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Accident & Incident Reporting and Investigation Policy and Guidance HSP12.0

Essex County Council

The aim of this Policy and Guidance

Legally, the Council must ensure the health and safety of all employees and others. This applies to all the work we undertake.

The Council must also check and review our health and safety arrangements. Accident reporting and investigation forms part of this process.

The aim of this document is to help managers and others to report adverse events such as accidents. To prevent adverse events, this document provides guidance on their investigation.

Accident & Incident Reporting and Investigation Policy and Guidance HSP12.0

Essex County Council

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1 Quick reference guide for employees

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The Council uses an on-line system (MySafety) to report adverse events.

Some adverse events must by law be reported to the Health & Safety Executive (HSE). These events have a short time frame for reporting. The Corporate Health & Safety Team (CH&ST) report these events for all Services. The CH&ST also report them for Community Schools and Voluntary Controlled schools.

Some acts of violence and aggression will also need to be reported to the HSE within a specified time frame.

Reporting adverse events, helps to prevent them happening again.

Managers must investigate adverse events.

2 Quick reference guide for managers

In a hurry? Here is what you need to know.

Adverse events include all accidents and incidents. Unless specifically agreed with the Corporate Health & Safety Team (CH&ST), Line managers must ensure all adverse events are reported to the CH&ST.

For Schools with children with Special Educational Needs and Disabilities the reporting requirements are detailed in "Understanding and Supporting Behaviour – Safe Practice for Schools and Education Settings". This can be found on the Safeguarding pages of Infolink.

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Immediate actions in the event of an adverse event

- Secure the area, make it safe and arrange first aid for injured persons before you do anything else
- Collect witness statements as soon as possible after the event
- Take or collect photos and CCTV and usually a plan of the area

Managers must investigate adverse events to prevent them happening again. MySafety allows for direct uploading of your investigation onto the system.

State what actually happened – stick to the facts, not conjecture.

Consider these 5 factors as part of the investigation:

1. Equipment – Not maintained, defective, inappropriate etc.
2. Organisation/ Management – Lack of information, instruction, training, supervision, risk assessment, procedures, resources
3. Premises/ Environmental – Weather, housekeeping, visibility, temperature, surface conditions etc
4. Human Factor – Human error, distractions, rushing, existing health conditions, physical/mental limitations
5. Violence/ aggression - Was the behaviour expected/ unexpected, assessed suitable, intervention training provided

Establish the root cause and the underlying causes. Use the "5 Whys"*, or a similar root cause analysis method, to find the root/ underlying cause.

Review/ update any risk assessments associated with the event. Draw up an action plan to stop this happening again

Consider the cost of the accident, including the uninsured costs (see Appendix 4 – Cost Calculator)

* 5 Whys – keeping asking why the event happened, to reveal the root cause. For more information, see Appendix 5.

3 Accident & Incident reporting and investigation - detailed information

3.1 Definitions

Adverse Event includes:

- accident: an event that results in injury or ill health;
- incident: there are two types of incident
  - 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, e.g. untrained nurses handling heavy patients

Work related ill-health. A condition that has been caused by or made worse by the work environment. Examples of work-related ill-health include occupational asthma or work-related upper limb disorders.

Work-related (workplace) Violence. The Health and Safety Executive (HSE) defines work-related violence as:
"Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work."
This can include verbal abuse or threats as well as physical attacks.
An Emergency - a serious, unexpected and often dangerous situation requiring immediate action. Examples include:

- All work-related accidents that result in the death of any person. (This excludes suicides and death by natural causes.)
- An accident to an employee, which then involves the Health and Safety Executive (HSE) and/ or the Police.
- A fire causing significant fire damage to an ECC building.
- An identified outbreak of an illness at an ECC site resulting in a several staff being absent.

If an emergency occurs or develops. Do not delay, follow the emergency response procedure in appendix (a).

If in doubt that a situation is an emergency – call CH&ST (0333 013 9818).

3.2 Responsibilities

Chief Executive Officer (ECC) is ultimately responsible for:

- Ensuring the effective implementation of this policy
- Allocating enough resources to ensure that incidents are appropriately investigated and managed

Executive Directors and Directors within their function have responsibility to ensure that:

- Arrangements are in place to enable investigations to be undertaken. The investigations must identify root causes and ensure corrective actions taken.
- Enough resources are in place to enable incidents investigation. The investigations must ensure lessons are learned and actions taken to prevent reoccurrences.

- Incident trends are identified, reviewed and discussed at Function H&S meetings.
- Staff in their areas of control are aware of the requirements of this policy

Heads of service, line managers and Head Teachers (Community V/C schools) must ensure that:

- Their employees are aware of the requirements of this policy.
- Employees report all incidents using the MySafety system. Incidents include injuries, property damage, near misses, violence, work-related ill-health and hazardous substances.
- Their managers investigate and manage incidents in line with this policy.
- Managers assign the appropriate person to identify and track corrective actions to completion.
- Review risk assessments after an incident, updating risk control measures where necessary.
- Managers communicate the outcome of the incident investigation and risk assessment review.
- Employees follow the emergency procedure in the event of a serious incident and notify CH&ST.
- They provide enough details on MySafety to enable RIDDOR reporting without delay.

Function Health and Safety meetings, Corporate Health and Safety Board, Schools Health, Safety & Welfare meetings & Schools Senior Leadership Team/ Governing Body meeting must

- Discuss details of serious incidents,
- Consider any trends and
- Take corrective actions, where necessary

3.3 Process

Incident reporting

Report all incidents, involving employees, via the MySafety system. Submit all incident investigations, involving employees, via the MySafety system. Report and investigate all incidents, that arise from a work activity, involving non-employees. Non-employees include members of the public, visitors, pupils, contractors etc.

This includes:

- Incidents, as defined above, at the employee's normal place of work
- Incidents outside the normal place of work e.g. visiting clients' premises
- Incidents outside of the UK as part of their work activity
- Road traffic incidents while driving on company business
- Incidents where damage or harm to the environment has occurred
- Near miss incidents, which could cause harm to people, property or the environment.

When submitted, near miss reports enable the introduction of control measures. These measures can prevent a reoccurrence of the incident.

All Community and V/C schools must report accidents and incidents. This includes RIDDOR reportable incidents and incidents involving employees and non-employees.

Schools can still keep a 'bump book' for minor pupil accidents only. Schools needs to exercise their judgement when deciding their reporting criteria. Report more serious incidents via MySafety.

For Schools with children with Special Educational Needs and Disabilities the reporting requirements are detailed in Appendix F of "Understanding and Supporting Behaviour – Safe Practice for Schools and Education Settings". This can be found on the Safeguarding pages of Infolink. See Appendix 6.

Report all incidents via MySafety within 5 days. Report RIDDOR reportable incidents and accidents as soon as possible.

Where a copy of the incident report has been provided to the person completing the form. Then it must be kept and secured locally under the Data Protection Act 1999.

3.4 Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) Reportable Accidents

The Health and Safety Executive (HSE) must receive all RIDDOR reportable incidents.

Under the Data Protection Act 1999, CH&ST must keep all RIDDOR forms (F2508).

Reporting requirements under RIDDOR differ for employees and members of the public.

For employees, RIDDOR reportable accidents include:

1. Death or a specified injury, this must be reported to the HSE without delay. (Follow the emergency procedure in Appendix A)

2. When a member of staff is absent or unable to do the full range of their normal duties for more than seven days as a result of an injury caused by an accident in connection with a work activity. This must be reported to the HSE within 15 days.

For members of the public an accident becomes RIDDOR reportable if:

1. It resulted in the death of a person and arose out of or in connection with a work activity

2. It resulted in an injury and the person is taken directly from the scene of the accident to hospital for treatment. The injury must result out of or in connection with a work activity.

"Out of or in connection with a work activity" means:

- A failure in the way the work activity was organised (e.g. inadequate supervision),
- Condition of premises (e.g. poorly maintained or slippery floor) or
- The way equipment or substances were used.

3.5 RIDDOR reporting for schools

For pupils, an accident becomes RIDDOR reportable if:

1. It resulted in the death of a pupil and arose out of or in connection with a work activity

2. It resulted in an injury and the pupil is taken directly from the scene of the accident to hospital for treatment. The injury must result out of or in connection with a work activity.

"Out of or in connection with a work activity" means:

- A failure in the way the work activity was organised (e.g. inadequate supervision),
- Condition of premises (e.g. poorly maintained or slippery floor) or
- The way equipment or substances were used.

For example, following a fall over a trailing cable a pupil breaks their arm and is taken to hospital. This would not reportable due to the condition of the premises.

A pupil has an asthma attack or epileptic seizure and is taken to hospital. This would not be reportable as it did not arise from a work activity.

Many of the incidents that cause injuries to pupils at school tend not to be reportable under RIDDOR. They do not arise from the way the school undertakes a work activity.

An injury caused by normal rough and tumble of a game would not be reportable.

Most playground accidents are not reportable. Most pupil accidents due to slips, trips and falls in schools are not reportable. Reportable incidents occur, when the injury results in a pupil

- Being killed or
- Taken directly to a hospital for treatment.

But only if caused by an accident that happened from or in connection with a work activity.

Note: Foundation, V/A and Academy Schools do not have to report H&S incidents to Essex County Council. If these schools choose to report via MySafety, CH&ST will review records and provide advice. This forms part of the H&S advisory service.

If these schools do not use MySafety, they must have their own internal system. The system should be capable of reporting and investigating incidents and identifying trends. They will also need to ensure that the HSE receives their RIDDOR reportable incidents.

3.6 Specified injuries to workers

'Specified injury' classified under RIDDOR must be reported to CH&ST as soon as possible. Ring 0333 013 9818 and a member of the health and safety team will provide advice.

Specified injuries classified under RIDDOR include:

Any bone fracture, other than to fingers, thumbs or toes

Amputation of an arm, hand, finger, thumb, leg, foot or toe

Permanent loss of sight or reduction of sight in one or both eyes

Crush injuries to the head or torso causing damage to the brain or internal organs in the chest or abdomen

Serious burns, covering more than 10% of the body. Serious burns damaging the eyes, respiratory system or other vital organs.

Scalping (separation of skin from the head) needing hospital treatment.

Loss of consciousness caused by head injury or asphyxia.

Any other injury arising from working in an enclosed space, which leads to:

hypothermia,

heat-induced illness. or

requires resuscitation or

admittance to hospital for more than 24 hours.

3.7 Action for work-related fatalities and specified injuries

If an employee witnesses a specified or fatal injury at work, he/ she must:

- Assess the situation, not put themselves at risk, and ensure that the area is safe to approach

- Assess the causes of the accident and ensure their actions will not further add to the situation
- If electricity is the likely cause, isolate the casualty from the supply source.
- If electricity is not involved, make the injured party as comfortable as possible.
- Ensure all breathing passages are free from obstruction
- Call for help e.g. first aider, paramedics or security.
- Where applicable, notify security if an ambulance is called. Security will direct the ambulance crew straight to the injured person
- Continue to render help until relieved by a trained first aid person or paramedic
- Notify the line manager at the earliest possible time
- Provide witness statements to the line/site manager and H&S Champion/ Coordinator.

Action by manager in the event of a specified injury or fatality

In the event of a specified or fatal accident the line manager should:

- Go immediately to the scene of the accident and assess the situation
- Call for a first aider if not present. (Details are on health and safety notice boards or contact security if in County Hall).
- If required, call for the emergency services.
- Where applicable, notify security if an ambulance is called. Security will direct the ambulance crew straight to the injured person
- Try to establish possible causes of the accident.
- Where practicable, locate any witness' names and record their statements
- Preserve the scene ensuring articles remain undamaged and in place
- Contact the ECC Corporate Health and Safety team (0333 013 9818) as soon as possible
- Follow the Emergency Response Procedure in Appendix A if it is an emergency
- Report the incident via MySafety.

3.8 Reportable occupational diseases

Some diagnosed reportable diseases are linked with occupational exposure to specified hazards. The reportable diseases and associated hazards are set out below.

Carpal tunnel syndrome

Severe cramp of the hand or forearm

Occupational dermatitis

Hand-arm vibration syndrome

Occupational asthma

Tendonitis or tenosynovitis of the hand or forearm

Any occupational cancer

Any disease attributed to an occupational exposure to a biological agent

3.9 Dangerous occurrences

Dangerous occurrences are certain, specified near-miss events. Not all such events need reporting. There are 27 categories of dangerous occurrences that are relevant to most workplaces. Examples include:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment
- Plant or equipment coming into contact with overhead power lines
- The accidental release of any substance which could cause injury to any person
- Explosions or fires stopping work for more than 24 hours.

Refer to the HSE guidance for a detailed list of dangerous occurrences, http://www.hse.gov.uk/riddor/

3.10 Reportable gas incidents

Distributors, fillers, importers & suppliers of flammable gas must report incidents where someone has

- died,
- lost consciousness,
- been taken to hospital for treatment to an injury

arising in connection with gas

They must report such incidents using the Report of a Flammable Gas Incident - online form

Any gas appliances or fittings considered dangerous must be reported. Registered gas engineers, under the Gas Safe Register, must provide the relevant details. Dangerous means that people could die, lose consciousness or need hospital treatment.

