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| **Agenda Item No:** | **8** | **Report No:** | **79/17** |
| **Report Title:** | **Accidents to Lewes District Council staff from April 2016 to March 2017** | | |
| **Report To:** | **Employment Committee** | **Date:** | **12 June 2017** |
| **Ward(s) Affected:** | **Employees and workers** | | |
| **Report By:** | **Jill Yeates** | | |
| **Contact Officer(s)-** | **Jill Yeates** | | |


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**Post Title(s):** **Health and Safety Officer**
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**Tel No(s):** **01273 085469**


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**Purpose of Report:**

To report the statistics on accidents sustained by Lewes District Council staff reported between 1 April 2016 and 31 March 2017.

**Officer's Recommendation:**

**1** That the Committee note the report and make any recommendations to the relevant senior officer or Council body for follow-up action considered necessary.

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**Reasons for Recommendations**

**1** This regular report to Employment Committee provides accident and near miss information necessary to fulfil items 2.4 (c), and 2.5 (g) and (k) of the Lewes District Council Constitution Section 5 Remit of the Employment Committee.

**2 Information**

**2.1** The statistics are presented as previously requested – with numbers and percentages, comparisons with the previous year (same period). Insurance information has been included as requested.

**2.2** Currently, whenever an accident or incident is recorded, the individual will have reported it to a supervisor or manager, who will then have discussed the accident or incident with them and completed the second side of the form which looks at the underlying causes, and reports on

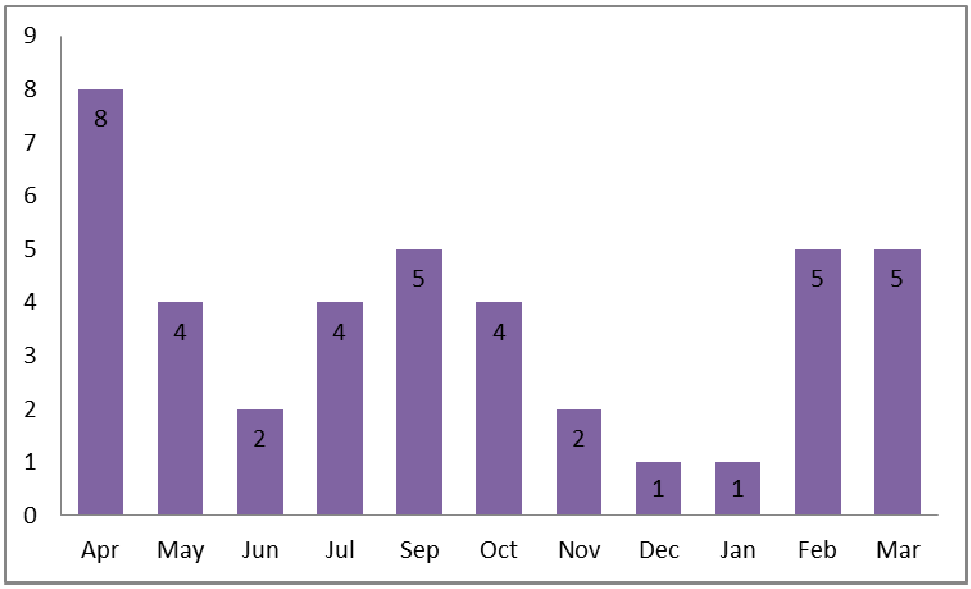
actions taken. This then comes to the Health and Safety Officer who will follow up any action and ask for updated documents where relevant.

**2.3** Starting in the current financial year (2017-18), a new accident and incident reporting system is being introduced, which will mean that one form covers accidents, near misses, aggression and violence at work reports. First Aid reports remain separate, but if they are caused by an accident, the accident will be reported on the new form. It reduces the amount of recording which needs to be done for near misses and minor accidents, but guides through what needs to be done for more serious accidents – in conjunction with the new Accident Policy (see Background Papers, Paragraph 8).

## 2.4 Accident Statistics - Staff

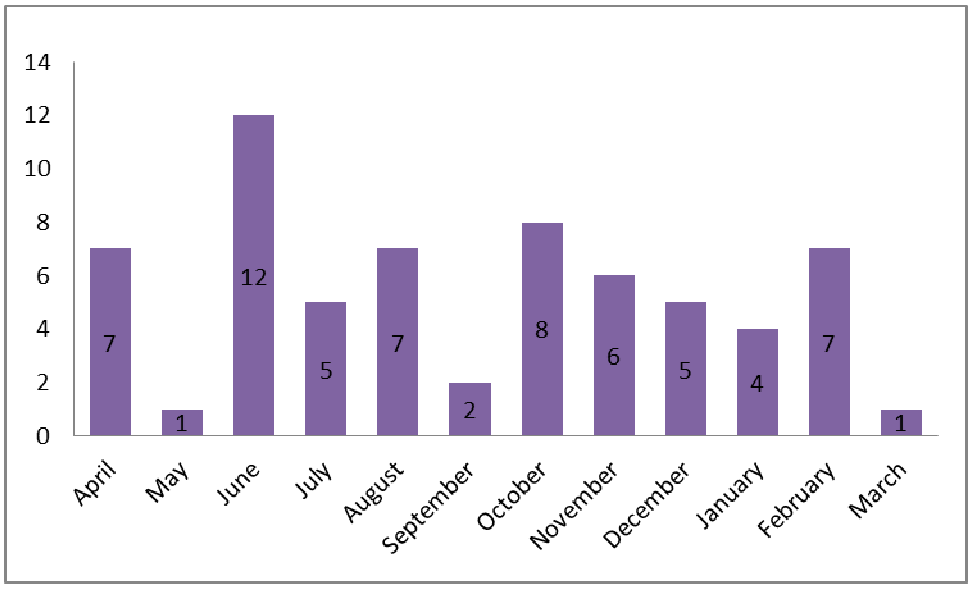
### Monthly accidents

Between April 2016 and March 2017, there were 41 accidents reported to staff and agency staff (63% of accidents reported for the period 2015-2016). Since the number of staff has been fluid this year and most staff were transferred to Eastbourne on 1 February, it is difficult to work out the percentage of staff. Taking last year's mean average of 390 staff, that is 10.5% of staff (again some had more than one accident). This year, it was April, September and February and March which had the highest numbers of accidents which shows no pattern with last year and the year before.



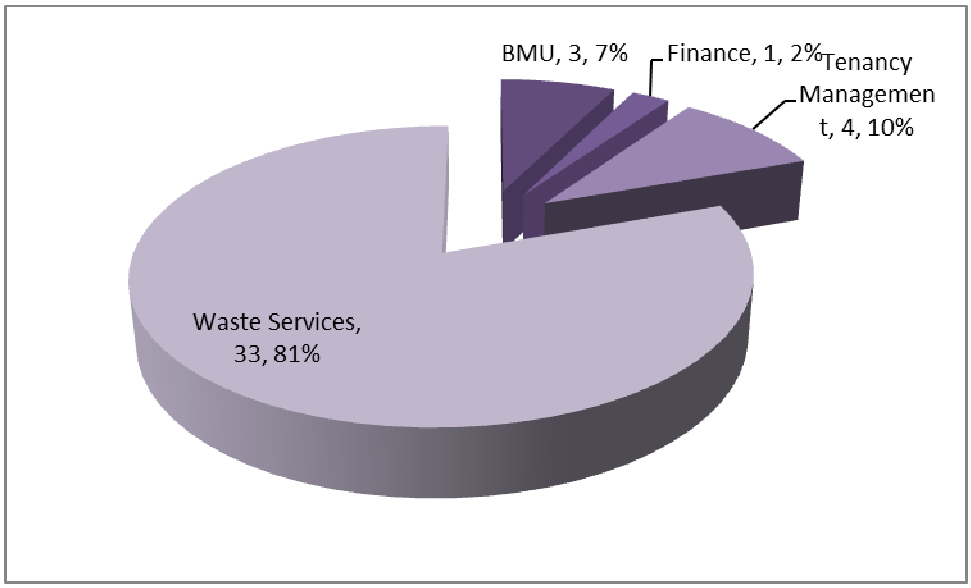

Last year April 2015 to March 2016, there were 65 accidents reported (83% of the number reported the previous year) (16% of mean average of 390 staff – although some had more than one accident). June had the highest monthly accidents, with April, August, October and February close behind; April, June and October were

amongst the highest the previous year too; the year before, however, didn't include these months.

