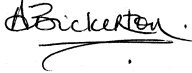

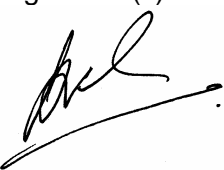


Corporate Health and Safety Code of Practice

Title: **Accident and Incident Reporting and Investigation**

Reference Number: **HSMS 0042-05**

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Author(s)	Name: A.Bickerton (2.1 Edition) (3 ^d Edition)	Signature (s): 	Date: July 07 Aug 07
Reviewer(s)	Name: D. Darkens	Signature (s): 	Date: Aug 07
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Issued by	Name: Corporate Health and Safety	Signature (s): 	Date: Aug 07



Accident and Incident Reporting and Investigation

Code of Practice

The lists below set out the standards that are expected of managers and employees with regard to Accident and Incident Reporting and Investigation (known as Reactive Monitoring). To ensure that you have the information necessary to allow you to meet these standards, the rest of the Code of Practice should be read.

Management Responsibility	Employee Duties
<p>Ensure that any injured person receives First Aid.</p> <p>Where appropriate summon an ambulance.</p>	<p>Must report all accidents and incidents to their line manager or supervisor.</p>
<p>Ensure the area is made safe following an incident but not to tamper with anything which might be considered as evidence</p>	
<p>Ensure the incident is recorded and notified to the appropriate sections.</p>	<p>Notify your manager of any accident or incident within your workplace.</p>
<p>Ensure employees are aware of AIR forms and actively encourage them to report incidents.</p>	
<p>Arrange appropriate training in accident reporting and investigation</p>	<p>Attend any training arranged by line managers</p>
<p>Make yourself aware of the timescales of reporting incidents as detailed in this COP.</p>	<p>Co-operate with their line manager/ supervisor in any investigation and make yourself familiar with the timescales given in this COP.</p>
<p>Co-operate with any investigation carried out by the HSE or Corporate H&S Team</p>	<p>Co-operate with any investigation carried out by the HSE or Corporate H&S Section</p>
<p>Ensure where required that counselling is offered</p>	
<p>Review any risk assessment or Safe Working Procedures after an accident or incident to ensure they are valid and do not require modification.</p>	

Introduction

This Code of Practice will provide you with information on how to report and investigate accidents and incidents. The aim is to provide managers with the information necessary to measure health and safety performance after an accident occurs i.e. to conduct reactive monitoring.

Background Information

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), the Council must report certain incidents to the Health and Safety Executive (HSE). Apart from this the Council needs to measure the success of our Health and Safety Management System (HSMS), to assess how well we are controlling risk and developing a positive health and safety culture. We also have a moral obligation to all staff to ensure their future health and safety at work.

A low accident rate, even over a period of years, is no guarantee that risks are being effectively controlled and will not lead to injuries, ill health or loss in the future. Effective performance measurement provides information on both the level of performance and **why** the performance level is as it is. If the performance measurement cannot be used as a means to understand the basis of performance then it is of little use. For instance if you have had 100 accidents this year, that measurement is of no use unless you know how many accidents you had last year, how many employees were working for you and how many days they worked.

To measure our performance the Council will seek to answer the following questions:

- Are failures occurring?
- Where are they occurring?
- What is the nature of the failures?
- How serious are they?
- What were the potential consequences?
- What are the reasons for the failures?

- What are the costs?
- What improvements in the HSMS are required?
- Are we getting better or worse over time?
- How do we compare to others?

Reactive monitoring in the London Borough of Havering includes:

- Accident and incident investigation

Which identifies and reports:

- Injuries and cases of ill health
- Other losses such as damage to property
- Incidents including those with the potential to cause injury
- Hazards
- Deficiencies in performance standards

Each of these allows the Council the opportunity to learn from mistakes, check performance and improve the health and safety management system.

It is important to ensure that all accidents and incidents are investigated with a 'no blame' culture.

Definitions

Dangerous Occurrence – Any incident which could clearly have resulted in a reportable injury, these are listed in RIDDOR 95 (the HSE website at: <http://www.hse.gov.uk/riddor/> explains the categories).

Reactive monitoring – measuring health and safety performance after an incident.

RIDDOR 95 – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

Reportable incident – an incident or accident that, under RIDDOR 95, must be reported to the Health and Safety Executive by the quickest means possible.