The danger could be due to the

- design,
- construction,
- installation,
- modification or
- servicing of that appliance or fitting,

which could cause:

- an accidental leakage of gas
- incomplete combustion of gas or
- inadequate removal of products of the combustion of gas.

Unsafe gas appliances and fittings should be reported using the Report of a Dangerous Gas Fitting - online form.

Premises managers must ensure that gas appliances on site are serviced and maintained. Gas appliances includes gas cookers. This also applies where you may act as the landlord for the property or are renting it out. For example, a ranger's cottage or a school premises manager's house. If unsure of your legal responsibilities, contact

- your premises manager,
- your property consultant or
- the CH&ST.

3.11 Acts of violence affecting employees

Employees need to understand what they should do if subjected to work-related violence.

In some areas of the Council's work, the use of abusive language by the public is very common. Some people may express their anger by using abusive language.

The Health and Safety Executive defines acts of violence as:

"Any incident, in which a person is abused, threatened or assaulted in circumstances relating to their work."

Report all behaviour which falls under this definition.

Report any incident in which an employee feels threatened, intimidated or upset. Employees should discuss such incidents with their line manager if unsure about reporting it.

Some learners with special educational needs communicate in ways that can be challenging. Their behaviour can appear abusive and threatening and can lead to assaults. The charity Scope state:

"Challenging behaviour indicates there is a problem in learning and not in the person"

When injured through such behaviour, employees must report these incidents to CH&ST. Behaviour in such circumstances does not imply intent of violence. Report such incidents as accidents rather than acts of violence. See Appendix 6 for more details.

If connected with Council work, report acts of violence involving visitors on MySafety.

Acts of violence between non-employees such as pupils fighting do not need reporting.

3.12 Road Traffic Accidents

Report any road traffic accident involving employees on ECC business on MySafety. This includes damage to a vehicle or staff injury.

Report incidents involving fleet vehicles insured by ECC, to the Insurance team. Contact Insurance on 0333 013 9819 or insurance@essex.gov.uk . This includes school minibuses. The driver completes an insurance claim form. The line manager signs off the insurance claim form before submission to Insurance.

Report incidents involving lease vehicles to the appointed Accident Management Company. This is usually the lease company drivers help line

Accident statistics and analysis

The CH&ST produce accident/incident statistics, trends and dashboards. Relevant committees use the information to inform decision making. The committees include:

- The Corporate H&S Board
- Function Group Meetings and
- Safety Committees.

3.13 Using MySafety Accident and incident reporting system

For information on how to access the MySafety accident and incident reporting system go to Appendix 1

3.14 Accident / incident investigation

The person responsible for carrying out the investigation is normally:

- The injured person's line manager
- The manager responsible for the area where the incident occurred
- The manager/supervisor responsible for the activity taking place.

Line managers may delegate the investigation to an employee responsible for an activity. The employee must be competent. The line manager must oversee the investigation. The line manager must ensure a satisfactorily conclusion is reported back to CH&ST.

Some incidents are premises related. The line manager of the affected person will need to raise the matter with the Premises Manager. The Premises Manager may need to assist in the investigation.

Managers undertaking accident / incident investigations are responsible for:

- Investigating the accident / incident and completing the online reporting form
- Reviewing the relevant risk assessment, safe systems of work and training. Where appropriate they may need to improve the control measures [HSP 5.0];
- Informing the following about specified injuries/ fatalities:
    - Union appointed safety representatives,
    - Health and Safety Champions/ Coordinators and
    - The Corporate Health and Safety Team.

The investigation of violent incidents should consider:

- The action taken against the assailant, and
- The adequacy of measures to control the risk of violence. (Including the adequacy of training provided).

Some accidents / incidents may need the CH&ST to lead the investigation. This may be in liaison with the Health and Safety Executive (HSE).

The HSE may choose to enquire about or investigate the accident / incident further. Line managers and staff should inform the CH&ST immediately if there is any formal contact with the HSE. 'HSE Inspector Visits – What to expect and how to manage' [HSG002], has further information. This includes their role, enforcement powers and how ECC responds to their enquiries.

COMPETENCE AND TRAINING

There is training and instructions in the use of the MySafety system on the H&S intranet pages. There is also a short training course available on MyLearning for accident investigation.

MONITORING AND REVIEW

This ensure this policy remains current CH&ST will review it at least every 2 years.

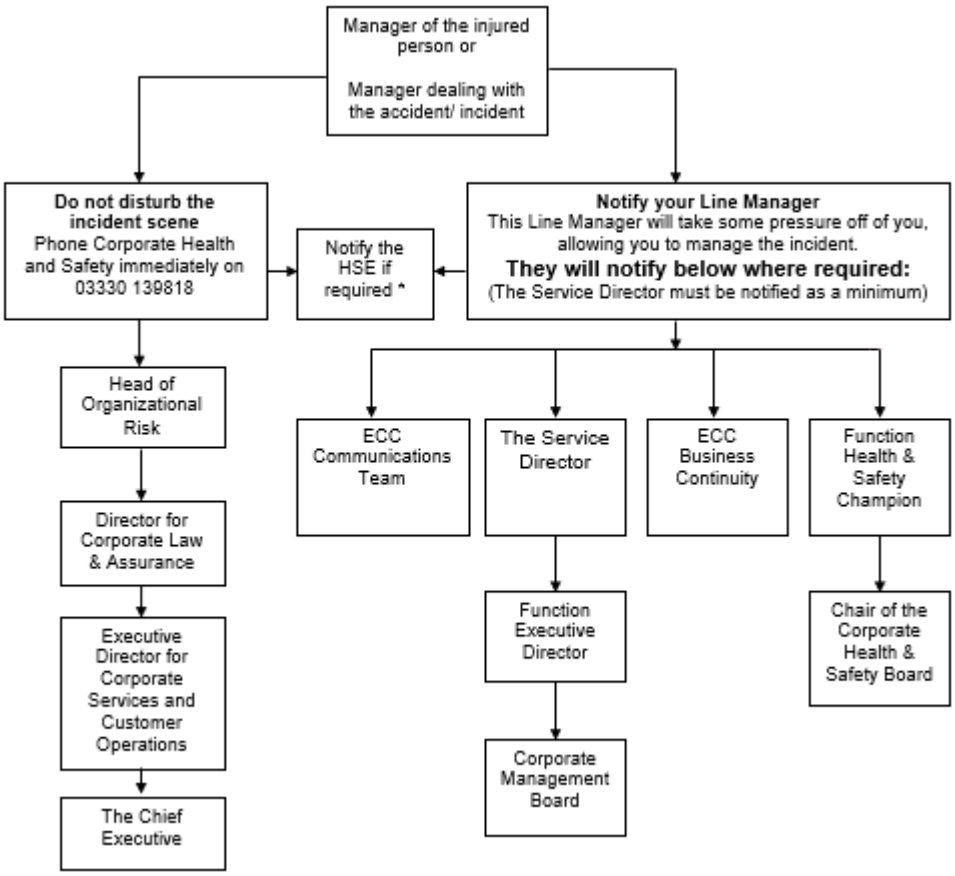
The CHST will check all incident reports submitted, via MySafety, to identify trends. CHSB will receive this analysis on a quarterly basis.

H&S Champions will review Function statistics, via MySafety, at Function H&S meetings.

RECORD KEEPING

Keep records in line with Retention of Records Policy [HSP 3.0].

ECC Emergency Accident/ Incident Response Procedure



3.15 Incident investigation - detailed guidance

Why events should be investigated

Control measures, such as PPE, should prevent incidents happening. The main reason for investigating incidents is to prevent them happening again. The investigation also ensures control measures are adequate. Investigating soon after the event is usually beneficial.

Understanding which events should be investigated

Usually investigations only consider serious incidents, such as a broken limb. Investigations should consider all incidents including near miss reports.

The level of detail depends on potential consequences and the likelihood of reoccurrence. Investigate a near miss that could have resulted in a broken leg. In this way, there has been no injury, but if it happened again the consequences are serious.

The process to be followed

After securing the area and making it safe the following take the following four steps:

1. Information gathering
2. Analysis

3. Risk control measures
4. Action plan

Information gathering – the amount of information gathered will vary depending on the event

Documents required may include:

- Risk assessments,
- Maintenance records,
- Training records,
- Previous accidents,
- Procedures,
- Contractor/visitor records,
- Relevant e-mails,
- Permits,
- Log books,
- Inspections.

It is also useful to sketch a plan of the area.

Photographic evidence. Photos taken immediately after the event convey the actual condition of the site. To indicate scale, display an object such as a ruler. Record items such as fire scorching and electrical fusing, corrosion etc.

Essential points

- Take plenty of pictures
- Photograph the scene before touching anything
- Do not fit broken pieces together but place close together to show how they formed the original.
- To show what a person saw take the picture at eye level to show any obstructions
- Overlap panoramic shots by 50%
- Do not use wide angle or telephoto lenses
- Use a mobile phone to check immediately if it illustrates what the incident.

Physical objects. Keep any components if component failure is relevant. Keep for testing any broken ropes, wires and chains used as lifting appliances. Preserve any slings, hooks, pallet legs or any other piece of lifting gear. Keep PPE, broken or worn tools if it's about personal injury claims. Keep evidence bagged and labelled. Label and secure big items.

Witness statements - Extracting accurate information from witnesses can be very difficult. Some witnesses may be reluctant to say anything for fear of blame or personal liability. Competent investigators put witnesses at ease and emphasise that witness evidence prevents reoccurrences. Encourage witnesses to have a companion to reduce tension. Trade Union Representative may be ideal for this role in some cases.

Effective interviews meet two basic needs:

- The practical needs of the interview, to obtain facts, and,
- The personal needs of the person you are interviewing.

The interviewee needs to feel valued, listened to and understood. The interviewer needs to be able to listen and enhance the persons self-esteem. The interviewer needs to empathise with them and encourage their involvement.

Essential points, always

- Plan the interview
- Have only one interviewer
- Be polite and professional
- Use appropriate language that the interviewee will respond to
- Use photographs and drawings to help the interviewee
- Ask open questions – e.g. how did this happen, when did this occur, why is that etc
- Never make assumptions
- Stick to the subject matter
- Avoid leading questions – e.g. was there a problem with the manager,
- Have an open mind
- Write down what is said, keep a copy, sign and date them
- Witnesses do not have to sign any statement if they do not wish to
- Give a copy to the witness and keep the original
- Score out any space under any text so extra text can't be added later.

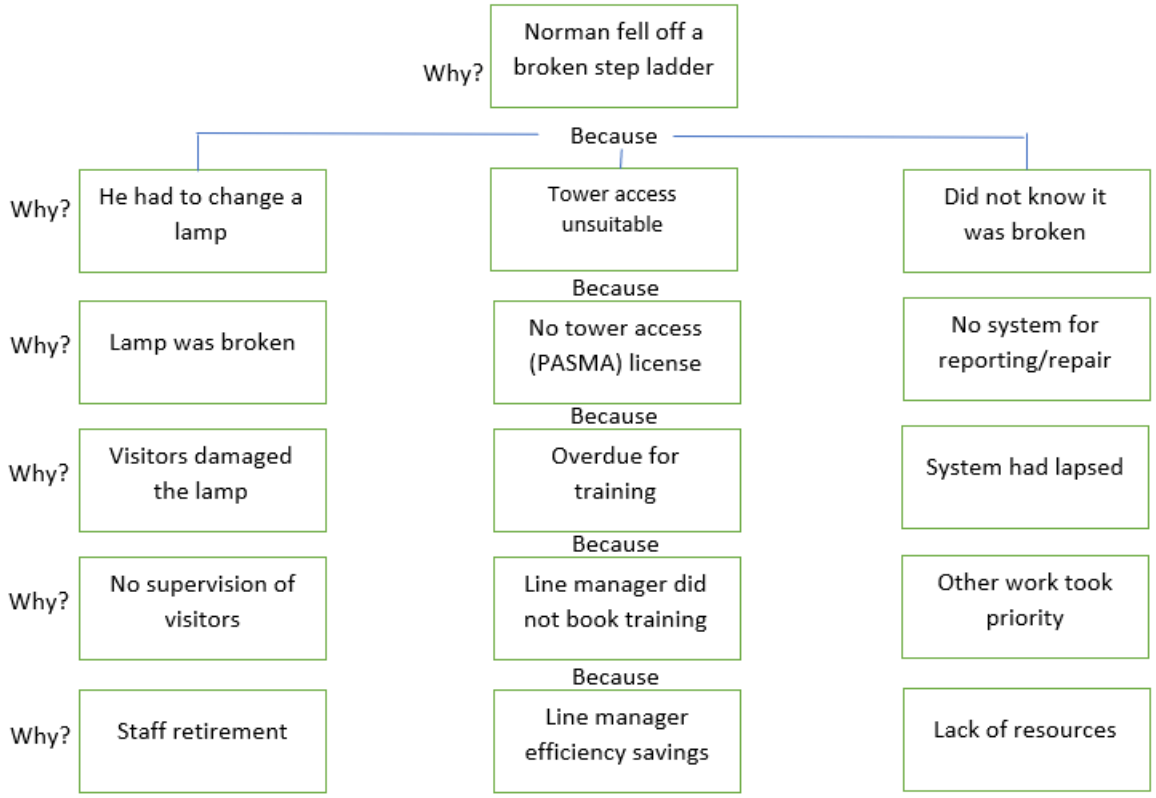
3.15.1 Analysis

You need to be objective and unbiased. Identify the sequence of events and conditions that led up to the event – a timeline is always helpful.