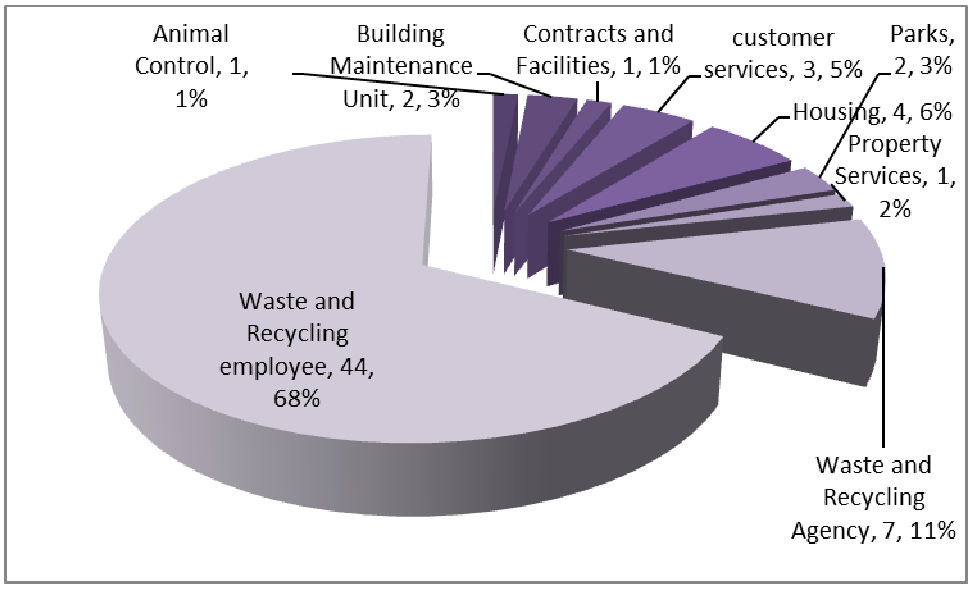



**Which teams**

This year, 33 staff and agency staff in waste services reported having accidents (80% of the total accidents reported – a fairly stable proportion of the accidents each year), 4 in tenancy management, 3 in building maintenance unit and 1 in finance.

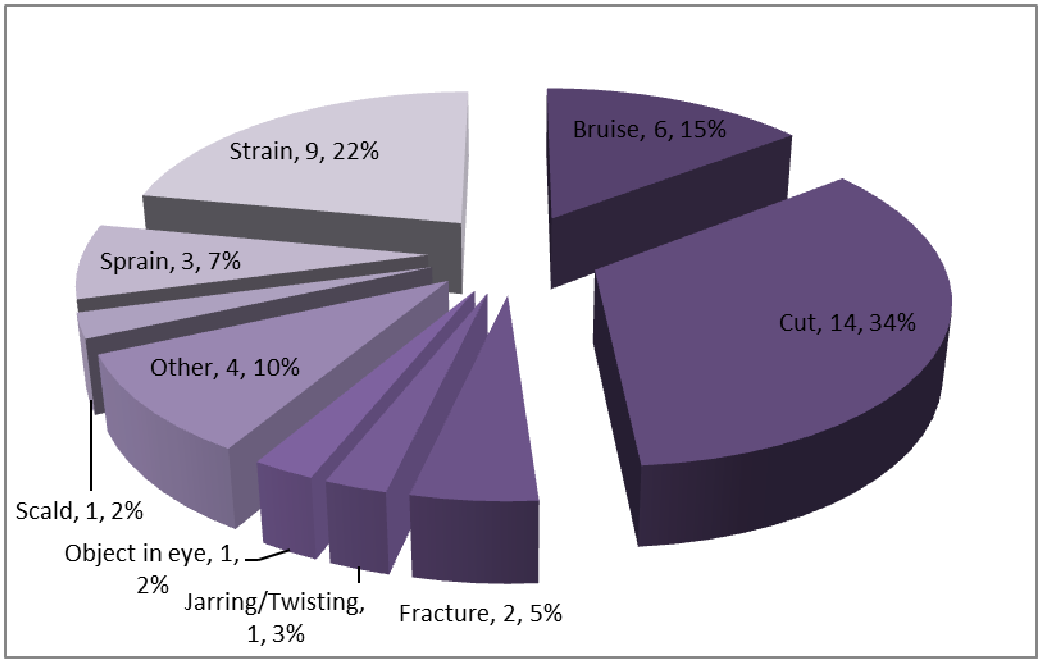



Last year, 44 employees and 7 agency staff in waste and recycling reported having accidents (79% of the total accidents reported – 2% of the total less than the previous year), 4 in housing and 2 in the building maintenance unit, 3 in customer services, 2 in parks and one each in animal control, contracts and facilities and property services.



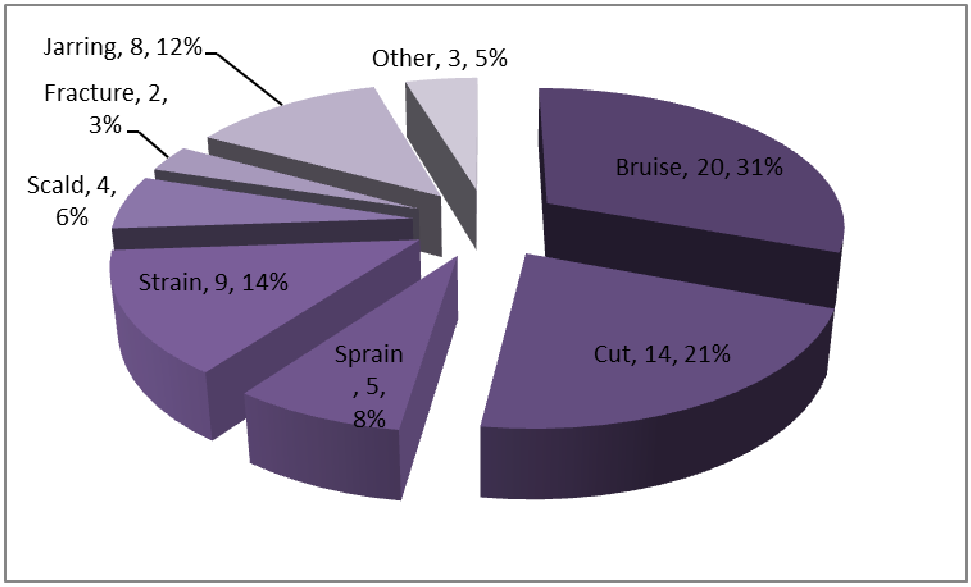

**Injuries**

This year, cuts and bruises and strains again account for most (29, 71%) of the injuries, with cuts having taken over from bruises as the dominant injury – although the same number as last year. Again we had two fractures, both ankles – both to agency staff – one stepping off a vehicle into a ditch, and the other dropping a brick on his foot when not wearing PPE. This year, only one scald was reported.



