



Accident and Incident Reporting and Investigation Policy

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1. Introduction

This compliance code and its associated guidance will ensure our duties relating to incident investigation are met, including reporting serious incidents to appropriate enforcement bodies..

2. Scope

This compliance code applies to all incidents, incidences of ill health, or near misses which occur to employees or non-employees where there is evidence that they are related to the work of Norfolk County Council (NCC) or NCC schools – that is, that one of these factors played a significant role in an incident or the development/exacerbation of an ill health condition:

- the work activity and the way the work was carried out or the management of the work, including violence to an employee (as defined below),
- any machinery, plant, substances, or equipment which was used for the work,
- or the condition of the site or premises.

Incidences of work-related stress and associated illnesses are within the scope of this compliance code where it is due in significant part to the role of the employee; this would include the nature of the role, incidents which occurred as a part of the role, or the way the risks of the role have been managed.

Conflicts between individuals (including employees) or individuals and organisations are not within the scope of this policy unless they constitute violence (either physical or verbal, as defined below), even if they lead to possible stress and ill-health, and should be managed in accordance with other NCC policies as appropriate.



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3. Principles

NCC has in place an effective and efficient system for recording, responding to and learning from incidents, near misses and cases of work-related ill health, in a way which is proportionate to the circumstances, to reduce negative impact on NCC's employees or others affected by its work. The aim is to:

- identify incidents that require statutorily reporting in a timely manner.
- undertake incident investigations proportionate to risk and severity in order to understand the direct and the underlying causes of incidents, establish appropriate corrective actions or measures, and put those measures in place to prevent any reoccurrence of the incident.
- identify incidents that require investigation and intervention by the Health, Safety and Wellbeing team (HSW)
- enable the development and reporting of management information regarding incident trends and issues

4. Responsibilities

The roles and responsibilities of all employees in NCC Services is outlined in the Health and safety organisation and responsibilities policy P611. This includes responsibilities regarding the recording, investigating and monitoring incidents.

Responsibilities in schools where NCC is the employer (Community, Voluntary Controlled or maintained schools) are set out in Model School Health and Safety Commitments Part 1 P611s and Model School Health and Safety organisation, responsibilities, and arrangements P611s Part 2.

4.1 Specific Line Manager Responsibilities

- Ensuring arrangements are in place to deal with the immediate dangers and consequences of an incident, including: first aid, making the area safe, contacting the emergency services where necessary.
- Ensuring incidents are reported and an investigation is carried out by a competent person in a timely manner proportionate to the risk and severity of the incident.
- Ensuring the findings and all actions arising from investigations are recorded in line with this compliance code and that all OSHENS incidents assigned to them are signed off after review.
- Providing management support to the injured party where required and ensuring that they are advised of the incident investigation outcome and any relevant actions.
- Informing the HSW team of serious incidents in line with this compliance code.
- Ensuring the HSW team is notified where an enforcement agency contacts them directly regarding an incident to enable professional support to be provided as appropriate.
- Periodically reviewing incidents and near misses for their area, looking for trends and taking appropriate action to ensure avoidance of repeat incidents.
- Ensure that a member of their Senior Management Team is notified in the event of a serious incident.



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4.2 Health, Safety and Wellbeing Team

- Make statutory reports to the relevant enforcement agency as necessary
- Undertake investigations as appropriate according to the risk and severity of the incident
- Liaise with enforcement agencies on behalf of NCC as appropriate
- Ensure that Senior Management and the Head of Health, Safety and Wellbeing are informed in the event of a serious incident occurring.

5. Reporting incidents

The following events must be reported on OSHENS:

- Incidents, whether they result in injury or not
- Incidents involving unreasonable behaviour (as defined in Managing unreasonable behaviour compliance code P630)
- Work related ill-health
- Near misses
- Incidents where there was damage to a building or property

Some incidents can be so serious that anyone aware of such incidents must contact the HSW team straight away, as well as reporting them via the online system. These are incidents that may be formally reportable to the Health and Safety Executive or that are serious enough that HSW may need to assist in or lead the investigation.