Identify the immediate causes (the source of injury). Norman fell from a broken ladder, the broken ladder is the immediate cause

Identify the underlying causes / unsafe conditions (Ladder was left in place although broken). Identify the unsafe acts (Norman used a broken ladder). See diagram below.

Identify the root causes – use the "5 Whys", root cause analysis tool (Appendix 5). Keep asking why until the answers are no longer meaningful. Each 'why' could lead to more than one reason and there could be more or less than 5 whys. Below is an example, simplified for brevity.



3.16 MySafety accident investigation

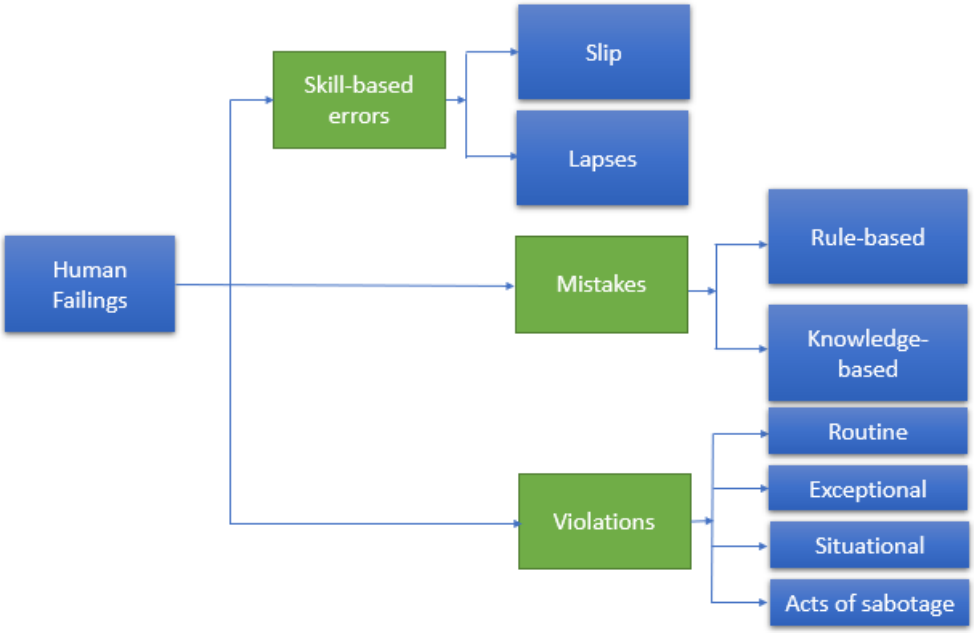
For information on how to use MySafety accident investigation tools go to Appendix 2.

Human Failings

Laying all the blame on one or more individuals is counterproductive. This approach can alienate the workforce and undermine the safety culture.

The HSE have said that Human failings can be divided into three broad types. The action needed to prevent reoccurrence depends on the type of human failing:

- Skill-based errors
- Mistakes
- Violations



Skill based error. These are stored patterns of pre-programmed instructions. Training is unlikely to remove these failings. Redesign of the operation is more likely. Examples include:

- A skilled driver stepping on the brake instead of the clutch.
- An experienced nurse administering the wrong medication by picking up the wrong syringe.

A slip. When a person is carrying out familiar tasks without thinking and that person's action is not as planned. For example, a plant operator pressed the start button for 'pump A' instead of 'pump B'.

A lapse. When an action is performed out of sequence or a step in a sequence is missed. For example, a control room operator misses a step in a plant start-up after taking a phone call mid task

Mistakes are errors of judgement or decision-making ("intended actions are wrong") -

Training is the key to avoiding mistakes. They can be further split into:

Rule based mistakes. When a person has a set of rules about what to do in certain situations and applies the wrong rule. For example, using woodworker's glue to mend a broken plastic eyeglasses frame.

Knowledge based mistakes. A person faced with an unfamiliar situation for which he has no rules. That person then uses his knowledge and works from first principles. For examples a cake failed to rise because a novice baker used Baking Soda in place of Baking Powder.

Finally, there are **violations**. Deliberate failure to follow the rules, cutting corners to save time or effort. Usually based on the belief that the rules are too restrictive and are not enforced.

There are 4 different types of violations

Routine violations. A behaviour in opposition to a rule, procedure, or instruction. This applies when this has become the normal way of behaving within the person's peer/work group.

Exceptional violations. These violations are rare, happening in unusual and particular circumstances. For example, in an emergency situation.

Situational violations. These violations occur as a result of factors in the immediate work space or environment. This can be physical or organisational such as

- Time pressure,
- Lack of supervision,
- Poor ambient conditions (e.g. light, noise, heat),
- Insufficient resources, and
- A negative safety culture.

Acts of sabotage. These are self-explanatory although the causes can be complex. Examples vary from vandalism by a de-motivated employee to terrorism

Risk control measures

It may be that for a simple event there is only one control measure needed to prevent a reoccurrence. It is more likely that several controls will be needed to address the event. In this case, draw up a risk control action plan, stating what the actions needed, by whom and when. Where possible, choose control measures in the following order:

- Those that eliminate the risk e.g. installing a lighting gantry which can be lowered
- Any that combat the risk at source e.g. using a tower scaffold to access the lights
- Those that minimise the risk by relying on human behaviour e.g. following safe procedures.

Some measures may be harder to put in place. For example, installing of a lighting gantry will take time, resources and money. All measures need to be "reasonably practicable".

Consider if this could happen or has happened in other parts of the Council. If so, highlight this in the report and escalate to the Corporate H&S Team and line management.

Action plan

The action plan should have objectives that are SMART:

- Specific,
- Measurable,
- Agreed,
- Realistic, with
- Timescales.

For minor events it is likely that the action plan is simple. For example, 'Keep the key for the electrical cupboard in reception. Only competent persons can sign it out.'

For events with potentially greater consequences, include contributions from:

- Senior management,
- Corporate H&S Team,
- Employees and their trade union representatives.

In deciding priorities for implementing control measures, think about immediate actions. Consider what needs to be done today to secure the health and safety of employees. Consider how high the

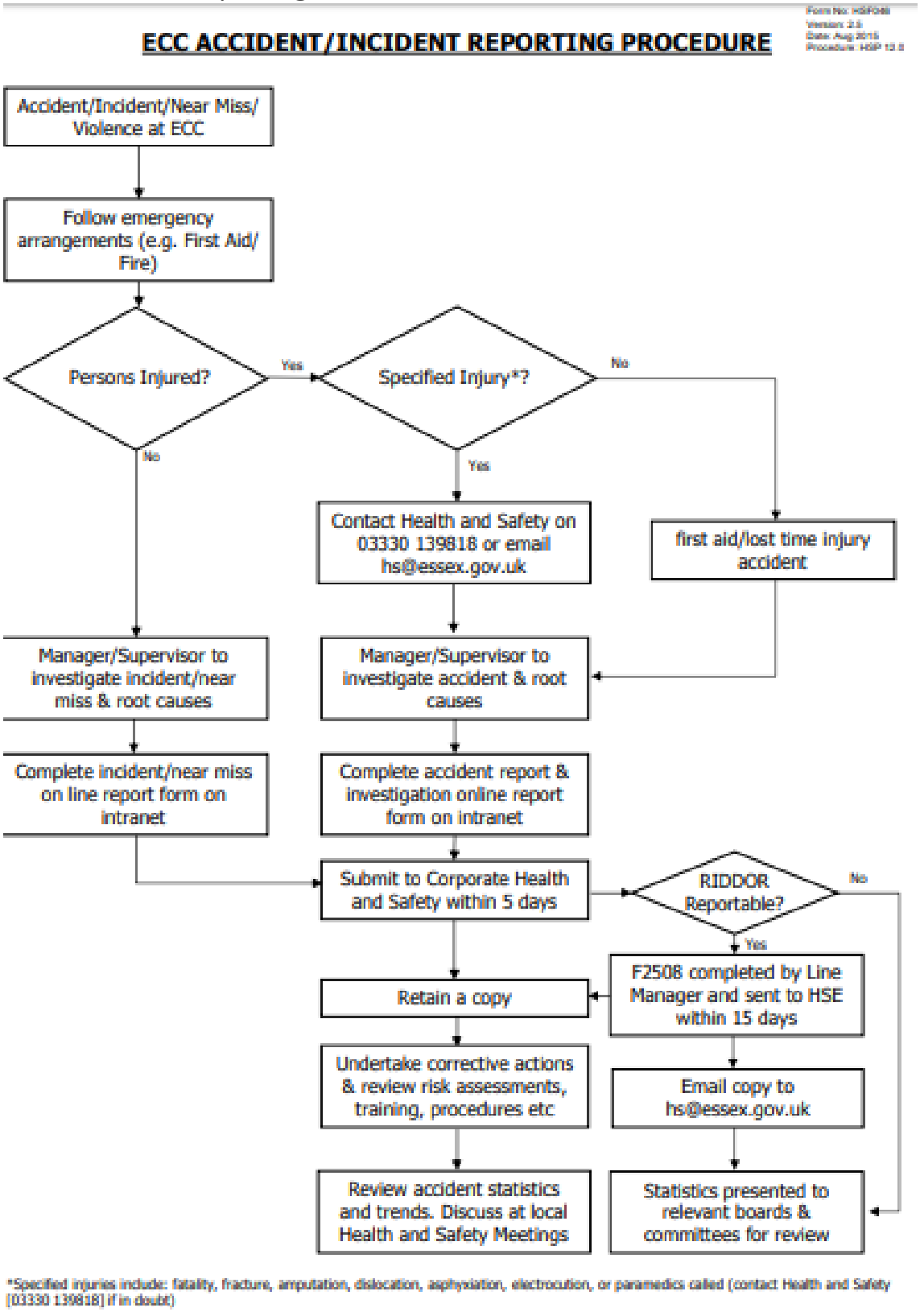
risk is if the control measure is not implemented immediately. The choice is to reduce the risk to an acceptable level or stop the work.

One person takes responsibility for ensuring that the action plan as implemented. Regularly review progress on the action plan. Keeping employees and their representatives informed.

Finally, review / update all risk assessments relating to the event. Make risk assessments suitable and sufficient where necessary. Review of risk assessment after an accident is a legal requirement.

Part 4 – Templates/ Risk Assessments

4.1 Accident reporting flow chart



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Part 5 – External references

HSE Reporting accidents and incidents at work INDG 453

HSE – RIDDOR reporting

HSE HS(G) 245 Investigating accidents and incidents

HSE Human Factors

Part 6 – Legal references

Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013

Accident & Incident Reporting and Investigation Policy and Guidance HSP12.0

Appendix 1 Accessing MySafety incident reporting software

For Services

On the intranet visit the intranet home page, type in 'MySafety' in the search section or you can click this MySafety link.

For Schools

On the Essex Schools Infolink Health and Safety Pages The incident forms can be found on the Essex School's Infolink. This is under 'Accident Reporting' or you can click this MySafety link.

There are five form options available:

1. Accident Reporting Form: This form is to record an accident.
2. Ill Health (work related): Report communicable disease via the employee's sickness record.
3. Near miss Reporting Form: This is a non-injury Incident (Near Miss). Report COVID-19 infections on this form.
4. Physically Harmful Behaviour Report Form (for Schools and Educational Settings): A Physically Harmful Behaviour Incident is defined as one in which a person has been harmed or injured by another person. This may have been unintentional or perceived as intentional and resulted in injury or harm to the individual or the work environment.
5. Violence (Physical and Verbal Abuse) Reporting Form

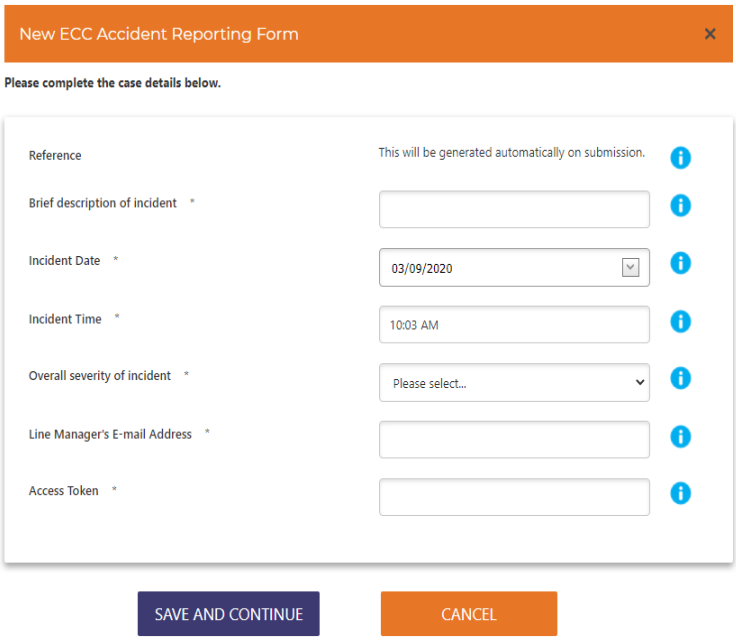
'physical harm' an event caused by an individual to deliberately cause harm to another person.