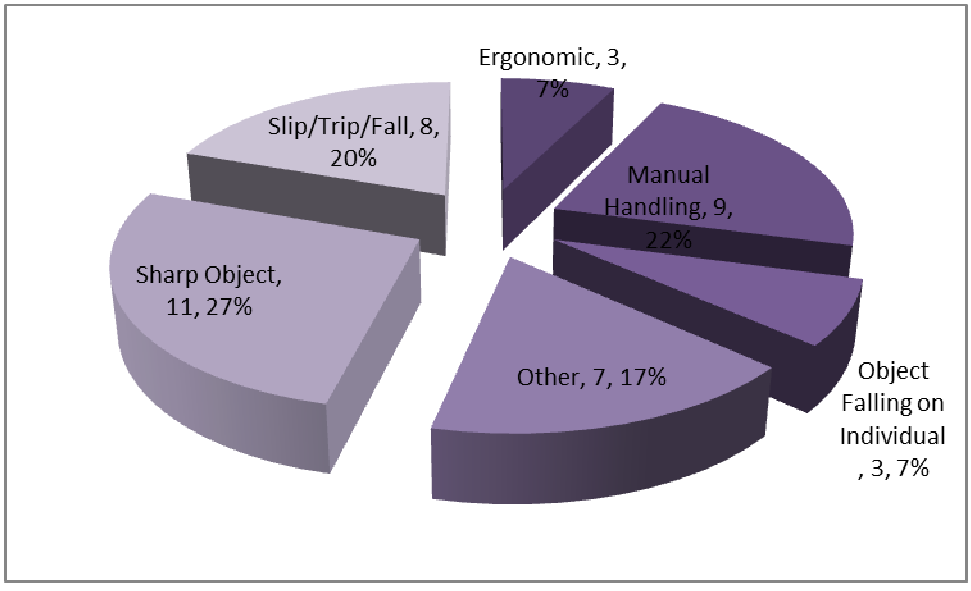

Last year, 20 of the accidents involved bruising, and 14 cuts. Jarring, strains and sprains, and scalds were the other main injuries. There were two fractures – one

where someone fell and landed on their wrist and it fractured, and one where someone lifted a bag – not incorrectly and it wasn't heavy, but for an unknown reason, their finger fractured. There were 4 scalds.

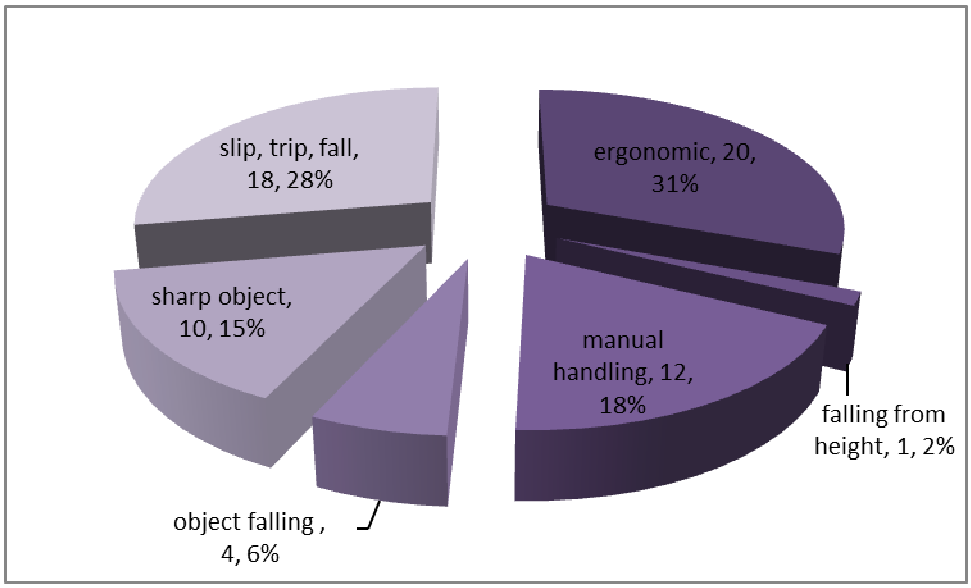



**Causes of injury**

This year, sharp objects (11, 27%) have been the largest cause of injury and a much higher percentage than in the past two years, although again – manual handling and ergonomic causes were responsible for 29% of the accidents. An increasing number of broken glass, needlesticks and tin in black sacks are causing injuries to waste and recycling staff. Again, violence and aggression were reported as near misses rather than accidents.



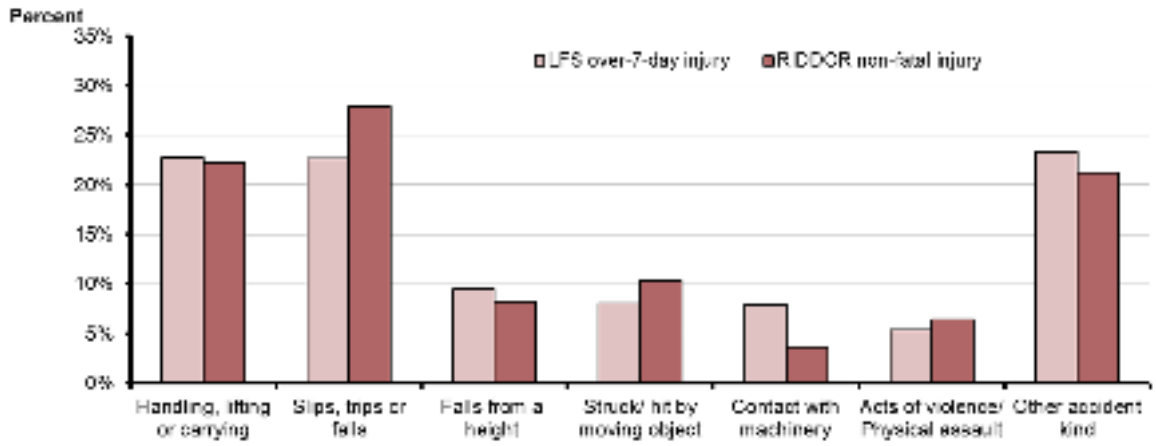
Last year, almost half the accidents were manual handling and ergonomic (a slightly higher percentage than the previous year), and a further 28% due to slips, trips and falls (almost the same percentage as the previous year). 15% were also due to sharp objects (compared to 15% the previous year). Last year, violence and aggression were near misses rather than accidents.




## HSE Figures

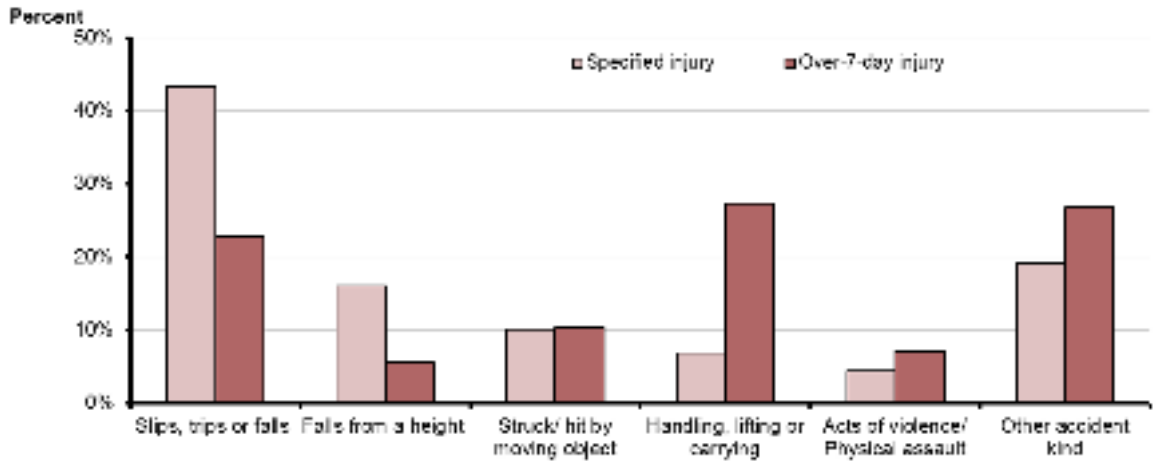
It is interesting that the latest Health and Safety Executive (HSE) accident statistics (2015-16) for non-fatal accidents don't show sharp objects specifically, so these probably come under 'other'. However, they do have manual handling (this will include ergonomic causes) and slips, trips and falls as equally highest for those who were away from work for more than 7 days as a result of the injury, unless the injury was a fracture (or worse) when slips, trips and falls were the highest. Our accident statistics follow the same pattern as the national ones.