Examples of the sort of incidents where the HSW team should be contacted include:

- Where serious injury occurs such as a fracture, amputation, loss of sight, crush injury, significant burn, or loss of consciousness of an employee
- Where an employee is off work or changes their duties for more than seven days as a result of an incident
- Where a member of the public, pupil, service user, or contractor is seriously injured
- Where a dangerous event occurred, even if no-one was harmed, for example plant or equipment coming into contact with overhead power lines, an explosion or fire, the collapse of a lift, or a suspected uncontrolled release of asbestos-containing material
- Where a doctor has certified a work-related disease or health condition such as occupational asthma or carpal tunnel syndrome
- Where you consider enforcing agencies may be made aware of the incident, for example through the media or a complaint
- The death of an employee or service user no matter what the circumstances are

Please note:

- This list is not exhaustive and if in doubt employees should treat the incident as serious and contact the HSW team who will then advise you appropriately. The Head of Health, Safety and Wellbeing will determine which incidents fall within these definitions where there is any uncertainty.



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- Managers must ensure that a member of their Senior Management Team is notified in the event of a serious incident. The SMT member may be needed to: support actions arising from the investigation, assist with business continuity needs, and ensure information is communicated appropriately, for example within the Department or in relation to press and social media, and work with any external investigation authority.

The HSW team can be contacted on 01603 5735623 or email healthandsafety@norfolk.gov.uk

6. Incident Investigation

All managers have a duty to ensure all incidents that relate to their teams are investigated in a timely way by someone competent to do so. This is important to ensure preventative action is put in place before another incident occurs, to help identify if the incident is formally reportable, and to share any learning more widely to prevent incidents elsewhere in the Council. All employees have a duty to cooperate with any investigation.

All incidents and investigation details must be recorded on OSHENS. Even if the investigation has been undertaken, if it is not recorded appropriately then should a similar incident be investigated by an enforcing body, such as the HSE, then the lack of evidence that care has been taken to keep incidents from recurring may be seen as demonstrating inadequate measures to keep people safe.

Managers must feed investigation information back to the injured or affected party/parties following investigation, so that they can be assured the incident has been looked into and are made aware of any necessary actions.

Having been notified of an incident and given basic information on what happened, the manager must decide what level and depth of investigation is appropriate. The potential consequences and the likelihood of the incident recurring must be used to determine the level of investigation, not simply the actual injury or ill health suffered on this occasion. Any incident should trigger the review of relevant risk assessments and their control measures to ensure they are suitable and sufficient.

For a minor incident, for example where the potential consequences and the likelihood of it happening again are both low, or the causes of the incident (both the immediate and underlying causes) are easily identified and there are simple actions which can be taken to prevent it happening again, then a simple investigation by the line manager and recorded in the 'Initial Investigation' section of the online reporting system may be all which is needed.

For more significant incidents a more thorough investigation using the local or full investigation tab on the online system may be required. A local investigation may be carried out by a line manager or their nominated competent person; a full investigation will require the involvement of the HSW team.

6.1 Making safe and preserving the scene following an incident

Following a significant incident, emergency procedures such as first aid and making the situation safe (where possible and safe to do so) must be followed. After this, the scene



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should be left as it was when the incident occurred so that investigators can observe it. This might require closing off the area by setting out barriers, locking doors, and putting up notices to restrict access.

The safety of any investigators should also be considered. When there is any doubt whether an area is safe to enter then access to it must be controlled until a competent person has assessed it. For example, if asbestos-containing material has been damaged, there must be no access to the area until a qualified asbestos surveyor or other competent person has assessed the situation and ensured it is safe for people to enter.

6.2 Timing of the investigation and resulting actions

Investigations should be carried out as soon as reasonably possible after the incident to allow all unsafe actions or conditions to be fixed as soon as possible, to prevent any further incidents occurring. However, where people have been injured or a traumatic event has occurred, this must also be taken into account.

It is important that employees involved in traumatic events are made aware of the means of support available to them, such as Norfolk Support Line. Where several employees witness an event or are involved, critical incident support can be arranged through the HSW team.

Where significant remedial action is required, initial temporary measures may be needed before the full solution can be implemented. For example, following failure of emergency lighting access to an area may need to be temporarily restricted, or torches and additional employee training utilised while waiting for new or upgraded emergency lighting to be installed.