'verbal abuse' an event caused by an individual to threaten another person.

Use the bottom row of forms for hard copy versions.

When starting a new form, a pop-up screen will appear.

Reference: on the next screen.



Brief description of incident. In a few words describe the incident (i.e. Person tripped over stool, person slipped on liquid on floor).

Incident Date: This picks up the current date. If it occurred in the past, click on the drop-down and a calendar will appear. You can then select your date.

Incident Time: This picks up the current time. You can type over the time with the actual time of the incident, then click away from the box to keep the time.

(The time is rounded up to the nearest 15-minute mark if you press enter).

Overall level of incident: There are 3 levels:

Fatal. This is for a person that has died as a result of a work-related activity.

Major. This is for incidents that involved:

For employees:

- Amputation,
- Blinding,
- Fracture, (excluding finger, thumb or toe)
- Crush,
- Exposure to chemical or biological agents,
- Loss of consciousness, occupational diseases, Scalping, Serious Burns (covering 10% of body).
- This also includes a dangerous occurrence. A near miss which could have resulted in fatal or major injury.

Non-employees:

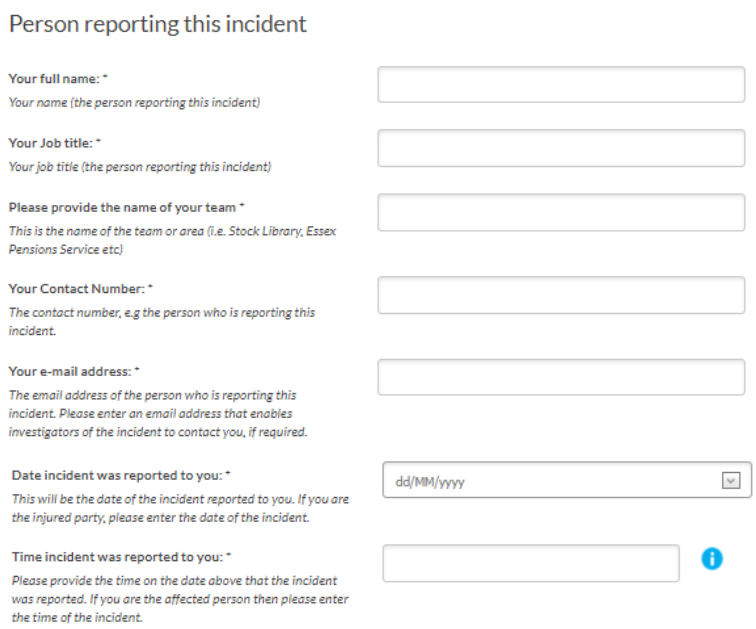
Anyone who taken directly to hospital for treatment.

Minor. This is for incidents that that do not involve any of the above.

Line Manager's email address. Provide your line manager's name. This will be the person that will be conducting the investigation. If you are a line manager for the area, then you can put your own email address in this field.

Access Token. This on the intranet before you enter the portal. This is an extra level of security to show that the form is being completed by an ECC employee.

Anything with an asterisk is mandatory.



Provide your **full name and job title**. CH&ST may contact you for further information.

Please provide the **name and contact details for your team**, this will be the team that you work with. If you are unsure, please speak with your line manager. This helps understand the part of the organisation that this occurred in.

Enter the date and time the incident was reported to you. This is to help understand the timeline to the incident. If this is the same date as the incident, then enter the same date.

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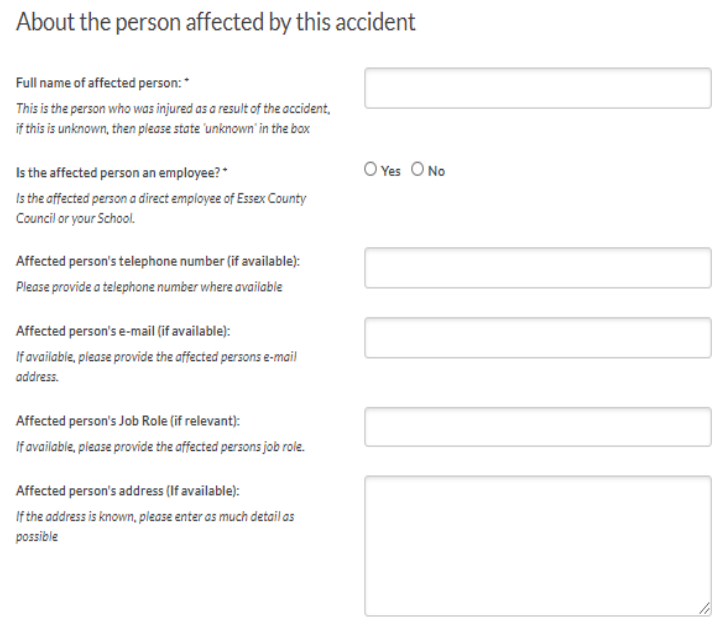


About the person affected by this accident

Full name of affected person: *
This is the person who was injured as a result of the accident, if this is unknown, then please state 'unknown' in the box

Is the affected person an employee? *
Is the affected person a direct employee of Essex County Council or your School.
○ Yes ○ No

Affected person's telephone number (if available):
Please provide a telephone number where available

Affected person's e-mail (if available):
If available, please provide the affected persons e-mail address.

Affected person's Job Role (if relevant):
If available, please provide the affected persons job role.

Affected person's address (If available):
If the address is known, please enter as much detail as possible

This section will capture who **the person affected by the incident**. In some cases, it might be yourself or the person is unknown, so please complete this to the best of your knowledge. This section includes:

- The affected person's name
- Their employment status
- Their contact number
- Their email
- Job role if it is relevant and
- Their address.

Different questions occur for employees and for non-employees. This helps to establish the actions needed with this incident going forward.

About the Accident/ Incident

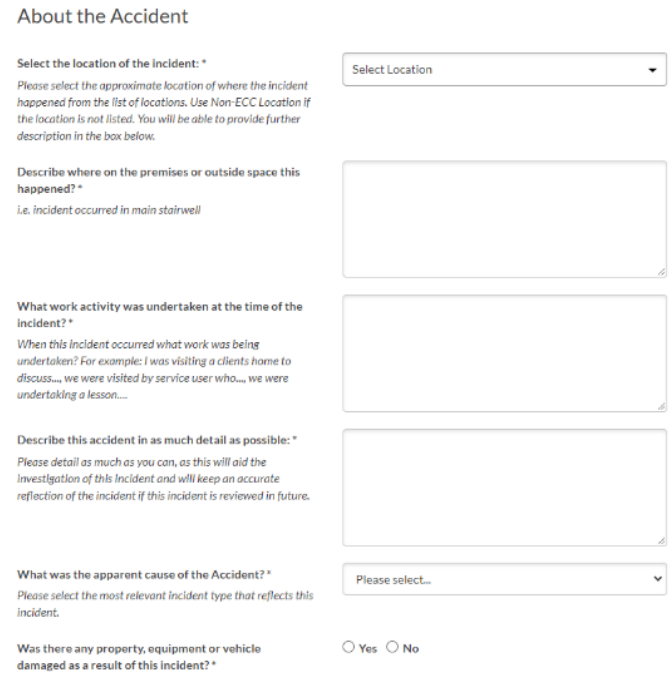
This section will vary depending on the form used. Also depending on if you select employee or non-employee above. On each form you can pick:

The location of your incident (there is a list of ECC locations and non ECC locations to choose from).

Describe the location where it happened. This is to help capture exactly where the incident occurred.

Describe the accident in a much detail as possible. This will help with the accident investigation.

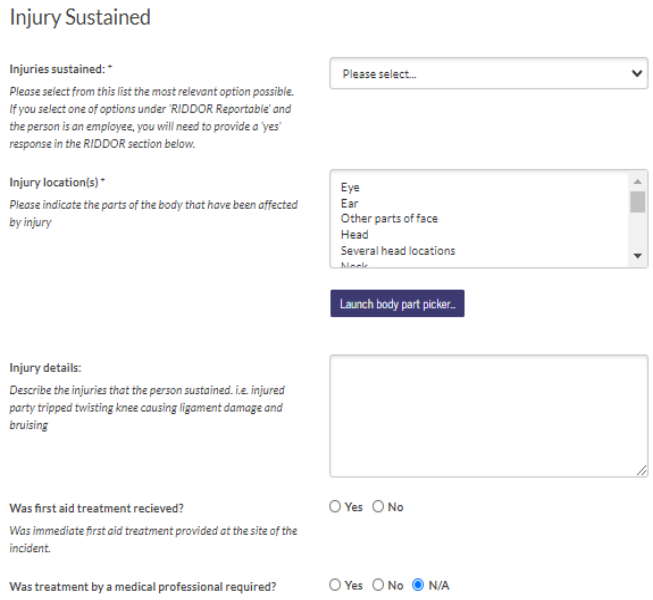
What was the apparent cause is of the accident? This statement appears on the accident and the ill-health forms.



The **Violence and Harmful Behaviour forms** ask about the events that led up to the incident. This provides a timeline to the incident. This includes potential triggers that may help stop a reoccurrence in future. It asks what affect it has had on the affected person.

For **Violence incident**, details of the assailant are also needed. This includes the relationship they have with Essex County Council. If you have a police reference number, please include this. Include any de-escalation techniques used by you or your staff.

Harmful Behaviour Form will just ask who the child/ young person was who caused harm.



Illness/ Injury Sustained (all forms except Near Miss)

Injuries Sustained. The drop-down box includes RIDDOR reportable events. More information will be needed if it refers to employees.

Injury Locations. You will have two options, to use the list or 'launch body part picker'. You can select the most relevant option by using the body map. The body map below is clickable, and you are able to click the relevant injured parts of the body. There is some online guidance to help you use the body map.

Injury Details. Provide more about the injury sustained (i.e. hairline fracture of the ankle, deep cut to the upper forearm).

First aid treatment. This part enables you to record any first aid given at the time of the incident. It also provides a place where you can record any first aid refused. This part is optional to complete.

Was treatment by a medical professional required? Where a person went to a doctor or onsite paramedic who provided medical treatment.

Attaching relevant documentation. Attach records if available. **Note**: Currently, you can only upload a single document, Add further documents at the bottom of the form.

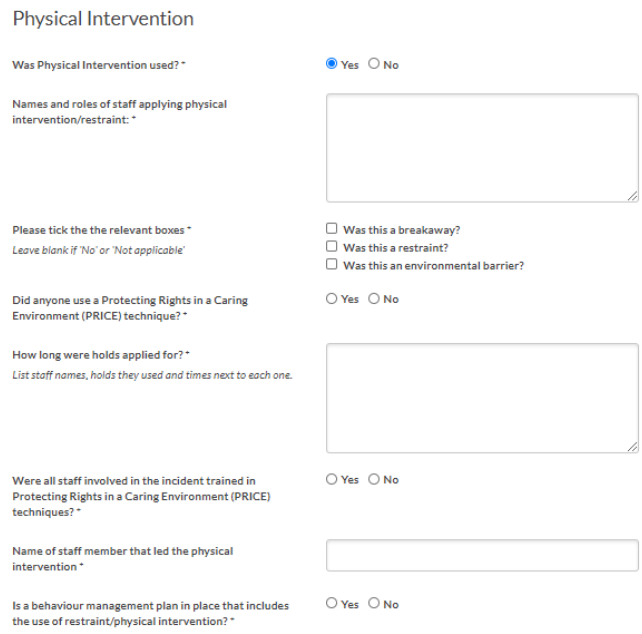
RIDDOR

This page helps your line manager and the CH&ST decide if the incident is reportable under RIDDOR. Answers to a series of questions confirm if it is reportable. If the CH&ST need to report this incident to the HSE, we need to know in which city, borough or district this occurred in. This page will provide information to confirm your responses about the incident. Please confirm the statement by selecting yes or no.

If it is a yes, then your line manager will need to complete the investigation within 5 days of the incident. You will also need to provide the district, borough or city council this incident occurred in.

Physical intervention

On both the violence and harmful behaviour forms, you can record information about **physical interventions** in this section. You can state:


Physical Intervention

Was Physical Intervention used? * — (•) Yes ( ) No

Names and roles of staff applying physical intervention/restraint: *

Please tick the the relevant boxes *
Leave blank if 'No' or 'Not applicable'
- [ ] Was this a breakaway?
- [ ] Was this a restraint?
- [ ] Was this an environmental barrier?