**Figure 3: Percentage of non-fatal injuries accounted for by different accident kinds based on (i) Self-reported over-7-day injury estimate from Labour Force Survey and (ii) Non-fatal injury notifications to RIDDOR**




**Source:** [http://www.hse.gov.uk/statistics/causinj/kinds-of-accident.pdf](http://www.hse.gov.uk/statistics/causinj/kinds-of-accident.pdf)

**Figure 4: Percentage of (i) Specified injuries and (ii) Over-7-day injuries to employees accounted for by different accident kinds 2015/16p**



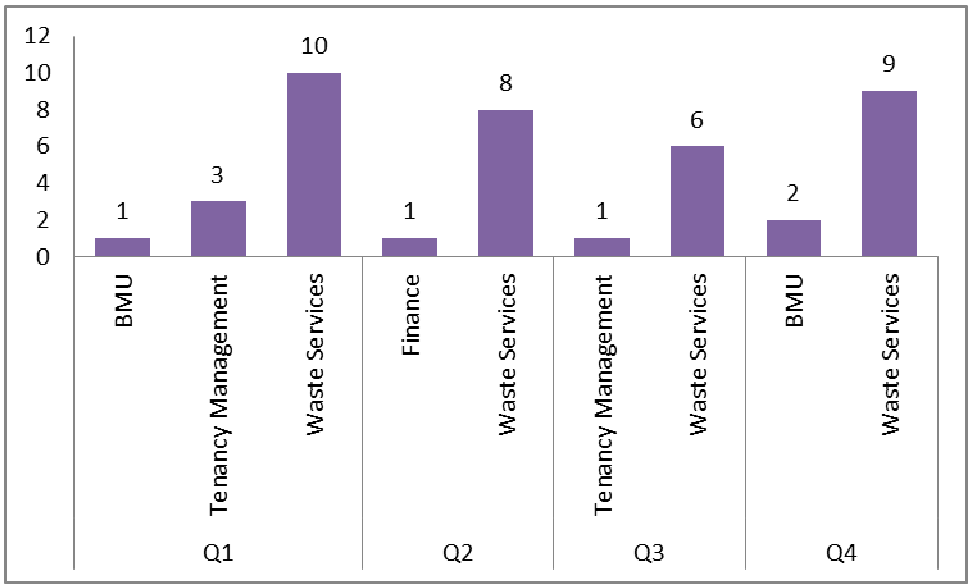

■ Almost 60% of specified injuries to employees are accounted for by slips, trips or falls and falls from a height, a much larger proportion than for over-7-day injuries (29%).

■ Conversely, only 7% of specified injuries to employees are accounted for by handling, lifting or carrying accidents, compared with 27% for over-7-day injuries.

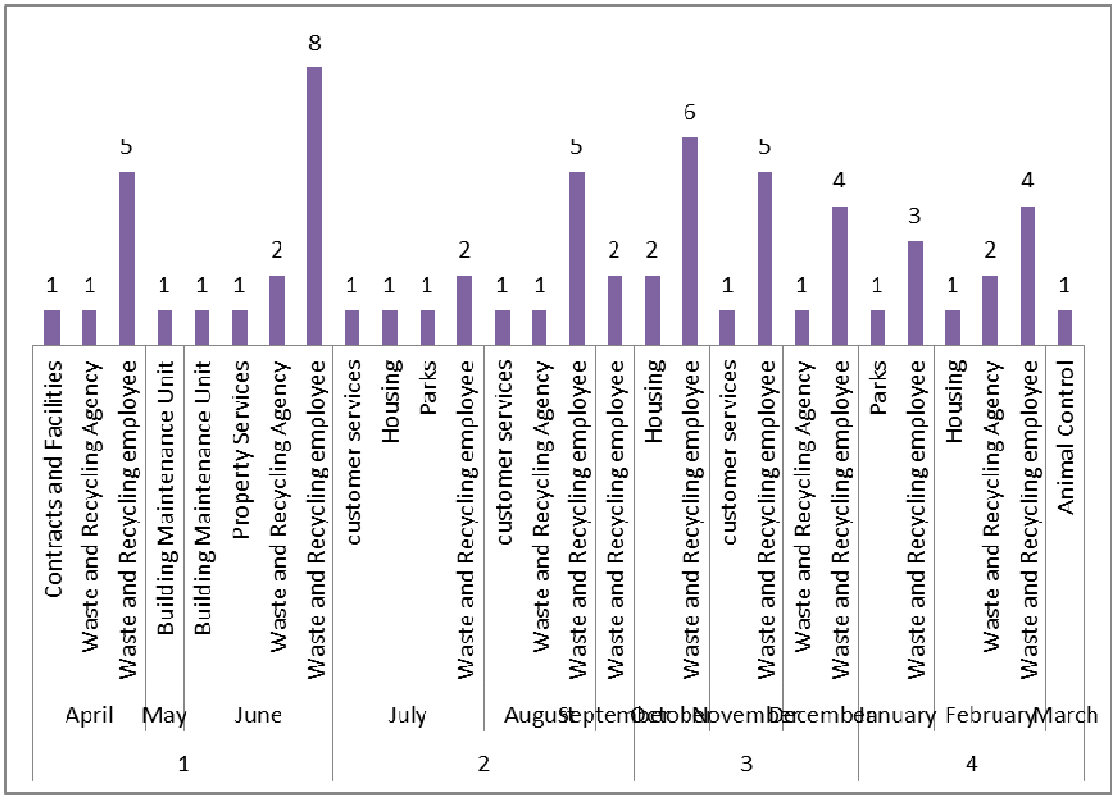
**Source:** [http://www.hse.gov.uk/statistics/causinj/kinds-of-accident.pdf](http://www.hse.gov.uk/statistics/causinj/kinds-of-accident.pdf)

## By season

This year, spring and winter had the highest number of accidents – 14 in spring (Q1) and 11 in winter (Q4) with summer having 9 accidents. Again, there are no patterns over the past two or three years.

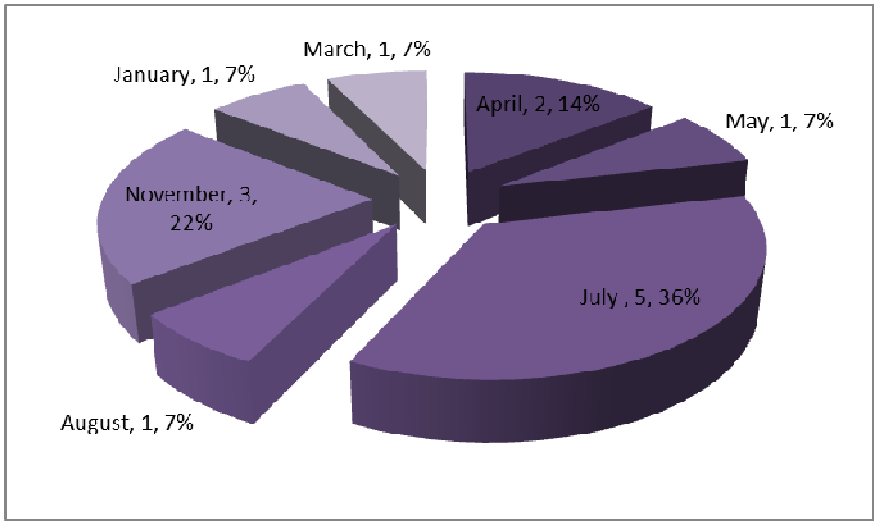


Last year, autumn and spring had the highest number of accidents – 20 in spring, 19 in autumn. For waste and recycling there were 16 in autumn and in spring, and winter had fewer than summer.