6.3 Gathering Information

Various types of information may need to be recorded, including anything which may help establish the immediate, underlying and root causes of an incident. The information and degree of detail needed will depend on the incident but may include:

- Information such as environmental conditions (noise, temperature etc) at the time of the incident.
- The activity and chain of events at the time the incident occurred.
- Any working procedures relevant to the activity e.g. risk assessments, safe systems of work.
- The names of any witnesses to the incident (and statements where appropriate).
- Physical features of the workplace that may have contributed e.g. cluttered flooring, over stacked shelving etc.
- Photographic evidence of the work area at the time of the incident.
- Physical details of the scene such as sketches or plans showing the position of people, equipment etc. Measurements may also be helpful.
- Relevant records e.g. for training, inspection, servicing and maintenance.
- Establishing whether any statutory or other notifications of the incident are required and the procedure for this.



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6.4 Being objective

An incident investigation should be undertaken with an open mind as to how it occurred. Though the investigation may point towards an act or omission by an employee, the primary purpose of investigating incidents is not to establish blame, but to establish what happened to prevent future occurrences – this should be made clear to people involved in the investigation. Where employees feel they may be blamed they are less likely to report incidents or be honest about the events that led to an incident occurring, meaning unsafe acts or conditions may continue.

6.5 Interviews and statements from witnesses and people involved in the incident

Depending on the circumstances of the incident, witnesses may be employees, partner organisation employees, contractors, members of the public, pupils etc. Witnesses need to provide accurate information about their recollection of the incident, along with any other information they may have that would help to understand why it happened. The status of the information must be made clear: actual knowledge, belief, conclusion from other events, or information received from others.

Indirect witnesses are individuals who may be able to provide information about the causes or contributory factors relating to the incident, but who were not direct witnesses to the incident itself. For example, they may have been involved in the development of a relevant risk assessment or have previously raised concerns about the activity.

Non-employee witnesses cannot be compelled to assist with enquiries but should be asked for their assistance where appropriate.

It may be useful to have written statements from any injured people and direct witnesses. In general, the statement should only contain information on what the witness saw, and not what others have said to them. However, it is important to record anything that may open a new line of enquiry or help in corroborating other information. In order to ensure all important information is recorded on the statement, witnesses and those involved in an incident may be interviewed by the investigators. Depending on the incident, an interview may be more appropriate, as people who are not involved in the investigation may not realise that background information can be just as important as details of the incident itself. Employees have the right to have a friend, Trade Union or legal representative present during an interview.

Interviews are to be conducted promptly, before details fade or become confused, and in a place where the injured person or witness feels comfortable. This, of course, depends on the condition of the injured person and witnesses. Appropriate first aid or medical treatment must be given before an injured person is interviewed, and they must be fit to answer questions before any interview is arranged.

The interview should be conducted in the following manner:

- The interviewer should put the injured person or witness at ease, remain calm and objective, and be sympathetic, honest, and courteous.



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- The interviewer should ask them to recount what happened in their own words and take notes – they should repeat back key points at the end of the interview to check the details are correct.
- The interviewer must not ask leading questions, interrupt, or argue.
- The interviewer must cross-reference the answers against the other evidence gathered.
- The interviewee should distinguish between fact and opinion.
- All parties should remember eye-witnesses are not always reliable, particularly where a stressful incident has occurred, and that witnesses may have only seen part of an incident or seen it differently to another witness who had a different angle, or different background knowledge of the circumstances.

6.6 Determining causes

There may be a number of causes or circumstances that led to an incident occurring. Investigations must identify immediate, underlying, and root causes, including human factors.

Immediate cause:

The direct reason why an incident happens, e.g. someone slipping over, coming into contact with moving machinery, etc. There may be several immediate causes identified for a single incident, the most prominent of which should be identified by the investigator.

Underlying cause:

The less obvious or background 'system' or 'organisational' reason for an incident happening, e.g. pre-start machinery checks were not carried out so a fault with the guarding was not identified, regular management walkthroughs of the premises had not been undertaken therefore a tear in the carpet had not been identified or fixed etc.

