide robust and reliable advice for other regulators to take into account when carrying out inspections or dealing with non-compliance.
- The procedure for completing the statutory LAE1 annual return is not up to date.
- There is no matrix in place to record the reason why decisions have been made not to prosecute. Flare does not detail the summary supporting this decision, nor is it recorded on the incident criteria sheet.
- Flare does not currently restrict access to specific service area prosecutions.
- Although the team are aware of the emergency grab bag (which contains relevant documentation which would be used by officers responding to an emergency incident, for example, a fatality) there is no regular check of its contents or a checklist or process documented for replenishing it after it has been used.
- After the severe flooding in December 2015, it was highlighted that the service could be improved by providing the officers with better equipment, for example smart mobile phones which would allow them to take photographs and download them promptly, access Flare, email, procedures, Riddor, RIAMS and the HSE website remotely. This would allow officers to work more effectively when out on site.

Comment from the Corporate Director of Governance and Regulatory Services

Thank you for the team and Internal Auditors' work on this audit, the output of which is helpful. The contents are noted and the Manager's actions agreed.

5.0 Audit Findings & Recommendations

5.1 Management – Achievement of the organisation's strategic objectives

5.1.1 The Regulatory Services Service Plan 2017/18 includes public health and safety / enforcement and was approved by the Corporate Director of Governance and Regulatory Services.

5.1.2 The service plan is aligned to the Council's plan. It includes priority objectives for the service area and is reviewed and updated after six months. Service updates are discussed at team meetings.

5.1.3 There is an up-to-date Health and Safety Enforcement Policy, however it was noted that it is not available on the Council's website. It is advised that the policy is placed on the Council's website.

5.1.4 Risks have been identified and detailed in the service plan. Management regularly monitor the risks using the City Council's monitoring software, Project Server.

5.1.5 Out of hours contact is available in the event of an emergency.

5.1.6 At the time of the audit only ad-hoc management checks on cases were being completed.

5.1.7 Audit testing identified the following errors and omissions within the current system:

- Not all information had been recorded on Flare, for example details of visits to premises.
- Lack of notes recorded on Flare to confirm if the corrective action had / hadn't been taken.
- Examples were noted on Flare where the incorrect codes had been used.
- An Enforcement Management Model form (EMM) could not initially be located on one case file, but has since been located, with a copy provided to Audit.
- Results for 3 swimming pool water samples had been received but had not been loaded onto Flare.

5.1.8 If cases are not accurately recorded on Flare there is a risk of reputational damage / sanctions arising from failure to meet health and safety laws and non-return of information to organisations such as the HSE.

Recommendation 1 – Quarterly management checks should be introduced to ensure the effectiveness and accuracy of information on Flare. These checks should be recorded on the system.

As part of the checks management should also ensure that:

- **Officers record all relevant information on Flare, including premises visits, notes for all relevant action taken, results of specific tests, for example water sample results.**
- **Correct codes are used on Flare.**
- **An EMM form is completed as required. (M)**

5.1.9 All of the relevant officers have up to date job descriptions and delegated powers to carry out statutory health and safety requirements for the Council.

5.1.10 A variety of relevant training is provided for the team and all training logs were up to date.

5.1.11 Currently team meetings and 1 to 1's are not completed on a regular basis. As a result there is a risk of Council objectives not being delivered due to a lack of timely updates to staff.

Recommendation 2 – Management should ensure that team meetings and 1 to 1's are regularly undertaken. (M)

5.1.12 Audit testing identified that not all incidents have been passed on to the responsible authority for action and as a result there is a risk that this could lead to reputational damage and possible sanctions against the Council. Additionally there is a risk incidents are not appropriately dealt with. It was noted during the audit that a national issue exists in reporting incidents to the Care Quality commission (CQC), and the matter is being addressed through the appropriate liaison networks and temporary arrangements have now been agreed with the HSE to reallocate CQC incidents.

Recommendation 3 – Management should ensure that all officers are aware of the requirement to check if the Council is the responsible authority, if not the case should be passed on to the responsible authority, for example CQC (Care Quality commission). (H)

5.1.13 There is currently no reminder on Flare for officers to check the Primary Authority Register to confirm if the business that they are dealing with has a Primary Authority. A Primary Authority gives companies the right to form a statutory partnership with a single local authority. The local authority can provide robust and reliable advice for other regulators to take into account when carrying out inspections or dealing with non-compliance. As a result there may be a risk that the relevant Primary Authority is not notified of an incident.

