



# Health and Safety

## Incident Reporting and Investigation

### Minimum Standard

<b>Version</b>	<b>V1.0</b>
<b>Author/s</b>	Lee McGurty
<b>Approver</b>	ELT Operating Committee
<b>Effective Date</b>	20/06/2022
<b>Review Date</b>	20/06/2025

## 1 Aims and Principles

The aim of this Minimum Standard is to ensure that all managers and employees understand their responsibilities in relation to the reporting and investigating of incidents which occur in their workplace.

All Departments should develop their own arrangements for ensuring that employees are fully aware of the procedures for reporting incidents and understand when incidents should be investigated, by whom and the investigation process.

The procedures must include the standards set out in this document or be of an equivalent or higher standard.

## 2 Legislation and Guidance

### a) Applicable Legislation

None

### b) Guidance

Health and Safety in the Workplace: A General Guide

Investigating Accident and Incident (UK HSE)

Investigating accidents and incidents - A workbook for employers, unions, safety representatives and safety professionals HSG 245 (UK HSE)

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (UK RIDDOR)

## 3 Definitions

### Incident

A work-related event (or events) in which an injury or ill health (regardless of severity) occurred, or could have occurred

### Accident

A work-related incident resulting in an injury

### Near Miss

Work related incident where no injury occurred but could have

### Incident Category

Incidents are usually categorised based on the severity of the outcome or in the case of a near

miss, how serious the outcome could have been. Categories of incidents are often used to determine the scale (or level) of investigation required.

#### [Causal Factor](#)

A major unplanned, unintended contributor to an incident that if eliminated, would have either prevented the occurrence of the incident or reduced its severity or frequency.

#### [Control Measure](#)

Physical or administrative measure put in place to eliminate or reduce the level of risk posed by a hazard.

#### [Health and Safety Inspectorate](#)

The government agency responsible for enforcing health and safety legislation in Jersey.

## **4 Who this Minimum Standard Applies to**

- All Government of Jersey (GoJ) and States' employees
- Voluntary staff or those on honorary contracts where there is no implied contract of employment

## **5 Links to other GoJ Policies, Minimum Standards and Guidance**

### a) Policies

[Government of Jersey - Health and Safety Policy](#)

### b) GoJ Minimum Standards

Asbestos  
Control of Contractors  
Risk Assessment

### c) Other Internal Guidance

[Reporting an incident, accident or near-miss](#)

[Incident Investigation](#)

## **6 Roles and Responsibilities**

Incident Investigation

Reference should be made to the Government of Jersey - Health and Safety Policy which clearly sets out the specific responsibilities held by the SLT Lead for H&S, H&S Professionals and Line Managers in relation to incident reporting and investigation.

The department's procedures for reporting and investigating incidents must clearly set out the roles and responsibilities of all those individuals involved and must be kept up to date.

## 7 Incident Reporting

All GoJ departments should develop their own incident reporting system which will enable employees to quickly and easily report incidents. A corporate system is available for use by all departments for [Reporting an incident, accident or near-miss](#).

Departments can choose to use this system as follows:

- To report all incidents
- To report certain types of incidents in combination with their own reporting system for less serious incidents

Departments may also choose not to use this and instead report incidents through their own internal system. These can also be accessed via the MyStates link.

For the incident reporting system to be effective, it should:

- Be available to all
- Be easy to use
- Provide details of the category of incidents which are required to be reported
- Be designed in a way which ensures that the required information is captured
- Ensure that all relevant parties are notified of the incident in a timely manner e.g. automatic notification with an electronic reporting system or visual instructions included on a paper system

As a minimum, the initial notification of an incident will usually require the following information to be recorded:

- The date and time the incident occurred
- The location of the incident
- A brief description of the incident
- The type of activity being carried out at the time of the incident
- Details of any work equipment involved
- Details of the employees involved
- Details of any other persons involved e.g. members of the public
- The consequences of the incident.

Other information which could be recorded includes:

- Category of the incident
- Details of witnesses
- Action taken immediately following the incident
- Details of any first aid/emergency assistance provided

As part of the arrangements set out in the [Government of Jersey – Health and Safety Policy](#) for reporting incidents, Departments must ensure that incidents resulting in the following types of injury\* are notified directly to the Health and Safety Inspectorate.

Fracture, other than to fingers, thumbs or toes

- Amputations
- Any injury likely to lead to a permanent loss of sight, or reduction of sight
- Any crush injury to the head or torso causing damage to the brain or internal organs
- Serious burns (including scalding) which:
  - cover >10% of the body
  - causes damage to eyes, respiratory system or other vital organs.
- Any scalping requiring hospital treatment
- Any loss of consciousness caused by head injury or asphyxia
- Any injury arising from work in a confined space which:
  - leads to hypothermia or a heat induced illness
  - requires hospitalisation for more than 24 hours

\* Based on UK RIDDOR requirements

Further description of the specified injuries is available on the UK HSE website, [Specified injuries to workers](#) and the form, [F.I.12 Accident Notification](#) can be used if preferred.