Did anyone use a Protecting Rights in a Caring Environment (PRICE) technique? * — ( ) Yes ( ) No

How long were holds applied for? *
List staff names, holds they used and times next to each one.

Were all staff involved in the incident trained in Protecting Rights in a Caring Environment (PRICE) techniques? * — ( ) Yes ( ) No

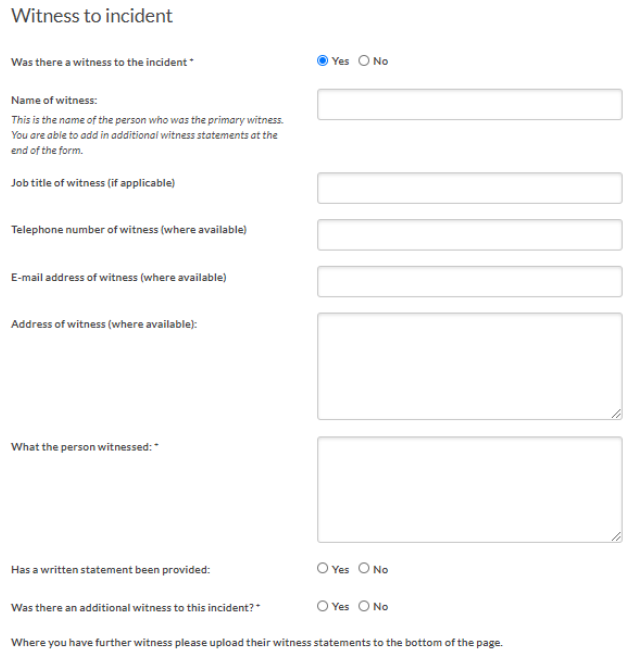
Name of staff member that led the physical intervention *

Is a behaviour management plan in place that includes the use of restraint/physical intervention? * — ( ) Yes ( ) No

- Those involved in the physical intervention
- The type of physical intervention used
- What training that staff had and
- Witness statement about the intervention.

Witness to the incident

If you click 'Yes' for witness to the incident, you can record the witness information here. This includes:


Witness to incident

Was there a witness to the incident * ◉ Yes ○ No

Name of witness:
This is the name of the person who was the primary witness. You are able to add in additional witness statements at the end of the form.

Job title of witness (if applicable)

Telephone number of witness (where available)

E-mail address of witness (where available)

Address of witness (where available):

What the person witnessed: *

Has a written statement been provided: ○ Yes ○ No

Was there an additional witness to this incident? * ○ Yes ○ No

Where you have further witness please upload their witness statements to the bottom of the page.

- The name
- Job title (if applicable)
- Telephone number (if available)
- E-mail (if available)
- Address (if available)
- What the person saw.

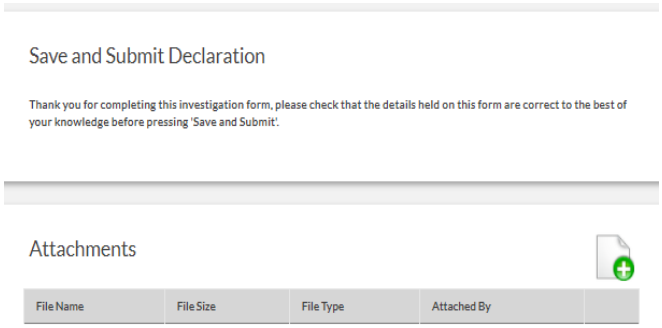
If you have a statement, you will be able to upload a single document.

Upload more witness statements at the bottom of the form. Managers can collate these and add them to the system at a later date if needed.

Save and Submit

As the name suggests, this part will provide you with the opportunity to finish and submit the form.

At the end you can Save and Submit or Cancel. At the start of this form, you provided an e-mail address for your manager. Clicking save and submit will send an e-mail to your line manager. The e-mail will provide a link to MySafety to complete the investigation.


Save and Submit Declaration

Thank you for completing this investigation form, please check that the details held on this form are correct to the best of your knowledge before pressing 'Save and Submit'.

Attachments

File Name	File Size	File Type	Attached By	

Upload more attachments as available by clicking the green plus logo. Attachments could include:

- More witness statements*
- Risk assessments*
- Training records*
- Assailants details (if more are available)*
- Any other injured parties*.

*Inform you line manager of any additional records you are uploading. The system allows them the opportunity to log

- witnesses; assailants and; other injured parties into the system.

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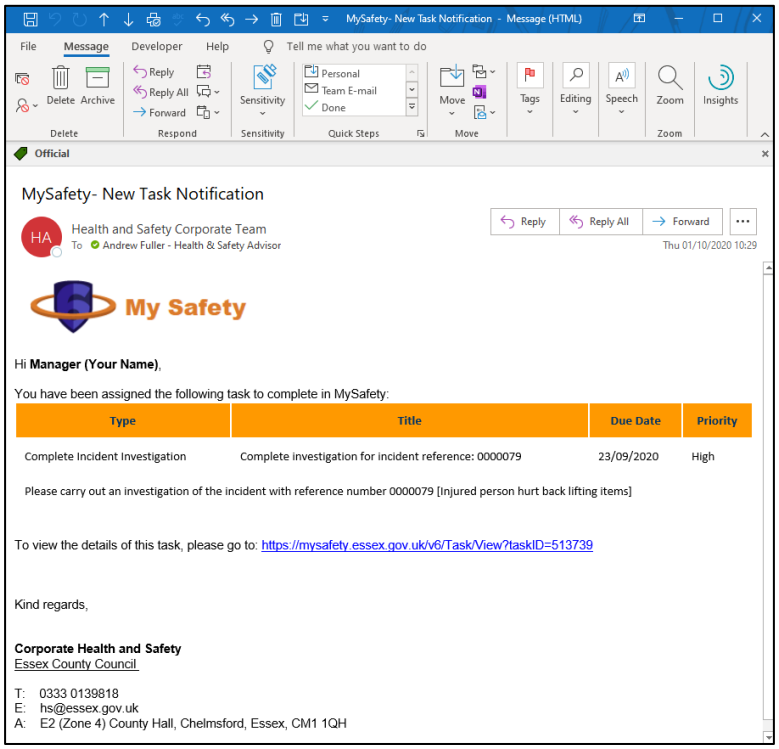
Appendix 2 MySafety investigation tool and checklists

All incidents reported trigger a New Task Notification e-mail to their line manager. This will provide a link straight into the system and take you to the task to complete the investigation. You can also access the system by clicking here.



Access is also available on the H&S intranet page. Type 'MySafety' in the search and the page for reporting will appear or click here.

Following the submission of an incident you will receive an email, as shown opposite:

Type: This shows what type of task you have been set

Title: This will tell you the reference number of the incident that you are being asked to complete.

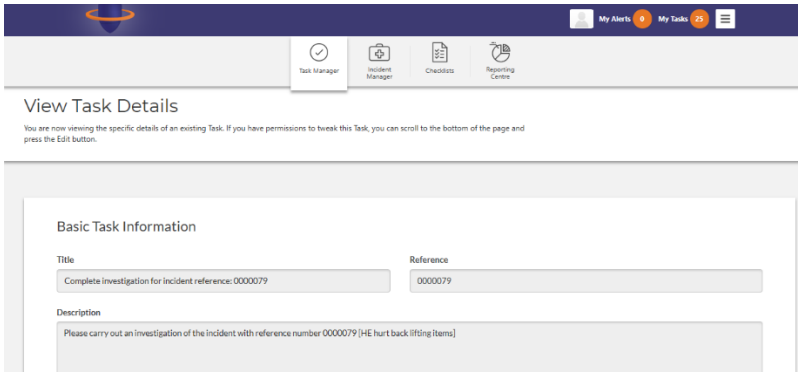
Due Date: This is when you will need to complete this task by.

Priority: There are 3 levels as describe at Appendix 1:

- Fatal
- Major
- Minor

Below the table. A description of the task with the brief description from the person who completed the form.

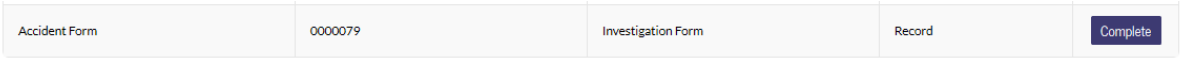
Link to the system. This will take you straight to the View Task Area and where you will find the investigation form.



View Task Details

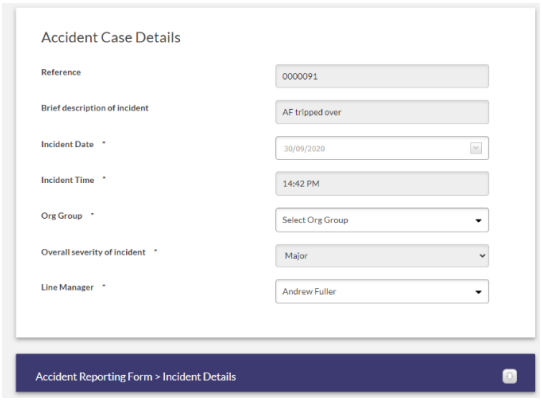
Clicking the link, logs you into the MySafety system. The screen opposite will appear, which confirms the task that you need to complete. Scroll down to the bottom of this page to Records Linked.

Under 'Records Linked to this task' select 'Complete'. This will take you into the record you need to investigate.

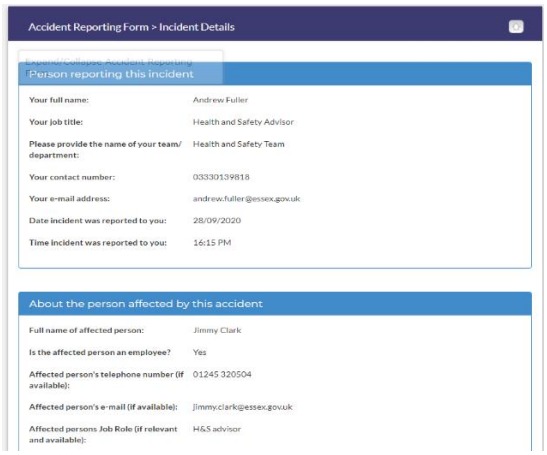


Accident Case Details

At the very top you will get some basic details about the incident you are investigating.



For further details about the incident, click on the drop-down icon. This will show you the full details of the incident that you are investigating (see below). Press the drop-down icon to hide the incident details



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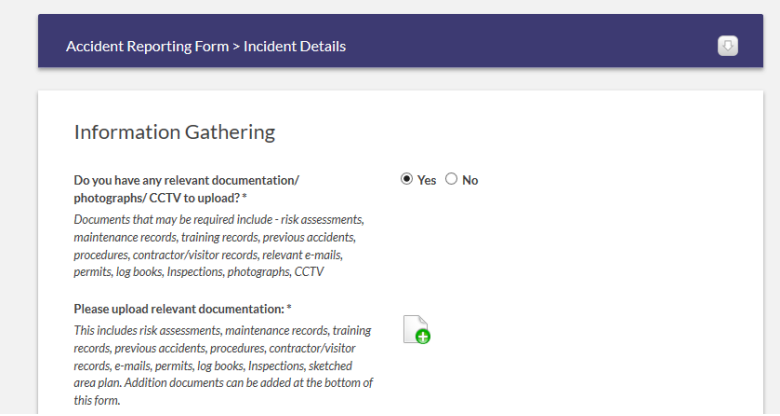
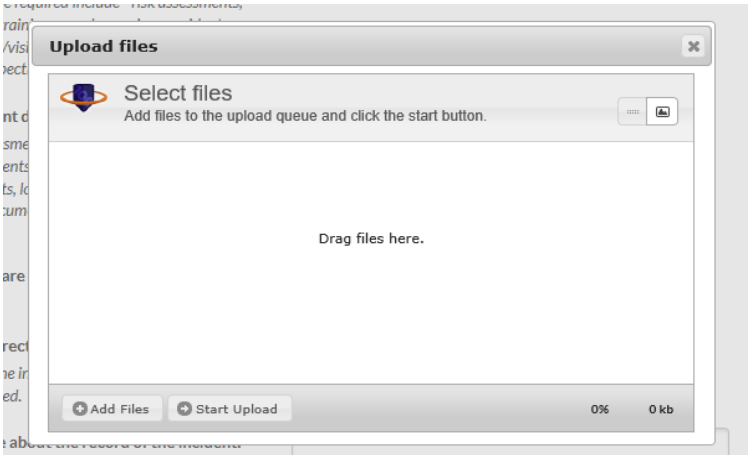
Information Gathering

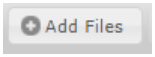
This section will capture information about the incident. There is guidance on the page to help with completing the form.



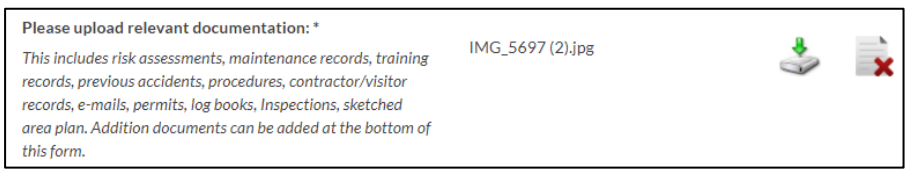
Uploading documentation, photographs or CCTV

Click on the  icon to drag your files into the box below.