Completing an AIR form

The AIR form can be downloaded from the Health & Safety website on the intranet. If difficulty is found obtaining an accident/incident form, contact the Corporate Health and Safety Team on ext 2745. Incidents may include the following (but the list is not exhaustive):

- Incidents whereby any injury is sustained by an employee
- Any incident where an employee is physically assaulted or subjected to verbal abuse where they feel threatened or intimidated
- Any incidence of work related ill health (or alleged work related ill health), whether or not the member of staff is absent from work, e.g., musculo-skeletal problems, dermatitis etc
- Incidents which results in an injury to a third party, i.e., someone not in the Council's employment, arising out of or in connection with work on Council premises or on behalf of the Council
- Any dangerous occurrence
- Any 'Near Miss' - that is any incident where although no one is injured the circumstances are such that, if no action is taken, the incident is likely to be repeated and an injury is foreseeable – whilst this can be seen as 'proactive', an incident has occurred, therefore making this a way of reactive monitoring. Further information on near misses (and what constitutes such, can be sought from the Corporate Health and Safety Section
- Any queries regarding faulty or dangerous gas cylinders should be made to the appropriate mechanical engineer in the first instance. Notification should then be given to the Corporate Health and Safety Section

The AIR forms specify the information required for all accidents, incidents and ill-health reports, all line managers and supervisors must ensure that employees are aware of the AIR forms and actively encourage them to report the incidents listed above. The Corporate Health and Safety Section or Organisational Development can arrange training in accident and incident reporting and investigation.

Reporting timescales

Employees are required to report all accidents / incidents, work related ill health, dangerous occurrence or near misses as soon as possible or no later than 12 hours to their supervisor / manager. In turn, Managers must then report these to Corporate Health and Safety and Human Resources within the given timescales below:

Major Injuries / Fatalities

Managers/supervisors are responsible for reporting all major injuries involving employees or non employees and dangerous occurrences immediately by telephone to the Corporate Health and Safety Section on extension 2745. The form must then be filled in and forwarded within 24 hours.

Three day injuries or work related illnesses

Any accidents resulting in more than 3 days off work (including weekends) must be reported to the Corporate H&S Section within 1 day of it becoming apparent that the individual has had this amount of time off.

Minor incidents

Minor incidents must be reported to CHSS within five working days

Line Management are responsible for carrying out initial and local investigations, in conjunction with Corporate Health and Safety within 48 hours of the accident occurring. This can be aided by the form at **Appendix Two** named "Accident / Incident Investigation Checklist".

All reported accidents will be analysed by the Corporate Health and Safety Section and presented to the Group Health and Safety Performance meeting, and summarised for the Corporate Health and Safety Performance Group every three months. These statistics will also be posted in graphical form to the health and safety website on the intranet regularly.

Accident investigation

The scale of any investigation should be proportionate to the circumstances and depend on the potential for injury or damage. The Corporate Health and Safety Section will investigate all reportable incidents and 5% of all other incidents chosen by them to be of note (especially if trends are appearing).

For the most serious accidents the investigation should be led by someone who has experience in accident causation and accident investigation. The person should also be knowledgeable of the workplace and processes and know the people and the industrial relations environment. This is not likely to be embodied in one person and the most practical approach is to make up an investigation team to combine these qualities if appropriate. However, due to time constraints of local Managers, this is likely to be a Corporate Health and Safety Advisor.

The Head of Service or his delegated representative should assist the investigation by Corporate Health and Safety (or Group Advisor). A Trade Union Safety Representative has a legal entitlement to carry out an inspection following an accident and must always be notified if an investigation takes place involving one of their members. To assist this process, Advisors who undertake investigations should ask the injured party if they wish for Union involvement. If appropriate the Insurance Section of LBH will be notified by the Manager of Corporate Health and Safety.

The Head of Service must ensure adequate resources are allocated to the investigation which may include:

- Employees taking time away from their work to assist the investigation
- Employees taking time away from their work to be interviewed
- An appropriate room to conduct interviews with witnesses and relevant employees
- Access to records, documents and policies as necessary for the investigation
- Access to the accident site to take photographic evidence.

Managers and supervisors must co-operate with any investigation undertaken by the Health and Safety Executive (see the relevant Code of Practice on this listed at the end of this document) or Corporate Health and Safety Advisors.

The Corporate Health and Safety section will be responsible for providing impartial advice to any relevant assistants on the conduct of the investigation and ensure that the accident investigation report is presented to the Group Health and Safety Performance meeting after Management have seen it.

For less serious accidents the line manager or supervisor can conduct the investigation using the AIR form as the basis for the report and contacting the Corporate Health and Safety Section for advice as needed, or use the checklist shown at **Appendix Two**.