Departments must also have a procedure for notifying the Director General in the event of a fatality, major injury or other major incident, as per the Government of Jersey – Health and Safety Policy.

## 8 Incident Investigation

The investigation and analysis of incidents forms an essential part of managing health and safety.

The primary aim of an investigation is to find out what went wrong by establishing the immediate, underlying and root causes to enable actions to be taken to minimise the risk of a similar event occurring in the future.

Investigations should be driven by a desire to prevent future incidents – not to apportion blame to individuals. Adopting the latter approach will not only result in failures in the system not being identified, but will also cause employees to become defensive and uncooperative. It will also lead to under-reporting of incidents which means that valuable safety signals will be lost. The department's procedures for ensuring the reporting and investigation of incidents should

clearly set out who is responsible for determining when an investigation should be carried out, the scale (or level) of investigation required and who should be involved in the investigation. The scale of the investigation will usually be decided on the actual outcome or potential outcome of the incident, whichever is more serious.

Example matrices for determining the level of investigation required are contained in Appendix A.

## 9 Effective Incident Investigation

### Incident Causes

An effective investigation will ensure that all causal factors are identified. This enables suitable control measures to be identified which should address the failures at all levels within the department.

The three main causes of accidents are:

<b>Immediate</b>	The agent of injury or ill health e.g. the substance, blade, hole in the floor etc.
<b>Underlying</b>	<b>Unsafe acts</b> An act by the injured person or another person (or both) which caused the incident; and/or
	<b>Unsafe conditions</b> Some environmental or hazardous situation which caused the incident, independent of the employee
<b>Root (organisational)</b>	The failure from which all other failures arise – often remote from the incident. These are generally management, planning or organisational failures such as lack of training, no risk assessment, no safe system of work, poor design of workplace etc.

The immediate cause is usually obvious and in many instances, can be readily addressed e.g. if a guard is missing from a piece of equipment, then it can be easily reinstated which is a cheap and quick fix. However, taking this action without investigating further will only address the immediate cause. This will provide a short-term fix but is likely to give rise to the same set of circumstances again as the reasons why the guard was missing have not been determined.

An effective investigation will ensure that the underlying and root causes are also identified. In the case of a missing guard, there are several reasons why this will have occurred and this should be established. Typical reasons include that the tool isn't suitable for the job i.e. the tool is being misused, the guard is broken or can't be located or the person using the equipment has not been trained so doesn't recognise a guard is missing. Each of these underlying or root causes would require different control measures to be implemented to address them and therefore it is important that they are properly identified.

A failure to identify these underlying and root causes means that it is likely that the conditions will be allowed to develop again which in some cases, can result in more serious consequences next time.

## 10 Root Cause Analysis – “5 Whys” Technique

The “5 Whys” technique is a simple yet powerful tool which can be used during investigations to establish all causes, including the root causes, of an incident.

The purpose of the 5 Whys technique is to explore, with the witnesses, why each of the causal factors of the accident occurred. Typical causal factors of incidents include, but are not limited to:

- Defective work equipment
- Unsafe working practice adopted
- Rushing to complete the work
- Deviation from the system of work
- Lack of user checks
- Lack of training
- Lack of available staff
- Lack of personal protective equipment
- Poor housekeeping
- Etc.

The causal factors of an incident are likely to be apparent at an early stage in the investigation and the “5 Whys” technique should be used to establish the underlying and root causes of each of the causal factors.

When using the “5 Why's” technique, it is important that the person investigating:

- Asks proper questions that delve deeper into the issue. Simply repeating the word ‘Why?’ is unlikely to be helpful
- Avoids being or appearing confrontational.
- Avoids making questions personal or accusatory (e.g. ask ‘Why do you think the ladder slipped?’ not ‘Why did you make the ladder slip?’)

- Avoids following a single line of enquiry only as there will be a number of causal factors which will need to be explored to identify the root causes of the incident.

The number of times it is necessary to ask a “why” question in response to an answer given will vary and may be more or less than five.

A simple example of the “5 Whys” technique used in an investigation is included in Appendix C.

## 11 The Investigation Process

There are four key steps to the investigation process:

- Step 1** Gathering the information
- Step 2** Analysing the information
- Step 3** Identifying risk control measures
- Step 4** The action plan and its implementation

### Step 1 - Gathering the Information

This step involves the collection of as much evidence as possible. It is important that the gathering of information commences as early on as possible to avoid the potential loss of evidence.