You can also click  and browse for your file. Once your file is selected then the box will close and it will display your file as uploaded (see below IMG_5697 (2).jpg)

To view or change the document that you have uploaded, click on the  or click on the  to delete your upload.



Witness Statements

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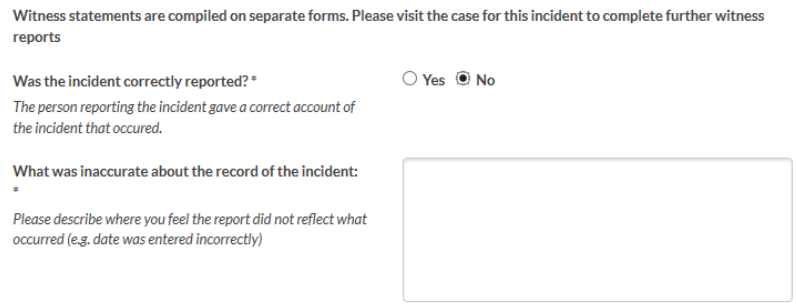
On the completion of this form there is the ability to record more witnesses to this incident.


Witness statements are compiled on separate forms. Please visit the case for this incident to complete further witness reports

Was the incident correctly reported? *
The person reporting the incident gave a correct account of the incident that occured.
○ Yes ◉ No

What was inaccurate about the record of the incident: *
Please describe where you feel the report did not reflect what occurred (e.g. date was entered incorrectly)

Was the incident correctly reported

If the incident was reported correctly, then you can move past this section.

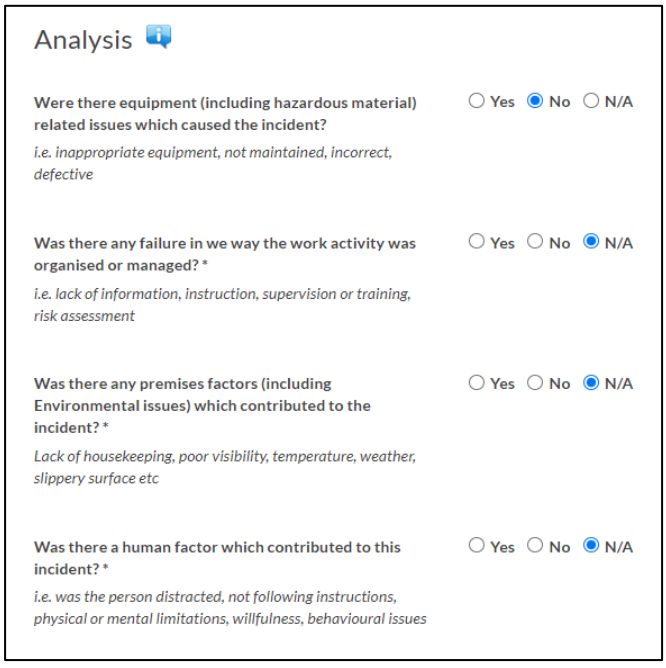
If there are inaccuracies in the original record that you wish to raise or clarify the details. If so, please select 'No', and use the box to reflect your changes.

For instance an incorrect:

- Account of the incident,
- Date/ time
- Location
- Record etc.

Or you may add extra information.

Analysis


Analysis

Were there equipment (including hazardous material) related issues which caused the incident?
i.e. inappropriate equipment, not maintained, incorrect, defective
○ Yes ◉ No ○ N/A

Was there any failure in we way the work activity was organised or managed? *
i.e. lack of information, instruction, supervision or training, risk assessment
○ Yes ○ No ◉ N/A

Was there any premises factors (including Environmental issues) which contributed to the incident? *
Lack of housekeeping, poor visibility, temperature, weather, slippery surface etc
○ Yes ○ No ◉ N/A

Was there a human factor which contributed to this incident? *
i.e. was the person distracted, not following instructions, physical or mental limitations, willfulness, behavioural issues
○ Yes ○ No ◉ N/A

This section provides an opportunity to get into the root cause of the incident. Completed this without bias and be objective. This part is broken down into:

1. Equipment (including hazardous material)
2. Failure in the way the work activity was organised or managed
3. Premises factors (including environmental issues)

4. Human factors
5. Was physical or harmful behaviour from a non-employee^ a factor in this incident
6. Was this incident a result of a playground or sporting incident
7. Did this incident involve a vehicle(s)
8. Was this incident a result of violence or verbal abuse

Review each section and select a response that reflects the cause of the accident.

Was physical or harmful behaviour from a non-employee^ a factor in this incident? *

Did the non-employee (^including Learner/ Service User/ Child/ Young Person) intentionally or unintentionally cause this incident.

Please select...

Was this incident a result of a playground or sporting incident?

Please select...

Did this incident involve a vehicle(s)?

This includes incidents involving vehicles, pedestrians or working on the road at the time of the incident.

Please select...

Was this incident a result of violence or verbal abuse?

This is relating from visitors and our service users (this excludes incidents of harmful behaviour which is covered above)

○ Yes ○ No ◉ N/A

The details of each checklist are shown in Appendix 3.

Each section provides a helpful checklist to identify issues and help analyse the incident and its cause. Each section also provides an ability to set actions by adding a Task. An example is shown below.

Were there a human factor which contributed to this incident? *

i.e. was the person distracted, not following instructions, physical or mental limitations, willfulness, behavioural issues

◉ Yes ○ No ○ N/A

Human Factors, please select the statements that apply: *

- ☐ The worker did not follow the safe operating procedures
- ☐ Workers did not have an appropriate level of skill and experience in the work being done
- ☑ Workers not trained to do the work (are there no training records)
- ☐ Workers not physically able to do the work
- ☐ Workers not in good health
- ☐ Worker fatigue or shiftwork likely to have had an impact (workers were not tired)?
- ☐ Worker stress (work or personal) is considered and deemed an likely factor
- ☐ Worker was not provided with enough time to complete tasks safely and procedures were not adhered to
- ☐ Workers were careless in not clearing up/ not signing the area or not reporting the issue

Below is an example of the physical or harmful behaviour, this section has an additional physical intervention question set:

Essex County Council

Was physical or harmful behaviour from a non-employee^ a factor in this incident? *

Did the non-employee (^including Learner/ Service User/ Child/ Young Person) intentionally or unintentionally cause this incident.

Yes

Please select the appropriate statements that contributed to the physical or harmful behaviour:

- ☐ Non-employee - Previously unseen and unpredicted behaviour
- ☐ Non-employee - Previously seen behaviour
- ☐ Non-employee - Understanding of behaviour needs further assessment

Did the physical/ harmful behaviour result from the way the person^ responded? *

^Adult who was with the child or young person

◉ Yes ○ No ○ N/A

Please select the appropriate statement where the member of supporting staff contributed to the physical or harmful behaviour:

- ☐ Member of staff supporting non-employee had not been trained to respond appropriately
- ☐ Member of staff supporting non-employee did not follow agreed response or management plan

Was Restrictive Physical Intervention used? *

This includes the Steps Approach (provided by ESSET), Team Teach, Protecting Rights in a Caring Environment (PRICE), or any other recognised Restrictive Physical Intervention (RPI) programme

○ Yes ○ No ◉ N/A

If you have selected yes to any of the above items on the checklist above, please describe the equipment issues that were found:

If the above doesn't adequately describe the issue, please provide a description here.

The bottom step was bent before the caretaker used it and there was no record of step ladder inspections.

From the equipment failure described above, what was the underlying reason for that failure

i.e. PPE not worn because of lack of availability, mechanical failure due to lack of maintenance, play equipment was not checked prior to use etc

Lack of maintenance, inspection and lack of training.

If you check any boxes in the above section, then:

In the first box, provide the detail about the issue. i.e. Employee had not attended work at height training.

In the second box describe the underlying reason i.e. person wasn't adequately trained.

You can set tasks and actions within the system to prevent a re-occurrence. To do this click Add Task

Add Task

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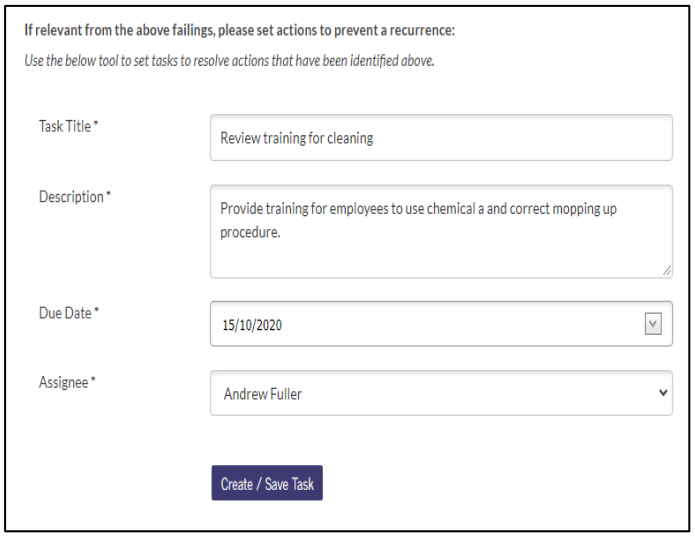
How to add a Task



This is a reminder for you to follow up an action or for a colleague to complete. Ensure that you provide enough detail for them to complete the task.

You can see from the box it is broken down into Task Title (keep this brief and to the point).

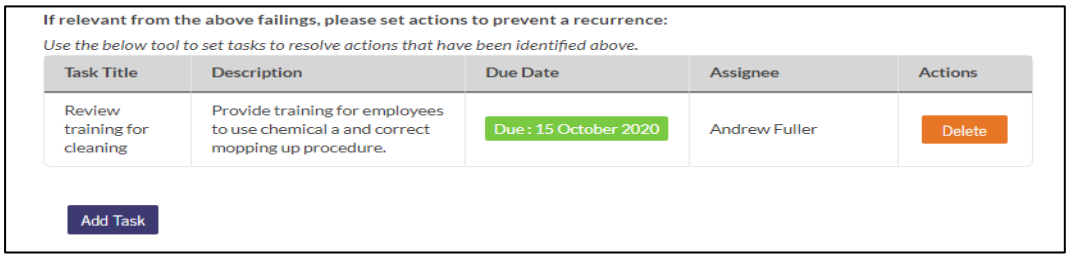
Description (be descriptive as possible to complete task).

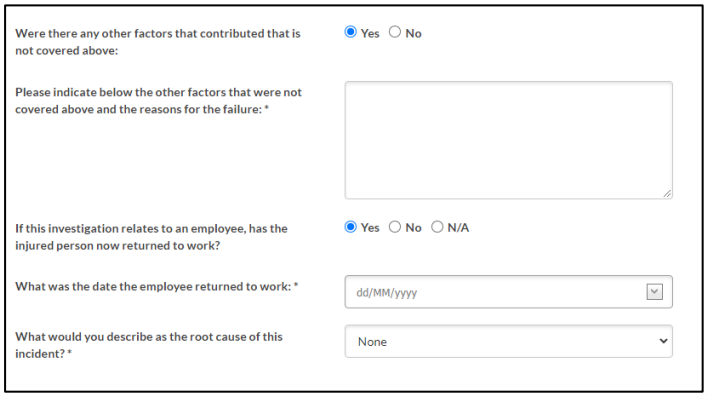
Due Date (provide a realistic timescale taking into consideration how urgent the task is).

Assignee (this is a drop-down list of persons within your area,)

Once finished select Create/ Save Task.

A confirmation of your task appears, which you can delete of add a new task.



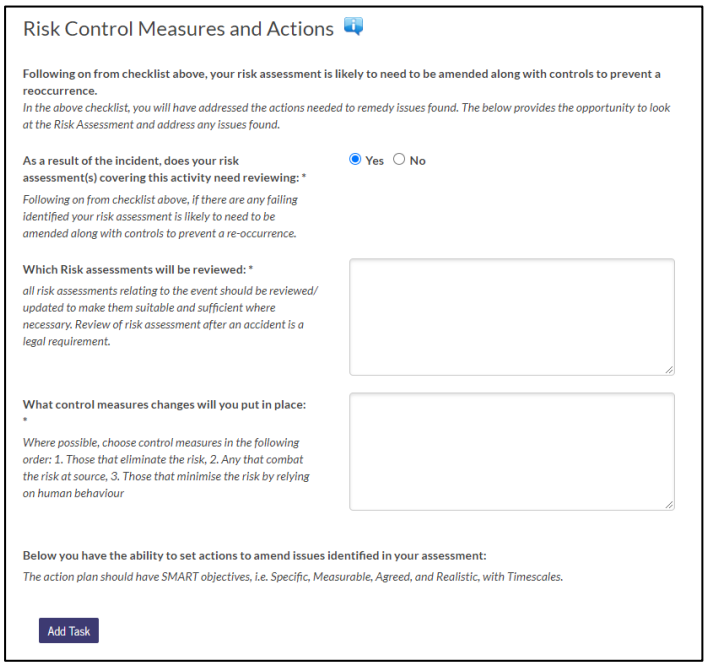


At the end of the analysis section you can include any other factors.