Corporate Health and Safety will adhere to their own accident investigation procedures whilst managers and supervisors should use this COP as guidance. The template for the Corporate Health and Safety Advisor to use, which has been agreed by Legal Services, can be viewed in **Appendix One**.

Evidence

When collecting or preserving evidence it should be remembered that there can be four types of evidence: documentary; photographic; physical; and oral evidence from witnesses and it should be considered whether or not it is necessary to keep equipment or material involved in incidents for future examination. Where this is not possible photographic evidence should be gathered. It is important to remember that in circumstances involving a death, major injury or dangerous occurrence the scene of the incident **must be left undisturbed** until either the HSE or Safety Advisor instruct otherwise, in order to preserve evidence.

Protective and preventative measures

Once an accident investigation has been completed the line managers and supervisors should put in place any measures or additional precautions that

may be necessary to prevent a reoccurrence of the incident, and make arrangements to monitor these measures to ensure that they are working effectively. Where the line manager cannot implement the necessary measures to prevent a reoccurrence because these are outside the jurisdiction of the line manager, it is the line manager's responsibility to ensure that details of the incident are passed on to the Corporate Health and Safety Section who will give assistance.

A review of any risk assessments or working procedures relating to the activities involved in the incident must be undertaken by the line manager or supervisor in order to ensure that the risk assessment is still valid. Corporate Health and Safety can assist with this.

The line manager or supervisor must ensure that staff involved in any assault whether verbal abuse or physical violence receives appropriate after care, including counselling and support, legal advice etc.

Record Keeping

All employers including the Council are required by law to keep accident and incident records or at least three years. Corporate Health and Safety collect accident details on the accident database and report to relevant groups and meetings on notable incidents.

Managers are required to keep their own records of any incident involving their area for three years. Managers should check with the Insurance Section to see if there are any impending claims, before they dispose of any records. Managers must also forward copies of the AIR form to Corporate Health and Safety Section, who in turn will pass it to the Group Health & Safety Advisor and Human Resources.

In the event of internal re-organisations where sections are amalgamated or disbanded, records should be forwarded to the Corporate Health and Safety Section. Records involving employees who have been off work for over three

days will be kept on the individual's file held by the Occupational Health Department.

Further reading and references:

- The Limitations Act 1980, section 11
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
- Management of Health and Safety at Work Regulations 1999

Other relevant documents:

London Borough of Havering Health and Safety Management System and the following Codes of Practice:

- First Aid Provisions at LBH HSMS 036-05
- Violence and Aggression HSMS 0030-05
- Risk Assessment HSMS 043-05
- Fire and Emergency Planning HSMS 015-05
- What to do if an Inspector calls (HSE information) HSMS 045-05

Related guidance and further information:

- RIDDOR explained, HSE Leaflet - HSE 31
- Successful Health and Safety Management HS(G) 65, HSE Book
- Violence at Work a guide for employers; HSE leaflet IND(G)69
- Accident Investigation: HSE book IND(G) 245

**If further guidance or information is required contact please
Corporate Health and Safety on extension 2745.**

**Appendix One –
The template used by Corporate
Health and Safety for accidents of
note and serious incidents.**



Investigation Report on

Incident at XXXXXX

XXXX 2007

by

XXXXXX

XXXXXXXXXXXXx
Corporate Health and Safety Advisor
Corporate Health and Safety Section
Fifth Floor, Mercury House
Mercury Gardens
Romford
RM1 3SL

Telephone: 01708 43XXXX
Mobile: XXXX

Fax: 01708 43XXXX
Email: XXXXX@havering.gov.uk

Reference: **XXXX**

Contents

Paragraph Number	Paragraph Contents	Page
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1.2	Purpose of this report	
1.3	Summary of conclusions	
1.4	The parties involved	
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1.6	Statements / Documents relied upon	
1.7	Disclaimer	
2.0	The Investigation	
2.1	Investigation findings	
2.2	Direct causes	
2.3	Indirect causes	
2.4	Control issues	
3.0	Conclusions	
3.1	The findings	
3.2	Recommendations and action required	
Appendices	EXAMPLES OF SUCH AS BELOW:	
1	Knowledge, experience, qualifications / training of author of report	
2	Knowledge, experience, qualifications / training of any other person assisting in report	
3	Statement of Methodology	
4	List of documents considered	
5	Details of any literature or other materials relied upon in making the report	
6	Photos, drawings, schedules, graphs and charts	
7	Chronology	
8	Glossary of Technical Terms	