Typical evidence collected during incident investigations is detailed in Appendix B with further explanation provided below.

- Observations**
  - Ideally, the scene should be viewed before any changes are made to it
  - Photographs should be taken to record the scene itself including locations of movable items at the time of the incident
  - The unique details of any machinery/tools/equipment should be taken to enable identification at a later date
  - If considered appropriate, items should be taken into possession for safe keeping

- Documents**
  - After capturing the relevant information at the scene itself, consideration should be given to the types of documents which may be relevant. These should be obtained as soon as possible after the incident.

- **Always** obtain the risk assessment and method statement for the works being carried out
- It is common for additional documentation, which was not initially apparent, to be required as the investigation progresses
- Documentary evidence which corroborates (or disproves) verbal evidence given should be obtained. It is better to have too much information which ultimately proves not to be relevant than to have insufficient evidence to determine the true causes of the incident
- Documents should be presented to the witnesses and validated when taking statements. In some instances, statements from the person who prepared the document may also be needed.

## Witness Statements

- If possible, speak with witnesses during initial attendance at the scene of the incident. The degree of questioning which should take place will depend on the nature of the incident and how the witnesses have been affected by it.
- As a minimum, personal data such as contact details should be taken, including from members of the public if involved.
- If possible, obtain a brief description of what the witness saw and believes happened. Take some notes which can be referred to at a later date if necessary, when taking a written witness statement.
- Where the nature of the incident is such that written witness statements are required, plan to take these as soon as possible to avoid possible 'memory loss' and/or corruption of the information e.g. where more than one person witnesses an incident, this will often be discussed and can result in confusion between what somebody actually saw and what they are told happened and then believe they saw.
- When taking statements from a witness the following approach should be adopted:
  - Put the witness at ease
  - Explain the purpose of the investigation is to stop similar incidents occurring again
  - Use open questions to encourage conversation

- Look for facts, not opinion, though the latter can be recorded
- Use a non-confrontational style of questioning
- Keep asking questions to find out “why” to establish underlying and root causes
- Listen carefully
- Ask the witness for suggestions on future prevention

### Step 2 - Analysing the information

The analysis of the information should commence as soon as the collection of evidence commences. The process of information gathering and analysis will therefore occur simultaneously.

The analysis will lead the direction of the investigation and will usually result in it being necessary to gather further evidence which was not immediately obvious.

Persons investigating must keep an open mind throughout and should not reject any possible causes until they have been given proper consideration. It is important that the person investigating does not jump to conclusions on the causes of the incident and then only seeks out evidence to support these conclusions. Therefore, all investigations should be carried out with an open mind and without bias.

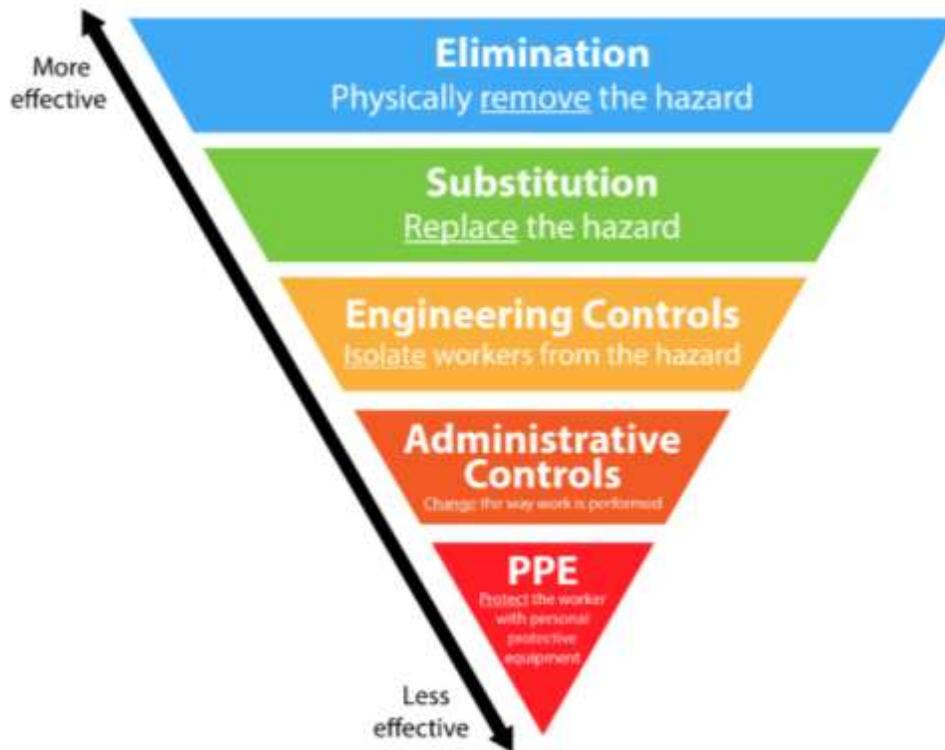
### Step 3 - Identifying risk control measures

The analysis and use of the “5 Whys” technique will help to identify those controls which have either failed or were not in place prior to the incident and which therefore need to be addressed.