You can also state if and when they have returned to work.

The final box in this section provides the root cause for this incident. The details entered above should provide sufficient details to decide this.

Risk Control Measures



Legally after an accident, the risk assessment for the activity will need reviewing. Use the analysis section as a guide.

Use the 'Which Risk assessments will be reviewed' box to list all risk assessments reviewed.

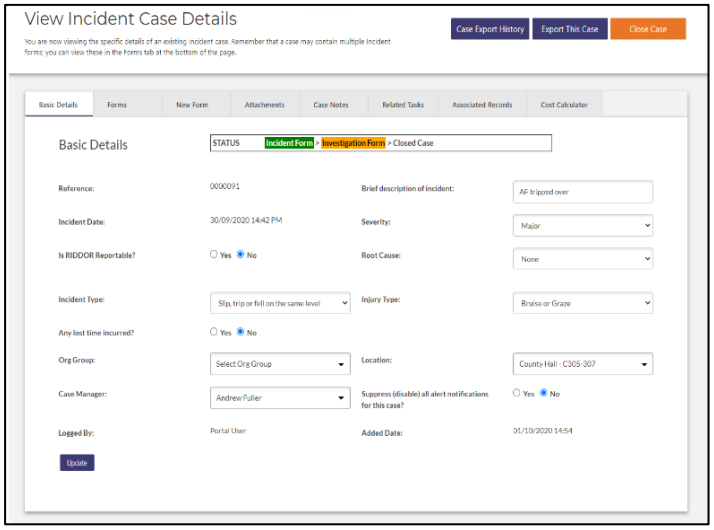
Use the information from the analysis section to decide what control measures need amendment.

At the end of this section click on Add Task to assign yourself or colleague/s an action.

Save and submit your investigation and, if needed, add any additional documents.

Case Management - When you click 'Save' or 'Save and Submit' View Incident Case Details screen will appear. Here you will see general key points about the incident.

There are tabs across the top that you can use as appropriate



Forms – This shows the forms that have been completed so far.

New Forms –Add more injuries, assailants and witnesses to the incident.

Attachments – This shows all attached files uploaded in the incident / investigation form.

Case Notes – You can add any extra notes as required to this incident outside of the forms.

Related task – Any tasks that you have set in the investigation will appear here.

Associated Records – This is where one or more associated records can be linked.

Cost Calculator – For more in-depth analysis of the cost of the incident, you can use this tool e.g. Property Damage.

You can also see the status of the incident case.

- If the status shows Green, the form has been completed.
- If Amber the form is in the process of being completed.
- If Red the form has not been started.
- It also shows if the record is closed.

This is the last part of the incident reporting process and closes the record (e.g. no further action needed). You can close the incident by selecting close case in the top right corner. At any time, you can go back into the case and re-open the record to add any further information or attachments

Appendix 3 Individual investigation checklists

Equipment section

The equipment condition was not as purchased and installed (Not broken or modified)

The equipment was not regularly maintained/ inspected/ examined and not in good working condition

The equipment was not for its' intended purpose (e.g. using a hammer on a screw)

The equipment guarding was not adequate/ broken or not working.

Safety measures associated with the equipment were not working (e.g. local exhaust ventilation)

There was a fault with the equipment design that contributed to the incident occurring.

Hazardous products not used appropriately for the task

Hazardous products not mopped up after use

Hazardous products not stored appropriately

The assessment was inadequate in assessing Personal Protective Equipment (PPE) for the task

There was a lack of Personal Protective Equipment (PPE) for the task

The person chose not to use Personal Protective Equipment (PPE) (including a lack of supervision)

Appropriate tools/ materials for the work unavailable for use

The lockout mechanism unavailable for use (stop button/ gas/ electric shut off)

Management/ Organisation section

The hazards and risks had not been previously identified and assessed in a specific risk assessment.

The controls had not been implemented to eliminate the hazards or control the risks

Pertinent safety documents were not made available? (e.g. risk assessments/ safe working procedures)

The safety documents were not communicated to and understood by all employees

The work procedures were not being enforced (i.e. supervisors were not checking)

The inspection of the workplace taken place had not undertaken within an appropriate timescale

Relevant poor condition(s) or concern(s) were reported but not dealt with beforehand

Work activities proceeded despite weather conditions being unsatisfactory

Housekeeping conditions were inadequate

Premises (including environmental issues) section

Were the weather conditions satisfactory (unlikely to have had an impact)?

Were trip hazards or spillages not picked up during housekeeping?

Was the area adequately ventilated (No dust/fumes)?

Were workers exposed to high or low temperatures without suitable controls?

Were noise levels satisfactory (did you need to raise your voice within 2m of each other)?

Was there adequate lighting (No missing or broken lamps)?

Were there potential falls from height (adequate guards rails/ no harness)?

Was access / egress not maintained (Clear passageways and exit doors)?

Was the surface inadequate (trip hazards caused by poor condition of flooring)?

Was the area concerned poorly maintained (nails sticking out/ wood splintering)?

Was the safety surface worn or was there a lack of depth in the loose safety surface?

Was the ground where the incident happened checked before use?

Human Factors section

The worker did not follow the safe operating procedures

Workers did not have an appropriate level of skill and experienced in the work being done

Workers were not physically able to do the work

Workers not in good health condition

Workers fatigue or shift-work likely to have had an impact (workers were tired)

Workers stress (work or personal) is considered and deemed a likely factor

Worker was not provided with enough time to complete tasks safely and procedures were not adhered to

Workers were careless in not clearing up/ not signing the area or not reporting the issue

Behaviour (violence & aggression) section

Non-employee – Unknown behaviour caused incident

Non-employee – Known behaviour caused incident

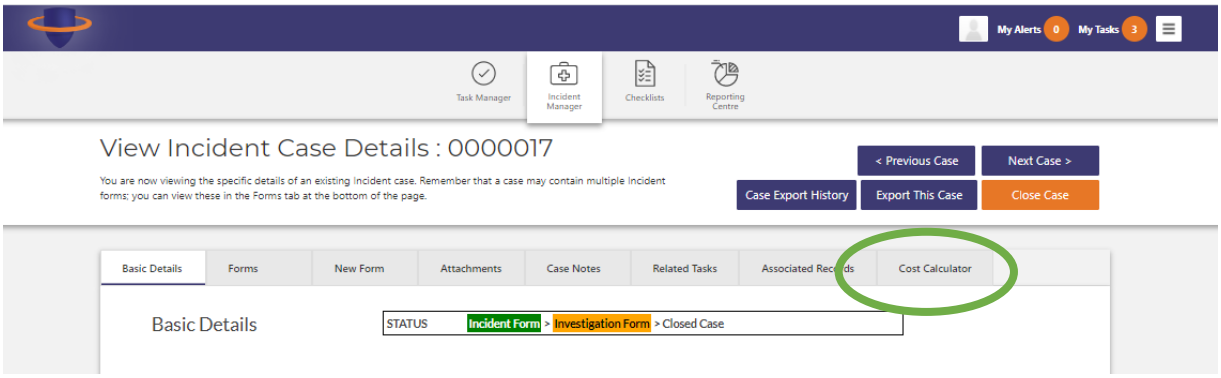
Non-employee – Assessment for behaviour is inadequate

Non-employee – Repeated behaviour caused incident

Non-employee – There was a lack of Physical Intervention training

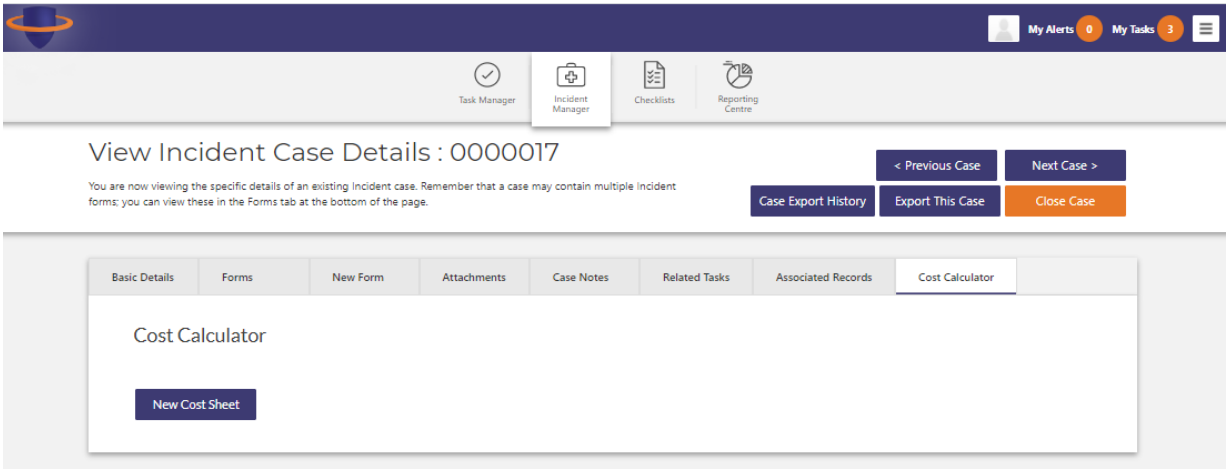
Appendix 4 The cost of accidents

MySafety has a cost calculator as part of the incident investigation process

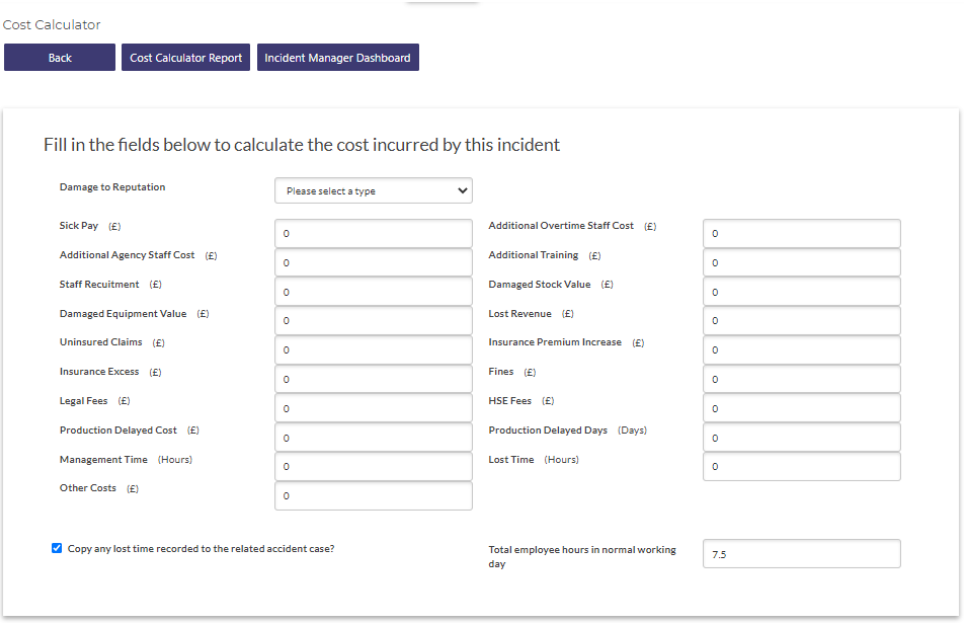


Click the Cost Calculator tab

Then click New Cost Sheet



The Cost Calculator will appear, simply complete each box



Then click the Cost Calculator report button

Cost Calculator

Back | Cost Calculator Report | Incident Manager Dashboard

Fill in the fields below to calculate the cost incurred by this incident

Damage to Reputation	Please select a type		
Sick Pay (£)	1,000	Additional Overtime Staff Cost (£)	300
Additional Agency Staff Cost (£)	200	Additional Training (£)	0250
Staff Recuitment (£)	150	Damaged Stock Value (£)	0
Damaged Equipment Value (£)	0	Lost Revenue (£)	0
Uninsured Claims (£)	0	Insurance Premium Increase (£)	0
Insurance Excess (£)	10,000	Fines (£)	0
Legal Fees (£)	£10,000	HSE Fees (£)	£12,000
Production Delayed Cost (£)	0	Production Delayed Days (Days)	0
Management Time (Hours)	98	Lost Time (Hours)	0
Other Costs (£)	120		

☐ Copy any lost time recorded to the related accident case?

Total employee hours in normal working day: 7.5

Appendix 5 The '5 Whys' Root Cause Analysis

One way to investigate accidents to find the root cause is known as the 5 Whys. This Root Cause Analysis uses three steps:

1. Define the problem
2. Analyse the causes
3. Select the best solutions

The first step of this type of Root Cause Analysis is to define the problem by asking the four questions:

- What is the problem?
- When did it happen?
- Where did it happen?
- And how did it impact safety?

Root Cause Analysis can be applied to the sinking of the Titanic.

One person may say that the problem was the Titanic sank. Another person might say that the problem was that it hit an iceberg, and a third person could say that the problem was it filled with water.