**Corporate Health & Safety
London Borough of Havering
Mercury House, Mercury Gardens
Romford RM1 3SL
Telephone: 01708 43 XXXX**

To:
From:
Copies to:

Date of Investigation:	
Investigating Officer:	
Date of Accident:	
Location:	
Witnesses:	
Injured Person (s):	
Job Title:	

1.0 Introduction

1.1 Background

This area should outline

- *the environment (premises, including weather, lighting ventilation etc)*
- *the person(s) affected*
- *bullet point the points of law to consider (e.g., HSWA 74 S.7 / MHSW Regs 99 as amended, Reg 5 etc) with a brief description of the Section or Regulation*

1.2 The purpose of this report

The purpose of this report is to ascertain the facts and causes of the incident on XXX at XXXX, which resulted in Mr A being injured and to prevent a reoccurrence.

1.3 Summary of Conclusions

This is similar to an 'Executive Summary' and would briefly state the case so that those who have been copied into the report need not read the entire document (unless they wish to).

1.4 The Parties involved

Detail names and DOB (if children) of all involved – injured party (ies) and witnesses. Also detail job title (s). Alongside this, detail any other relevant interviewed persons, e.g., the manager, OH / HR and why these persons have been approached.

1.5 Technical Terms and explanations

Use the following statement if it applies to your investigation:

'...I have indicated any technical terms from HSG 245 in bold type. I have defined these terms when first used and included them in a glossary in Appendix XX. I have also included in Appendix XX extracts of published works which I refer to in my report and in Appendix XX there are diagrams, charts and photographs to assist in the understanding of the report.'

1.6 Statements / Documents relied upon

If you have interviewed personnel for any reason or relied upon other documentation (e.g., past risk assessments or permits to work etc), and these are separate documents, list these in an appendix and state the following:

'...I have précised at Appendix XX a list of the main documents I have examined and relied upon.'

1.7 Disclaimer

State the following:

'All information in this report is true to the best of my knowledge and information has been gained legally'

2.0 The Investigation

2.1 Investigation Findings

Include / consider the following:

- *the facts of what happened before, during and after the event*
- *the actual injury / near miss / dangerous occurrence **facts** (when writing about NM / DO just describe the danger which occurred, i.e., '...the individual involved reports that they were narrowly missed being struck by the falling bricks and as a result was covered in brick dust as they hit the ground approximately six feet away...')*
- *witness statements – refer to these but attach as appendices*

- *photos – refer to these with reference numbers but attach in appendix – ensure, if possible that the ‘date and time’ button is used when taking photos and also insert a watermark digitally. (HOWEVER – it is thought that in the future we will procure a Polaroid camera so that there is no dispute whatsoever.*
- *equipment details as appropriate, including maintenance (see questions from the accident investigation form) – did the use of plant or equipment cause problems (ergonomic design, consultation of staff during procurement, layout of controls, inadequate guarding etc)?*
- *was the safety equipment in place sufficient?*
- *the impact the weather had on the event area (e.g., made it slippery, glaring sunlight etc)*
- *was there anything different about the working conditions?*
- *did the workplace layout influence the incident – e.g., holes in floor, slippery, access and egress issues?*
- *have Workplace Inspections taken place, were follow up actions carried out?*
- *did the nature or shape of the materials influence the incident?*
- *details of any risk assessments / safe systems of work / method statements / permits to work, including dates, review, author, verifier etc – were these safe working procedures being adhered to by employees, had they lapsed, were they inadequate – don’t forget normal and emergency operations*
- *details of supervision if required*
- *other people affected*
- *detail any training for the activity*
- *the behaviour of the people involved – did they fail to do anything which contributed to the event, were they unsuitable for the job (physically or mentally) were they once competent but performance is not sustained? Did they do the right thing in the wrong way, choose the wrong action or violate the system (i.e., do the wrong thing on purpose)?*
- *are adequate resources and time available to carry out the job safely?*
- *are job descriptions clearly set out and understood?*
- *were contractors involved in the incident?*
- *has this or a similar incident happened before – were follow up actions carried out?*

2.2 Immediate causes

This would include things that happened at the time, e.g.,

- *Mrs X hit Carer Y due to her confusion and dementia OR*
- *Mr X slipped on the leaves outside the Town Hall*

2.3 Underlying causes

This would include things which had happened prior to the event and also any factors which made the event worse, e.g.,

- *Mrs X had not been given enough of her medication (refer to witness statement, in this case nurse in charge) to treat her confusion due to her dementia OR*
- *The Town Hall entrance had not been swept in a timely fashion as per the agreement by the hall-keepers*

2.4 Root causes

This would include any health and safety system controls which failed to prevent this occurrence. For instance,

- *'...the latest risk assessment had not taken into account the possibility that Mrs X would be given inadequate medication...'* OR
- *'...the risk assessment and agreement for the Town Hall hall-keepers to sweep leaves was not put into writing...'*

3.0 Conclusions

3.1 The findings

A précis of your findings with a final sentence to ascertain the surrounding cause.