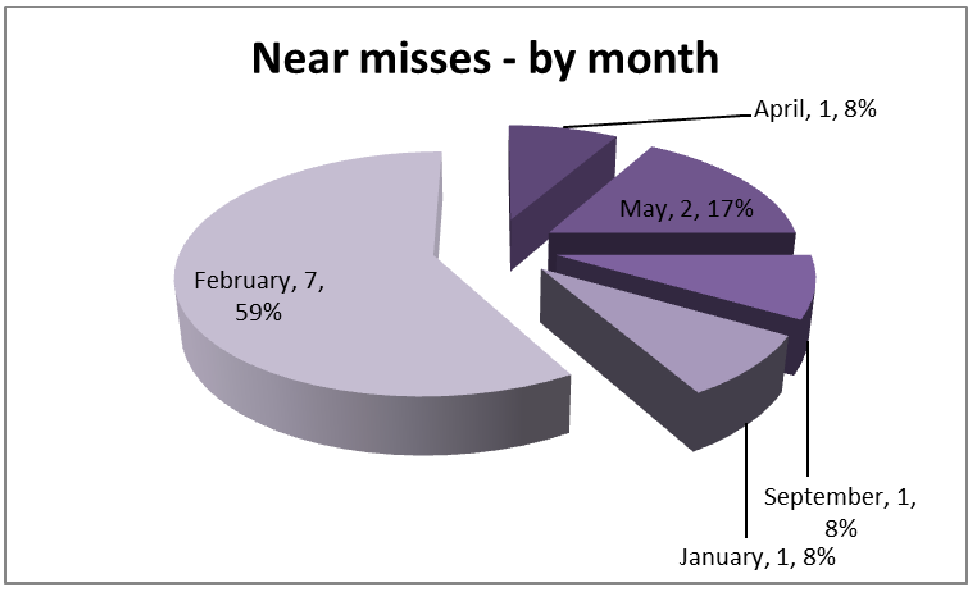



## Near misses

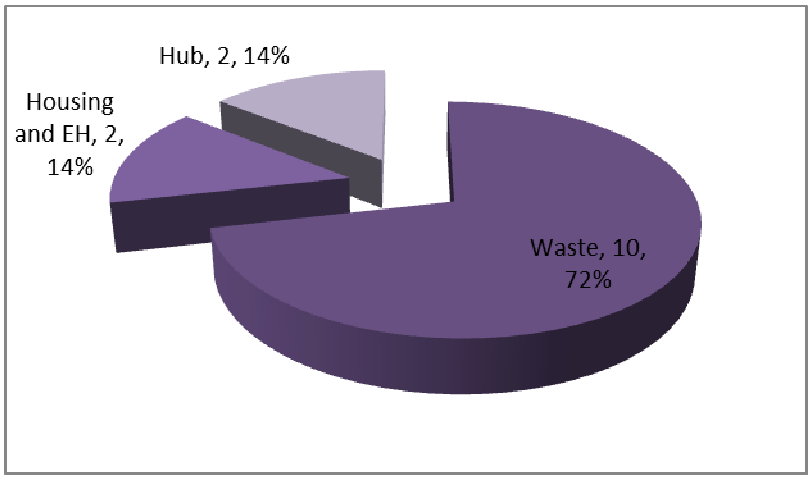
Although the 'near miss campaign' was dropped due to lack of interest, we still had 14 near misses reported in 2016-17. Most of these were in July and November for some reason (no pattern with the accidents reported, or with last year's near misses reported).



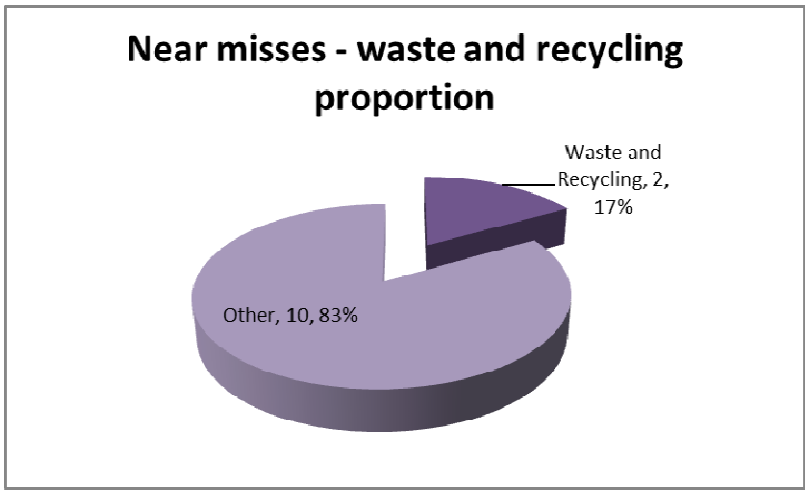
Last year, we had more near misses reported, but still a total of only 12 in the 2015-16 year.



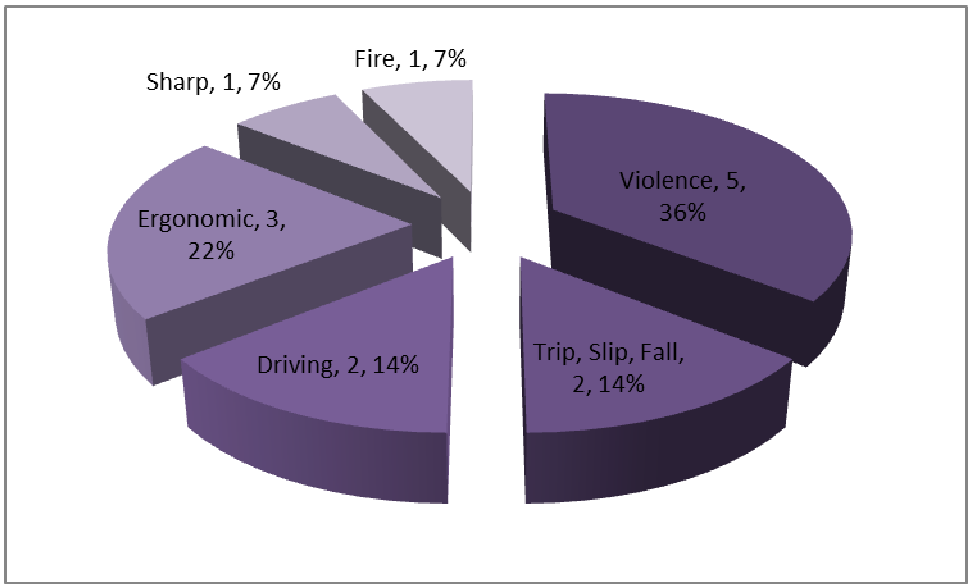

This year, 72% were from Waste:



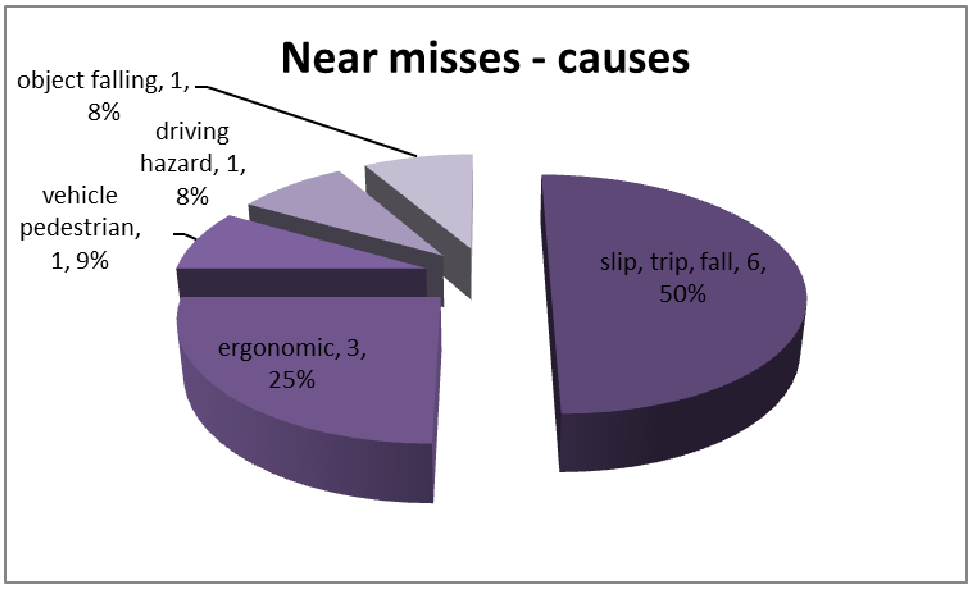

Whereas last year only 17% of these were from waste and recycling:




The causes of the near misses this year were mainly violence, and ergonomic.