We can write down these three "problems" on the first line. Most group may disagree, so all three responses are written down.

When and where should have been already recorded in the accident report.

The Titanic sank several hours after it hit the iceberg. The date the Titanic hit the iceberg was April 14th, 1912 at11:40 pm and at about 2:20 am on the morning of the 15th the ship was under the surface. The accident happened away from the normal workplace.

What	Problem(s)	Titanic sank, Ship hit an iceberg
When	Date	14/04/1912
	Time	11:40 pm ship struck an iceberg
		15 April 1912 02.20 am ship underwater
Where	Site address	Whitestar line UK
	Event address	North Atlantic Shipping Lane, Labrador Current
	Specific location	41^0 46' N latitude, 50^0 145' W Longtitude

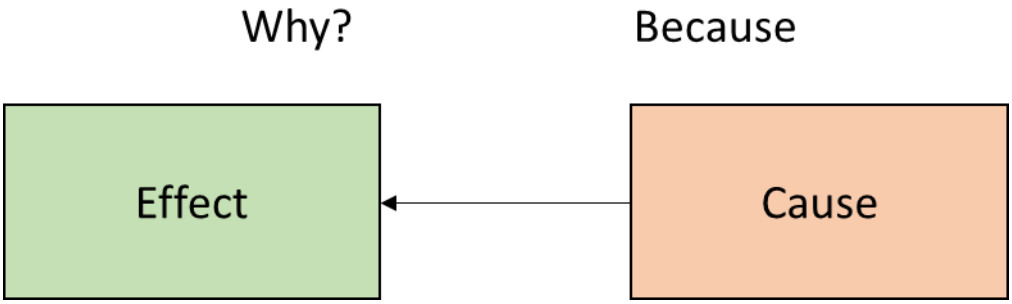
Safety impacts	**Loss of 1,500 lives**

The analysis step is where the incident is broken down into causes which are captured on a flow chart or Cause Map.

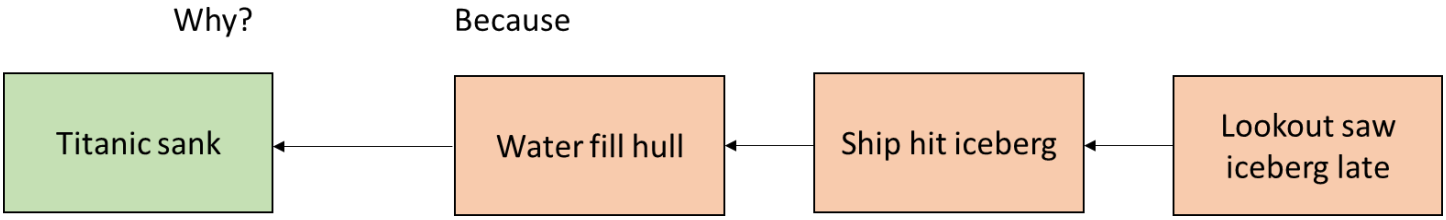
The flow chart starts with an effect – the Titanic sank, to which you ask Why?

The response to that Why question is because, which identifies the Cause.

The cause goes to the right and an arrow links them going from cause to effect.

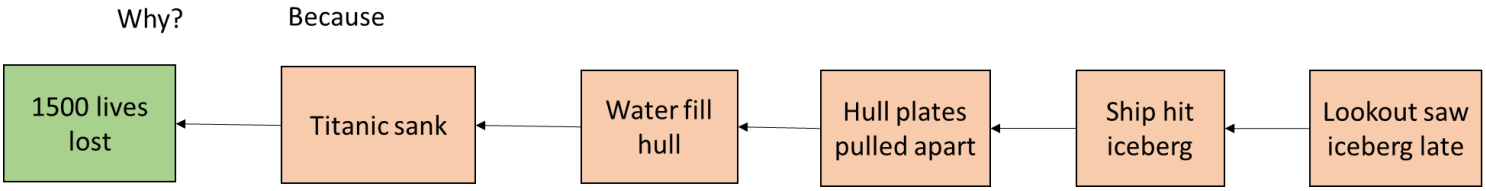


The Cause Map starts by writing down the goals that were affected as defined in problem outline. For the Titanic the safety goal was impacted because of the 1500 lives that were lost and the vessel goal was impacted because the entire ship was lost. These are the first two cause-and-effect relationships in the analysis.



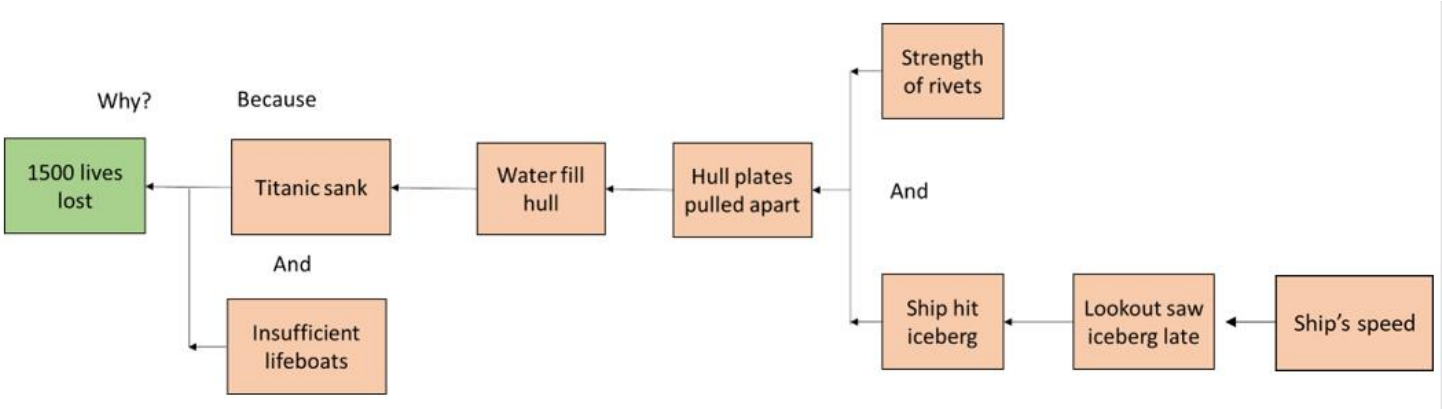
In reality, the sinking of the Titanic was the cause of the safety impact of losing 1500 lives

You can see how this is true, it is accurate and clear. You could ask why the lookout saw the iceberg late and delve deeper into the root and underlying causes.



You could also say that the reason that the water filled the hull is because the hull plates pulled apart at the seams.

added



Looking deeper you could ask: Why were there insufficient lifeboats?

Because it was deemed unnecessary.

Why?

Because it we considered unsinkable -It was widely believed that ice posed little risk; close calls were not uncommon, and even head-on collisions had not been disastrous.

The Titanic complied with maritime safety regulations of the time. The sinking showed that the regulations were outdated for such large passenger ships.

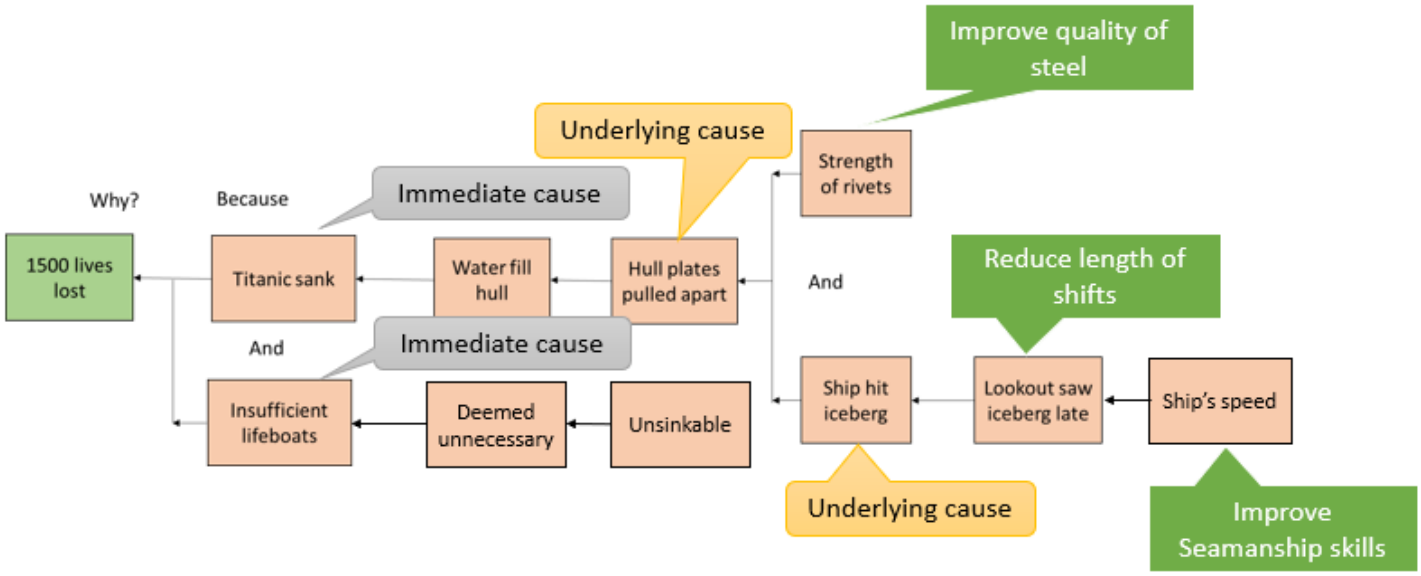
The Inquiry also revealed White Star Line wanted fewer boats on the decks. This was to provide unobstructed views for passengers and give the ship more aesthetics from an exterior viewpoint.

Similarly, you can ask. Why did the look-out see the iceberg late?

Because the ship's speed was to high (18 – 20 knots)

Why?

Because the North Atlantic liners prioritised timekeeping above all other considerations. They stuck rigidly to a schedule that would guarantee arrival at an advertised time. They were frequently driven at close to their full speed, treating hazard warnings as advisory rather than calls to action.



Now we can see the immediate, underlying and root causes. This should enable the identification of appropriate control measures.

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Appendix 6 Levels of reporting and recording difficult or harmful behaviour

Level 1 When there was no need for first aid or medical attention, or when there is no long-term anxiety or stress as a result of the incident for a member of staff	**Level 2** When there was a need for first aid or medical attention, or if the staff member experiences long term anxiety or stress as a result. When there was a need for non-restrictive physical intervention	**Level 3** When it was deemed absolutely necessary to use restrictive physical intervention in order to co-regulate the child/young person and prevent harm (where this is an agreed intervention to manage the harm as part of the Adult Response Plan/Behaviour Support/ Management Plan)	**Level 4** When it was deemed absolutely necessary to use restrictive physical intervention in order to co-regulate the child/young person and prevent harm (when this has not been an agreed intervention to manage the harm as part of the Adult Response Plan/Behaviour Support/ Management Plan)
These are behaviours that are likely to be responsive to the usual range of support and interventions set out within the school behaviour policy. They will also be monitored and reviewed through personalised 'One Planning' when appropriate. Examples of such behaviours: • Eating or mouthing non-edible items, such as stones, dirt, pen lids, bedding, metal, faeces • Smearing of faeces • Rocking, repetitive speech and repetitive actions or manipulation of objects • Absconding removing of clothing items • Self-injury/harming, including head banging, scratching, hitting, kicking, biting and poking • Language-based personal abuse or sexual comments • Racist, sexist, or homophobic behaviour or comments	These will encompass behaviours that have duration, frequency, intensity or persistence and are beyond the typical range for the school. Such behaviour is less likely to be responsive to the usual range of support and interventions identified within the school behaviour policy. These behaviours may also: • compromise the child or young person's own and / or other CYPs learning • disrupt the day to day functioning of the school, making it a less safe and routine environment • Language-based persistent personal abuse or persistent sexual comments • Persistent racist, sexist, or homophobic behaviour or comments	These will encompass behaviours that are harmful in that they compromise the safety and wellbeing of the child/young person or staff. This will include: • causing harm towards adults or other children/young people (including pushing, punching, kicking, biting, scratching, spitting, head-butting) • causing harm to the learning environment, including that of property • striking another adult / child or young person with an object	These will encompass behaviours that are harmful in that they compromise the safety and wellbeing of the child/young person or staff: This will include: • a one-off serious incident involving behaviour not previously observed in the child or young person • causing harm towards adults or other children/young people (including pushing, punching, kicking, biting, scratching, spitting, head-butting) • causing harm to the learning environment, including that of property • striking another adult / child or young person with an object
Expected Reporting and Recording			
Systematic reporting and recording at the school/setting level in accordance with policy.	Systematic reporting and recording at the school level in accordance with policy. When Headteacher deems appropriate, these incidents may also be reported to ECC via MySafety	Systematic reporting and recording at the school level in accordance with policy. These incidents must be reported to ECC via MySafety	Systematic reporting and recording at the school level in accordance with policy. These incidents must be reported to ECC via MySafety

Accident & Incident Reporting and Investigation Policy and Guidance HSF 12.0