3.2 Recommendations and Actions Required

A set of recommendations for relevant personnel to be actioned. Ensure that it relates to the chart, as below:

Control issue Identified	Risk level	Action required	By Whom	By When
<i>e.g. Failure to identify wrongly administered medicine to Mrs X</i>	<i>e.g. High</i>	<i>e.g., 1. risk assessment to be updated on administering medicine and the possible consequences 2. update training for nurses in charge of medicine trolley 3. Updates for all staff when individuals' medicine is changed</i>	<i>e.g. Matron in charge of Care Home</i>	<i>e.g. Within one month</i>

(Actually write)

End of report

Ensure that it is signed (digitally if necessary), marked 'Confidential', and sent to the relevant personnel. Also ensure that you state your designation and any qualifications at the end of the report as well (if the report ends up in court, it's important to show credibility).

Appendix Two – Accident / Incident Investigation Checklist



Accident / Incident Investigation Checklist

This form should be completed by the Line Manager or Health and Safety Advisor conducting the investigation in conjunction with a TU Safety Representative if appropriate

Corp H&S Section
use only - Ref No:

The Premises	Yes/No/NA
Were housekeeping conditions adequate (eg no trip hazards, no spillages etc.)?	
Was the lighting adequate?	
Was safe access / egress maintained?	
Was the area free of potential falls from height (eg adequate guards, rails etc)?	
Did the area have adequate weather protection?	
Was the area adequately ventilated and of ambient temperature?	
The Plant, Equipment and substances	Yes/No/NA
Was the equipment as purchased and installed?	
Has the equipment been regularly maintained?	
Was the equipment used for its intended purpose?	
Was the equipment adequately guarded?	
Were the guards in position and functioning?	
Were safety devices / equipment required for the activity?	
Were the safety devices / equipment working?	
Was there any Local Exhaust Ventilation (LEV) in place?	
Was the LEV in date for inspection?	
Was the LEV being used properly?	
Was the control of hazardous substances adequate?	
The Procedures	Yes/No/NA
Is there a documented risk assessment for the activity?	
Is the risk identified in the assessment?	
Has the risk assessment been reviewed as per the review date set and / or any other incident?	
Is there a documented safe system of work for the activity?	
Is the task identified in the safe system of work?	
Has the Safe System of work been reviewed in the last 12 months?	
Has the injured party been trained in it?	
Was the safe system of work followed at the time of the accident?	
Were there any specific instructions for the activity?	
Were they being followed at the time of the accident?	
Was the activity subject to a permit to work?	
Was it being complied with?	
If there was a maintenance activity associated with the accident has it been carried out adequately?	
If personal protection equipment was required for the activity was it being used?	
Had the working hour requirements been adhered to?	

If the activity required an emergency procedure was there one available?	
If the activity required an emergency procedure was it being followed?	
Had an inspection of the workplace taken place in the last 7 days?	
Had all actions arising from the inspection been completed on time?	
Was there adequate supervision?	
The People	Yes/No/NA
Were all persons involved in the accident acting in a safe manner?	
Was there a safe method to follow?	
Were all personnel involved with the accident adequately trained?	
Were the responsibilities of all involved with accident clearly laid out?	
Was the correct incident reporting procedures adhered to?	

In your opinion, what triggered the unsafe act?

In your opinion, what would encourage a safe method to be used?

In your opinion, if the incident resulted from employee error or mistake, what may have motivated the employee to act in this way?

Conclusions:

INVESTIGATION COMPLETED BY

Name:

Position:

Signature:

Date:

Name of safety representative involved in investigation:

Safety representative's comments:

Safety representative's signature:

Date:

Corporate / Group Health and Safety Advisor involved in investigation:

Corporate / Group Health and Safety Advisor's signature:

Action to prevent reoccurrence – if Line Manager or TU Rep' this is to be completed in liaison with Health and Safety Advisor

Action point	Action	By who	By when	Review
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				