Last year it was slips, trips and falls.




**RIDDOR Reports**

There were 6 accidents reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (compared to 9 last year); all these were for people being incapacitated for more than 7 days. One of these was the person who was bruised through bins falling onto him, one was where the driver of the Electric Vehicle (EV) clipped by another lorry, had whiplash, another was due to someone being bruised by a reversing EV, two were manual handling strains, and the other is one we have reported in the following (current) financial year because the person has been signed off with problems which have arisen six months later from the incident.

We also had two ankle fractures, but these were agency staff so their employers would have reported them to the HSE.

## 3 Financial Appraisal

At least 96 (165 last year) employee working days have been lost, all of them in Waste Services (8 accidents – plus 2 which were Agency staff taking who didn't return). This means that around 96 (124 last year) days' Agency staff would have to be paid for as a result of the accidents. (The previous year, all 17 accidents where time off resulted were in Waste and Recycling.)

This year, 30 (plus) of these days were on one accident where a member of Recycling staff was sitting in the driving seat of an EV which was clipped by a lorry. He had whiplash and was off for a month. 23 days were lost by the person who was knocked over by bins falling of the lorry which had been unloading them. He was bruised as a result. 12 days were lost by an EV backing into the banksman who was bruised. Another 21 days were lost by two manual handling injuries.

### Insurance

The Council is insured 'for accidents' although much depends on who's having the accident and whether the Council are negligent. Employer's Liability (EL) insurance covers the Council's liability to its employees arising from negligent acts and omissions. Public Liability insurance covers the same in respect of third parties. We have an insurance (EL) claim from the member of staff who was knocked over by the bins, and our insurers have accepted liability.

We also have a Personal Accident (PA) policy. This is benefit rather than an indemnity policy and no liability need be demonstrated. So if, for example, a worker cut his fingers off in a bizarre accident involving power tools then he or she would be entitled to claim on the PA policy even if an EL claim failed or was not pursued at all.

## 4 Legal Implications

The Committee should consider, in light of the statistics and trends presented in this report, whether to recommend to the relevant person(s) specific measures intended to fulfil the Council's legal duty to ensure, so far as is reasonably practicable, the health, safety and welfare at work of its employees.

Lawyer consulted 30.5.17. Legal ref: 006374-LDC-OD.

## 5 Sustainability Implications

I have not completed the Sustainability Implications Questionnaire as this Report is exempt from the requirement because it is a progress report.

## 6 Risk Management Implications

I have not completed the Risk Management Implications Questionnaire as this Report is exempt from the requirement because it is a progress report.

## 7 Equality Screening

I have not completed the Equality Questionnaire as this Report is exempt from the requirement because it is a progress report.

## 8 Background Papers

With reference to section 2.3, the new Accident Policy is attached.

## 9 Appendices

There are no appendices.

Lewes District Council

# ACCIDENT INVESTIGATION POLICY AND PROCEDURES

| | |
|---|---|
| **Author** | Jill Yeates, Health and Safety Officer |
| **Derivation** | Updated policy and procedures as part of the Health and Safety Management Plan |
| **Origination Date** | March 2016 |
| **Reviser** | Jill Yeates, Health and Safety Officer |
| **Date of last revision** | March 2017 |
| **Status** | Version 3 for Implementation |
| **Summary of changes** | Make more incremental changes; clearer accident policy through all stages, include all other incidents, include forms |
| **Circulation** | Health and Safety Forum |
| **Required Action** | Brief and implement policy and procedures |
| **Approval and implementation** | Health and Safety Forum 20 January 2017 |
| **Version** | V3 |

**Contents**

# 1. OUR POLICY ON ACCIDENT INVESTIGATION

## 1.1 General Policy Statement

LDC acknowledges and accepts its responsibilities under The Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. Under our Health and Safety at Work Policy Arrangements, the Chief Executive is the Council's nominated Health and Safety leader at the top of the organisation to co-ordinate and monitor policy implementation.

It is the Policy of Lewes District Council (LDC) to ensure that, where practicable, accidents or incidents of work-related ill health, dangerous occurrences and near misses during the course of any work activity will be avoided through the use of risk assessments, safe systems of work, instructions, training and supervision.

Where accidents, incidents and near misses do happen, they will be investigated according to this Policy and Procedures.

Our definitions are taken from the Health and Safety Executive (HSE):
Adverse events include:
'accident' – an event that results in injury or ill health
'incident' – a near miss or an undesired circumstance
'near miss' – an event that, while not causing harm, has the potential to cause injury or ill health

There are further definitions in Appendix 1.

This policy will apply to all accidents or incidents involving employees, councillors, visitors, contractors and members of the public on LDC property and/or people carrying out LDC work.

## 1.2 Aims and Objectives

The aims and objectives of the policy are:

- To ensure that we follow a clear and logical procedure and record the results of the investigation so that we can learn from the accident, and so that we have information if it is required by an enforcing body, our insurance company or those involved in the accident.
- To ensure where reasonably practicable (as judged by an initial assessment), all adverse events are fully investigated by suitably competent staff with IOSH Managing Safely level qualified staff.
- To demonstrate that accident or incident investigation is not a means of determining fault or apportioning blame.
- To improve the quality of investigations carried out with respect to the questions which are asked and the information which is recorded.
- To ensure that immediate, underlying and organisational failings are all addressed.

The aims and objectives of the accident investigation are:

- To ensure that all necessary information in respect of the accident or incident as guided by the accident investigation form (Appendix 4) is collated.

- To understand the sequence of events that led to the accident or incident.
- To identify the unsafe acts and conditions that contributed to the cause of the accident or incident.
- To identify the underlying causes that may have contributed to the accident or incident.
- To ensure that effective remedial actions are taken to prevent any recurrence.
- To enable a full and comprehensive report of the accident or incident to be prepared and circulated to all appropriate parties. This will present firm recommendations and an action plan as a result of the investigation.
- To ensure that the action plan is implemented, and feed the investigation outcomes back into risk assessments and safe systems of work.
- To facilitate compliance with statutory requirements.

### 1.3 Duty as an employer

The Council will comply with the Investigating accidents and incidents HSG245, (2004) issued by the Health and Safety Executive, in respect of the investigation of adverse events, in a proportionate and practical manner.

### 1.4 Information, Instructions, Training and Supervision

All managers who deal with adverse events, shall be given all necessary information, instruction, suitable and sufficient training and supervision to enable them to investigate accidents and incidents. Appendix 3 gives a competence checklist for accident investigations advised by IOSH (Institute of Occupational Safety and Health).

## 2. ACCIDENT INVESTIGATION PROCEDURES

### 2.1 Immediate response

Make the area safe and take prompt emergency action (eg first aid) in whichever order is appropriate for the situation.

Preserve the scene, note the names of people involved and witnesses, and equipment involved. If the accident is a dangerous occurrence, such as a fatality, major injury, electrocution, chemical spill, then the Police are likely to be involved.

Report the adverse event to the person responsible for health and safety who can decide what further action (if any) is needed. This will usually be the responsible manager, and/or the Health and Safety Officer.

The responsible manager will report the adverse event to the regulatory authority if appropriate (for us it is usually the HSE, but could be the fire authority).

### 2.2 Decision whether to Investigate

The potential consequences, the likelihood of the adverse event recurring, and the potential for learning lessons should determine the level of investigation (see Appendix 2). If the public are affected, there should always be an investigation of an adverse event.
The investigation should be carried out with the involvement of management and the workforce, as well as health and safety professionals and, where appropriate, senior management including Directors. It should be led by – or report to – someone with the authority to make decisions and act on the recommendations.
Trained and competent people are needed to do the investigation – this means having a detailed knowledge of the work activities involved, health and safety good practice, standards and requirements, those with investigative skills such as information gathering, interviewing, evaluating and analysing.
The urgency of the initiation of the investigation will depend on the magnitude and immediacy of the risk involved, and in any case as soon as possible so that people don't lose evidence, or forget, what has happened.
The Insurance Officer can help decide which information is needed from each accident or incident.