Root cause:

An initial event or failing from which all other causes or failings spring. Root causes are generally management, planning or organisational failings. For example, a lack of arrangements for management of machinery checks, a suitable and sufficient risk assessment for general workplace hazards such as slip trip fall incidents hadn't been undertaken therefore no arrangements for management walkthroughs had been identified, etc. These should also be identified

The investigator should ask questions – 'who, what, why, where, and how?' – while reviewing the evidence they have gathered to identify these causes and continue to ask why to establish the underlying causes. For example, though the trailing cable may have been the immediate cause of a trip and subsequent injury, why was it there? Was it because of poor housekeeping, insufficient plug sockets being available in the area, the person who plugged it in being given too little time to complete their tasks, or other reasons? Then ask why was the housekeeping insufficient or why were there insufficient plug sockets? Keep asking why until you no longer generate any more useful information.

6.7 Human failings

Though incident investigation is not about blame, it is important to address the reasons for human failing.



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These may be errors – which are made more likely by stressors in the workplace, or violations – deliberate deviations from rules or procedures, either routine (such as cutting corners to save time, a perception that rules are restrictive and can be ignored or no longer apply, etc.), situational (where the pressure of the task in a particular set of circumstances – a lack of time, equipment, bad weather etc – leads to violations in order to complete the job), or exceptional (which tend to occur when something has gone wrong and more mistakes are made as attempts to fix the situation).

The incident investigation should look at the reasons why errors or violations have occurred. It is important to note that violations often occur where employees perceive that managers are turning a blind eye to unsafe acts, indicating managerial approval to those acts. This means it is important that any weaknesses in management systems such as supervision are also looked at. Employee involvement in developing new procedures and reviewing risk assessments following an incident can help ensure that the new measures are practical, achievable, and thorough.

6.8 Reviewing control measures

Where incidents occur the risk assessment and control measures need reviewing. Appropriate controls will need to be determined by the likelihood of the incident reoccurring and the potential severity of the incident.

The need to review controls in place applies to work-related ill health as well as other incidents. For example, an employee suffering a musculoskeletal condition caused or exacerbated by working at their workstation will need their workstation assessment reviewed. This individual case might also highlight the need to review all DSE assessments in the team where this hasn't been done recently, or where assessments have been inadequate; employees may also need to take or review their DSE self-assessment training.

Just as the investigation should identify underlying causes, the review of the controls should seek to address them. Using the trailing cable example again, dealing with:

- The “immediate” cause might mean moving the cable so it cannot cause further trips.
- The “underlying” causes might mean issuing instructions to employees not to leave trailing cables, or installing a new socket that is better placed
- The “root” causes might mean reviewing the resources allocated to health and safety and why this situation was allowed to develop, and strengthening the commitment to providing a safe working environment.

6.9 Sharing information and providing feedback

Information gained from an incident and its investigation might prevent an incident occurring under similar circumstances elsewhere and so wherever possible relevant information should be shared.

Feedback should be provided to relevant staff on the actions that have been taken to prevent a reoccurrence. Where human failings are identified, the incident should be discussed with the individual/s involved with a view to determining why they felt the

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incident occurred, why they had acted as they had and what they feel might help prevent this happening again.

7. Retention of records and forms

Details of incident reports, investigations and associated supporting evidence should be retained in line with the NCC or schools' record retention schedule.

Where an incident may result in long-term ill health for an employee, a PDF copy of the OSHENS incident report should be provided to HR, where requested, so that it can be placed on the individual's personal file. In schools, it should be placed on the individual's school personal file.

8. Additional supporting/related documents

- Online incident reporting for employees G601c
- Online incident reporting and investigation for managers G601e
- Online incident reporting system privacy notice G666
- Incident reporting - musculoskeletal condition reporting guidance G601f
- Witness or Injured person personal statement F601

9. Changes since last revision

Date	Details of change	Approved by	Version number
21 November 2022	Updated telephone number for HSW team. Additional information to ensure line manager notifies Senior Management in the event of a serious incident. Minor changes throughout document.	Paul Downer - Health, Safety and Wellbeing Manager	159