Recommendation 4 – Management should enquire if it is possible to have a prompt within Flare to remind officers to check the Primary Authority Register to see if the business has a primary authority. This process should be documented within the relevant procedure. (M)

5.2 Regulatory – compliance with laws, regulations, policies, procedures and contracts

5.2.1 The team use various sources of reference for advice and guidance in their day-to-day roles, including the Enforcement Policy, RIAMS (Regulatory Information and Management System), HSE (Health & Safety Executive) website etc.

5.2.2 The Principal Health & Housing Officer regularly attends the Health & Safety Technical Working Group, they share ideas, best practices and updates from HSE. This information is shared across the team.

5.2.3 The team also receive email alerts updates from RIAMS in relation to changes to regulations / legislation.

5.2.4 The statutory LAE1 2016/17 annual return which reports health and safety inspections and enforcement activity was completed and submitted prior to the deadline.

5.2.5 It was noted that the procedure / guidance for completing the statutory LAE1 annual return is not up to date. At the time of the audit only one officer was able to complete this return. In their absence there is a risk that the return would not be accurately completed which may result in the reporting deadline not being met and the Council being subject to sanctions.

Recommendation 5 – The procedure / guidance for completing the annual return should be brought up to date to enable other officers to accurately complete the return if required. (M)

5.3 Information – reliability and integrity of financial and operational information

5.3.1 The team are aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) and these procedures were last updated in August 2016.

5.3.2 Audit testing identified a number of cases which were appearing on RIDDOR but not recorded on Flare. This was investigated and all were found to be non-reportable incidents which do not need to be recorded. This highlighted that the Accident and Reporting procedure needs to be updated to reflect this and a prompt should be included for officers to check RIDDOR when appropriate for other non-reportable incidents, which may aid their investigation. (Advisory)

5.3.3 During the audit it was noted that there is no matrix in place to record the reason why the decision has been made not to go ahead with court proceedings. Flare does not detail this, nor is it recorded on the incident criteria sheet.

5.3.4 This may result in the Council failing to evidence they have achieved their statutory obligations by failing to properly document appropriate inspections / investigations which have taken place.

Recommendation 6 – A matrix should be introduced to record the reason why a decision has been made not to go ahead with court proceedings. Details of this should also be recorded on Flare. This process should also be included in the accident and reporting procedure and the Enforcement Policy. (M)

5.3.5 Flare does not currently restrict access to specific service area prosecutions.

5.3.6 There is a risk of unauthorised access to sensitive data which may lead to reputational damage to the Council.

Recommendation 7 – Management should review how sensitive information is electronically stored and restrict access where needed. (M)

5.4 Security – Safeguarding of Assets

5.4.1 All Flare users have their own individual user ID and password and the system regularly prompts users to change their password.

5.4.2 A document retention schedule is in place and the team are currently working through all their documentation to bring the service up to date.

5.4.3 Although the team are aware of the emergency grab bag (which contains relevant documentation which would be used by officers responding to an emergency incident for example a fatality) there is no regular check of its contents or a checklist or process documented for replenishing it after it has been used.

5.4.4 As a result, key documentation may be missing in the event of an emergency which could result in failure to comply with health and safety laws.

Recommendation 8 – A checklist and guidance should be documented including regularly checking and replenishing of the contents of the emergency grab bag. (M)

5.5 Value – effectiveness and efficiency of operations and programmes

5.5.1 Customer satisfaction questionnaires are sent out quarterly, and are randomly selected by Flare. Audit testing noted a delay in sending the last two quarters out. It is advised that these are sent out as soon as possible.

5.5.2 After the severe flooding in December 2015, it was highlighted that the service could be improved if officers had better equipment, for example smart mobile phones to enable them to take photographs and promptly download them, access Flare, email, procedures, Riddor, RIAMS and the HSE websites remotely. This would allow officers to work more effectively when out on site.

Appendix A – Management Action Plan

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 1: **Quarterly management checks should be introduced to ensure the effectiveness and accuracy of information on Flare. These checks should be recorded on the system.** **As part of the checks management should also ensure that:** **-Officers record all relevant information on Flare, including premises visits, notes for all relevant action taken, results of specific tests, for example water sample results.** **-Correct codes are used on Flare.** **-An EMM form is completed as required.**	**Priority** M	**Risk Exposure** If cases are not accurately recorded on Flare there is a risk of reputational damage / sanctions arising from failure to meet health and safety laws and non-return of information to organisations such as the HSE.	**AGA code introduced for Auditing Management checks. Principal Health and Housing Officer (PHHO) responsible for checks. Regulatory Services Manager to monthly report AGA codes for Principal to monitor checks are completed.** **Inform/brief officers of the need to record correct H&S action codes** **Review Flare reports to ensure 'check data' included for quarterly management checks – enable PHHO to target Flare records for audit checks (AGA code)** **EMM code to be added to Flare accident record (action diary template) – officers to be informed/briefed on requirement to attach EMM**	**Regulatory Services Manager and Principal Health and Housing Officer** **PHHO** **PHHO** **PHHO**	**15th November 2017** **12th December 2017 (Team meeting)** **31st December 2017** **12th December 2017 (Team meeting)**