**2.3 Gathering the information**

Gathering all the information available includes physical from the scene of the incident, verbal accounts from witnesses, written risk assessments, procedures, instructions and safe systems of work. Pre-conceived ideas should be put to one side and the investigation will be open, honest and as objective as possible. Everything will be questioned, without looking for 'blame' for individuals.
Investigations are conducted with accident prevention in mind, not placing blame. The underlying and root causes are sought, not the immediate cause.
The investigation should be thorough and structured to avoid bias and leaping to conclusions.
Explore all reasonable lines of enquiry and set out what is known and what is not known.
All necessary equipment required to carry out investigations will be supplied, located in a suitable environment and well maintained. All staff necessary will be trained in the use of such equipment.
The HSG245 provides lists of questions to help with gathering the information.

**2.4 Analysing the information**

Underpinning 'human error' will be a number of underlying causes; most of these are management, organisational or planning failures.
The analysis should be objective and unbiased, identify the sequence of events and conditions which led to the adverse event, identify the immediate causes, the underlying causes and the root causes.

**2.5 Identifying risk control measures**

Identify risk control measures which were missing, inadequate or unused, compare conditions and practices as they were with statutory requirements,

identify measures needed to address all levels of cause and provide meaningful recommendations which can be implemented.

**2.6 The action plan and its implementation**

An action plan with SMART objectives (specific, Measurable, Agreed, Realistic and Timescaled). The action plan needs to deal with the immediate, underlying and root causes, and include lessons which may be applied to prevent other adverse events. It will need to have been out for consultation with all appropriate parties before being completed to ensure that the findings and recommendations are correct, address the issues and are realistic. Risk assessments and safe systems of work should be reviewed. The action plan should have arrangements for implementation and monitoring.
The results of the action plan should be communicated to everyone who needs to know.

**2.7 Management of Joint Investigation**

Agree with other relevant authorities how the joint investigation is to be managed and kept under review.
Establish who will take primacy.
Make joint arrangements for the investigation including lines of enquiry, resources required, gathering, processing and sharing relevant material, identifying specialist advice where necessary, interview strategy and communications with all interested parties.
In the event that the enforcing authority wishes to carry out an investigation, the organisation will strive to meet all of its legal reqponsibilities when co-operating with the enforcement authorities concerned (HSE, Fire Authority, other authority).

**2.8 Working with victims**

A victim for the purposes of this policy is " person who has been injured or directly affected by an accident arising out of, or in connection with work, or is a member of the family of someone who has been hurt or worse in connection with an incident at work".
We will inform, advise and support victims and be sensitive to the victim's personal circumstances and requirements. We will treat each victim with dignity and respect and provide them with timely information and advice about the conduct of an investigation and any subsequent legal proceedings.
We will be considerate to the potential diversity of the victim and the victim's family. Every effort is taken to ensure everyone is treated fairly, with decency, dignity and respect. Staff who liaise those injured directly in an incident and with their families are provided with support and training on how to deal with traumatised persons.
We will be as open as possible in providing victims with details about the progress of an investigation whilst complying with the statutory bounds of disclosure and without prejudicing any subsequent legal proceedings.

**2.9 Remedial Action**

Lewes District Council will, so far as is reasonably practicable, implement any recommendations made as part of the investigation. In the event of any

remedial action taken, staff will be fully involved and provided with the necessary information, instruction and training.

**2.10 Records and Reports**

Records of any accident will be kept by the Health and Safety Officer, and anonymous statistics produced on a regular basis. These records will be kept in accordance with the Data Protection Act 1988. Employees and their representatives will be given access to any report in so far as it is applicable to do so.

## 3. ACCIDENT INVESTIGATION ROLES AND RESPONSIBILITIES

**Chief Executive**

The Chief Executive is the Council's nominated Health and Safety leader at the top of the organisation to co-ordinate and monitor policy implementation overall. They will ensure that this Policy and associated Procedures are implemented, reviewed and updated accordingly.

**Managers/Supervisors**

Managers and Supervisors have responsibility for ensuring that health, safety and welfare arrangements are suitable and sufficient within their service areas. Where there is an accident, they will decide on the need for an investigation on consultation with competent health and safety advice. However, anyone involved in an accident or incident should not carry out the investigation because of potential conflicts of interest, possibility of compromising findings. (See Appendix 2 for levels of investigation.)

**Employees – Duty of care**

Employees will co-operate with the investigation, honestly and openly answering questions and working with management to ensure that the investigation is effective.

**Training**

Managers will use this Policy and Procedures, and HSG245 to ensure that the investigation is competently carried out.

**Health and Safety/Trade Union Representatives**

Recognised health and Safety/Trade Union safety representatives or other employee representatives, will be given access to any necessary information and workplaces to enable them to fulfil their duties. Safety representatives will also be encouraged to participate fully in any investigation. This is a legal requirement, and also ensures that management and the workforce are fully involved. Where there is full co-operation and consultation with representatives and employees, the number of accidents is half that of workplaces where there is no employee involvement.

**Health and Safety Officer**

The Health and Safety Officer will provide competent and relevant information on this policy and procedure, and support managers as required by them with informed advice relevant to any investigation, as well as ensuring that any records of incidents or accidents are kept.

**Communications Team**
The communications team will work with senior management in order to ensure that only appropriate information is released at any time to people outside the organisation.

**Table 1: Accident Investigation and Who Becomes Involved When**

| | |
|---|---|
| Staff at supervisory level | • When an incident is reported to them by an employee under their supervision, which the employee believes indicates the presence of any danger to persons, plant or equipment. |
| Staff at managerial level | • When an incident occurs within the manager's area of responsibility involving the failure of or damage to any part of the premises, plant, equipment, tool or substance.<br>• When an incident occurs in which an employee or other person within the manager's area of responsibility has suffered death or injury.<br>• When an incident occurs within the manager's area of responsibility which could have led to the death or injury of persons or to the failure/damage of any company property. |
| Health and safety advisor/manager | • Incidents to be reported to the enforcement authority.<br>• Incidents involving the death of, or personal injury to, anyone doing anything with or in relation to any activity carried out by the company.<br>• Incidents which a department manager believes could have led to the death of, or personal injury to, any person. |
| Specialists and consultants | • When specific skills, knowledge or experience are required to carry out an effective investigation. |
| Staff representative | • Any incident in which a member of staff that they represent is involved. |

## 4. REVIEWS

4.1 The procedures and arrangements will be reviewed annually, and upon any significant change in the organisational activities or any building.

4.2 Changes may also be carried out following advice from the Health and Safety Executive, our insurers or other accident investigation enforcement agencies.

## Appendix 1: Definitions

Our definitions are taken from the Health and Safety Executive (HSE): Adverse events include:

‘accident’ – an event that results in injury or ill health

‘incident’ – a near miss or an undesired circumstance

‘near miss’ – an event that, while not causing harm, has the potential to cause injury or ill health

‘undesired circumstance’ – a set of conditions or circumstances that have the potential to cause injury or ill health, eg untrained nurses handling heavy patients

‘dangerous occurrence’ – one of a number of specific, reportable adverse events, as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

‘hazard’ – the potential to cause harm, including ill health and injury; damage to property, plant, products or the environment, production losses or increased liabilities

‘risk’ – the level of risk is determined from a combination of the likelihood of a specific undesirable event occurring and the severity of the consequences

‘immediate cause’ – the most obvious reason why an adverse event happens eg the guard is missing; the employee slips etc.; there may be several immediate causes identified in any one adverse event

‘underlying cause’ – the less obvious system or organisational reason for an adverse event happening eg the hazard has not been adequately considered via a suitable and sufficient risk assessment; task achievement pressures are too great etc

‘root cause’ – an initiating event or failing from which all other causes or failings spring; root causes are generaly management, planning or organisational failings

## Appendix 2: Levels of investigation

At each stage, if it could have resulted in something more significant, the investigation should be expanded, possibly to the next level up.

Minimal Level

Minimal level investigation – the relevant supervisor will investigate the circumstances of the event and try to learn any lessons which will prevent future occurrences. Unison Health and Safety Representatives will be helpful. This could include things like – manual handling issues where something was heavier than expected, cuts from broken glass in bags – not labelled, trips on kerbs or stairs, stings from insects.

Low Level

Low level investigation – a short investigation by relevant supervisor or line manager into the circumstances and immediate, underlying and root causes of the adverse event. Unison Health and Safety Representatives will be helpful. This could include things like items falling on staff from lockers, store sheds, gardens, dust getting into eyes and causing problems, strains and sprains from manual handling.

Medium Level

Medium level investigation – a more detailed investigation by the relevant supervisor or line manager, the health and safety adviser and employee representatives; they will look for the immediate, underlying and root causes. This could include items or vehicles catching fire, people being hit or knocked over by heavier items falling on them, scalded hands, whiplash, more serious cuts and needlestick injuries. Fractures and hospital visits are often involved.

High Level

High level investigation – team-based investigation, involving supervisors or line managers, health and safety advisers and employee representatives, all under the supervision of senior management or directors; they will look for the immediate, underlying, and root causes. This would involve serious accidents with possible fatalities, such as vehicle and road traffic accidents, heavy items (eg ceilings) falling onto people, serious escapes of dangerous substances, electrocution, falling from height.

## Appendix 3: Competence Checklist for Accident Investigation

### Analytical skills

can form an independent, unbiased opinion, not unduly influenced by their relationship to the organisation they're investigating?

can stay independent and if necessary criticise peers and/or senior management?

can make meaningful observations, notice relevant environmental factors and recognise when detail is important?

can gather and analyse information effectively?

can look beyond the immediate causes of an event to identify the root causes?

can identify what evidence is missing and evaluate contradictory evidence?

### Interpersonal skills and characteristics

can communicate effectively at all levels of the organisation, and with external parties, such as bereaved relatives, the police and regulatory authority, the media and contractors?

can use effective interview techniques, including gaining the confidence of 'reluctant' witnesses?

can manage their own stress when dealing with highly emotive situations?

can use tact and sensitivity when communicating?

can identify barriers to communication and overcome them?

can summarise and explain the objectives, methods, progress and results of the investigation?

can influence decision-makers?

are assertive enough to express their unbiased professional opinion?

**Technical knowledge and skills**

can use appropriate accident causation theories and associated checklists and analysis tools?

can use hazard and risk management techniques?

know and understand the activities going on at the time of the event?

can apply and interpret relevant legislation and guidance?

understand the roles and interactions of the police and regulatory authorities?

understand the laws on gathering/using evidence, and other relevant legal issues?

are aware of sources of evidence (eg equipment, sites, people and documents) and know how to identify, preserve, gather, analyse and record objects and data?

can photograph, video or sketch a scene to an adequate quality, or source such expertise at short notice?

**Administrative skills can manage and/or work within a team?**

can work effectively with other professionals (eg medical staff, HR professionals and lawyers)?

can report their findings concisely and accurately?

can record and preserve evidence appropriately?

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**Appendix 4:** Incident/Accident report form

| **Accident, Ill Health or Violent/Aggressive Incident Report Form**<br>Please complete the relevant section with your team leader/manager, and send a copy to the Health and Safety Officer.<br>**Please Note:**<br>1 If you are just reporting a **Near Miss, you only need to complete Section 1**<br>2 If you are reporting a minor accident, incident, case of ill health, case of verbal or physical aggression, please complete Sections 2 and 3<br>3 If you are reporting a major accident, incident, case of ill health, case of verbal or physical aggression, please complete Sections 2, 3 and 4<br>Thank you | |
|---|---|
| Data Protection: the details will be used to analyse incidents, but anonymously. However, management will need to investigate incidents to look for ways of avoiding similar or worse events in future. | |
| **1 Near Miss** | |
| Name of person reporting: | Date of near miss: |
| What happened? Please include Who, What, Why, Where, When and How. | Please comment on what happened and what can be done to avoid an accident: |
| **2 Accident, Ill Health or Violent/Aggressive Incident Report** | |
| Name of injured/aggrieved person: | Name of person reporting accident if different:<br>Witnesses: |
| Home address: | Address where accident happened: |
| Job role:<br>Work process: | Date of accident: |
| Please circle:<br>Employee/Agency/<br>Consultant/Visitor/Tenant/<br>Member of public/Other? | Please describe briefly what happened: |
| Signature of injured/aggrieved person: | Date signed: |
| Signature of person reporting if different: | Date signed: |

| | |
|---|---|
| | |

| **3 Minor Accident, Ill Health or Violent/Aggressive Incident Investigation Report** | |
|---|---|
| Type of incident: | Date, time and place of incident: |
| People involved in incident:<br>Name/contact details if known:<br><br>Description: | Witnesses to incident: |
| Actual severity: minor/serious/major<br><br>Potential severity: minor/serious/major | Probability of recurrence:<br>Injured person: low/medium/high<br>Others: low/medium/high |
| More detailed description of accident: | |
| Details of injury: | Treatment eg first aid, doctor, hospital: |
| Description of how incident occurred: | Sketches, plans, list of photos attached: |
| Immediate causes of incident: | Secondary causes – root factors |
| Recommendations to prevent recurrence (if linked to Customers of Concern, please ensure process begins): | |

| | |
|---|---|
| | |
| Name of investigator:<br><br>Signature of investigator:<br><br>Date: | Follow up actions identified with deadlines: |
| Reviewer – name:<br><br>Position:<br><br>Signature of reviewer:<br><br>Date: | Reviewer recommendations: |

| **4 Major Accident, Ill Health or Violent/Aggressive Incident Investigation Report** | |
|---|---|
| Type of incident: | Date, time and place of incident: |
| **Accident Investigation Equipment Required** | |
| Items: | Responsible person: |
| **Accident Investigation** | |
| Place of accident: | Area of accident: |
| Date of accident: | Time of accident: |
| If reported under RIDDOR, reference number: | If Police involved, reference number: |
| **Physical details** | |
| Have all physical details been recorded (photos, sketches, measurements, notes, items sent for examination) | Yes/No<br>Please list and comment |

| | |
|---|---|
| Have all vehicles, equipment, items been examined and samples taken if appropriate? | Yes/No<br>Please list and comment |
| **Interviews and statements** | |
| Have injured/ill person(s) been interviewed and statements made and signed? | Yes/No<br>Please list and comment |
| If the person(s) causing the accident is different, have they been interviewed and statements made and signed? | Yes/No<br>Please list and comment |
| Have all witnesses been interviewed and statements made and signed? | Yes/No<br>Please list and comment |
| **Documents** | |
| Have all appropriate documents been collected, examined and relevant information noted? | Yes/No<br>Please list and comment |
| **Analysis** | |
| Is it believed that all immediate causes have been identified? | Yes/No<br>Please list and comment |
| Is it believed that all underlying and root causes have been identified? | Yes/No<br>Please list and comment |
| Did the workplace or premise involved contribute to the incident? | Yes/No<br>Please list and comment |
| Did any vehicles, plant, equipment or substances being used contribute to the event? | Yes/No<br>Please list and comment |
| Did the process or procedures being used contribute to the event? Were the risk assessments and safe systems of work being carried out? Were safety procedures employed? | Yes/No<br>Please list and comment |

| | |
|---|---|
| | |
| Did the people involved contribute to the event (this is for analysis, not blame)? | Yes/No<br>Please list and comment |
| Were any people involved adequately informed, trained, competent and appropriately supervised? | Yes/No<br>Please list and comment |
| Was there adequate co-operation and communication? | Yes/No<br>Please list and comment |
| Any other relevant issues to note? | Yes/No<br>Please list and comment |
| **Remedial actions** | |
| Remedial actions identified: | Remedial actions to be carried out by (responsible person, and date): |
| Name: | Signature:<br><br>Date: |