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 2: **Management should ensure that team meetings and 1 to 1's are regularly undertaken.**	**Priority** M	**Risk Exposure** There is a risk of Council objectives not being delivered due to a lack of timely updates to staff.	**PHHO scheduled one to ones and meetings. These will be minuted / recorded.** **Findings of quarterly management checks to be raised at 1-1's and/or team meetings.**	**PHHO**	**30 Nov 2017**
Recommendation 3: **Management should ensure that all officers are aware of the requirement to check if the Council is the responsible authority, if not the case should be passed on to the responsible authority, for example CQC (Care Quality commission).**	**Priority** H	**Risk Exposure** There is a risk that this could lead to reputational damage and possible sanctions against the Council. Additionally there is a risk incidents are not appropriately dealt with.	**PHHO review incident recording procedure, in particular referrals to other enforcement bodies – CQC & HSE.** **PHHO to monitor referral process as part of quarterly management checks**	**PHHO**	**31 Dec 2017**

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 4: **Management should enquire if it is possible to have a prompt within Flare to remind officers to check the Primary Authority Register to see if the business has a primary authority. This process should be documented within the relevant procedure.**	**Priority** M	**Risk Exposure** There may be a risk that the relevant Primary Authority is not notified of an incident.	**Primary Authority Flare action diary code to be added to appropriate enforcement record templates, including accidents. This will act as a prompt to check.** **Amend incident recording procedure.**	**PHHO** **PHHO**	**31st December 2017** **31st December 2017**
Recommendation 5: **The procedure / guidance for completing the annual return should be brought up to date to enable other officers to accurately complete the return if required.**	**Priority** M	**Risk Exposure** In their absence there is a risk that the return would not be accurately completed which may result in the reporting deadline not being met and the Council being subject to sanctions.	**LAE1 return procedure to be developed.** **Staff trained/briefed on the procedure.**	**PHHO** **PHHO**	**31st January 2017**

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 6: **A matrix should be introduced to record the reason why a decision has been made not to go ahead with court proceedings. Details of this should also be recorded on Flare. This process should also be included in the accident and reporting procedure and the Enforcement Policy.**	**Priority** M	**Risk Exposure** This may result in the Council failing to evidence they have achieved their statutory obligations by failing to properly document appropriate inspections / investigations which have taken place.	**Enforcement decision matrix to be added to the Health & safety Enforcement Policy**	**PHHO**	**1/2/2018**

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 7: **Management should review how sensitive information is electronically stored and restrict access where needed.**	**Priority** M	**Risk Exposure** There is a risk of unauthorised access to sensitive data which may lead to reputational damage to the Council.	**Only Groups responsible for Enforcement can access Environmental Health Flare. Other servers can not be further restricted. All Groups with access understand need for confidentiality. We have considered further restrictions but concluded that the disruption to good working practices will outweigh any benefit. Clean Neighbourhoods work closely with Regulatory Services on matters such as noise and fly tipping, it would not be helpful to restrict access. Flare audits track officer modifications made to databases – the new version of Flare, which should be operational by April 2018, may also allow audits of documents being opened / viewed.** **A full review of the digital storage within Regulatory Services is being undertaken and any sensitive data stored**	**Regulatory Services Manager**	**Review completed**

			incorrectly will be moved to the N drive and coded appropriately.		

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 8: **A checklist and guidance should be documented including regularly checking and replenishing of the contents of the emergency grab bag.**	**Priority** M	**Risk Exposure** As a result, key documentation may be missing in the event of an emergency which could result in failure to comply with health and safety laws.	**Checklist / advisory note to be developed and placed within the grab bag to remind officers to replace items used. This process will be brought to the attention of staff at the next team meeting.**	**PHHO**	**12th December 2017**

Appendix B

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk. *Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.*	The controls tested are being consistently applied and no weaknesses were identified. Improvements, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Appendix C

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are two levels of audit recommendations used; high and medium, the definitions of which are explained below.

	Definition:
High	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	Some risk exposure identified from a weakness in the system of internal control

The implementation of agreed actions to Audit recommendations will be followed up at a later date (usually 6 months after the issue of the report).