Any new control measures identified as necessary should be properly evaluated to ensure they will provide sufficient protection against a recurrence and will also not introduce any new hazards

The position of the control measure on the hierarchy of controls, see Fig.1, should be taken into consideration as this will indicate how robust it is. As the hierarchy is descended, the likelihood of the control measure failing increases as more reliance is being placed on the actions of people.

Some measures will be more difficult to implement for reasons such as cost but must not be discounted on this basis alone and should be considered in the longer term.



**Fig.1**

#### Step 4 - The action plan and its implementation

The action plan provides a simple method of recording the additional control measures identified, the date by which they should be put in place and the person who is responsible for implementing them. The action plan should also include a method of recording the fact that the control measures have been introduced.

Where several control measures are identified as being necessary, they should be prioritised in the action plan with the priority given being based on the magnitude of risk and the effectiveness of the control measure being put in place.

The action plan should include a requirement for the risk assessment(s) covering the activity to be reviewed and updated and the system of work should also be reviewed and amended as required. Where required, additional training should also be provided.

Actions plans should be reviewed regularly until all actions have been completed.

An Action Plan template is available in Appendix E.

## 12 Preparing an Investigation Report

An investigation into an incident can generate a large amount of evidence as multiple lines of enquiry are pursued.

It is therefore important that the details the information obtained, the analysis of the information and the findings of the investigation are recorded in a format which can be easily understood and which is readily available for reference in the future e.g. if legal proceedings are brought against GoJ.

The level of detail contained in the investigation report will depend on the nature of the incident and the scope of investigation carried out. For many incidents, the corporate [Incident Investigation](#) online form will be sufficient.

Where a more extensive report of the investigation is required, the form contained in Appendix D may be suitable.

## 13 Training

Employees who are required to carry out investigations of incidents must be competent in the methodologies being used and have both knowledge and experience of the working activity being carried out at the time of the incident.

Individuals responsible for conducting incident investigation or managing the process must have attended a GoJ-approved incident investigation course appropriate to their level of involvement in the process.

## Appendix A

### Incident Type and Investigation Level

The following table provides an example of who should be involved with investigations into different levels incidents.

This table can be amended to suit the internal health and safety support available to the department.

Catastrophic	Major	Moderate	Minor	Insignificant	Near Miss
<p>The most serious types of incidents resulting in:</p> <p>Serious injury, permanent incapacity, loss of limb, fatality, severe damage to property, environment, long-term loss of services.</p>	<p>The most serious types of incidents resulting in:</p> <p>Major injury, multiple injuries, long term ill health, damage to property, short-term loss of services, significant effect on property or environment.</p>	<p>Any incident which results in:</p> <p>Fractures, sprain, strain, laceration, ill health, moderate damage to property, environment, interruption to services.</p>	<p>Any incident which results in:</p> <p>Cut, bruise, basic first aid treatment required minor impact to services, property or environment.</p>	<p>Any incident which results in:</p> <p>Minimal injury (no first aid needed), no repairs required, minimal impact to services, property or environment.</p>	<p>Any incident which results in:</p> <p>No harm or damage to property or environment but had the potential to cause harm or damage.</p>
<p>Full investigation required- Investigation will be required by the Health &amp; Safety Team (with manager's support).</p>	<p>Investigation will be required by the Health &amp; Safety Team with manager's support</p>	<p>Investigation will be required by managers (with H&amp;S support if required).</p>	<p>Manager to complete initial investigation to learn lessons and prevent reoccurrence.</p>	<p>Manager to complete initial investigation to learn lessons and prevent reoccurrence.</p>	<p>Manager to complete initial investigation to learn lessons and prevent reoccurrence.</p>

## Appendix A

The following is an alternative matrix which can be used to determine the level of investigation based on the seriousness of the incident.

Likelihood of recurrence	Potential worst consequences of incident			
	Minor	Serious	Major	Fatal
Certain	Yellow	Orange	Red	Red
Likely	Yellow	Orange	Red	Red
Possible	Yellow	Orange	Red	Red
Unlikely	Blue	Yellow	Orange	Red
Rare	Blue	Yellow	Orange	Red

This description of 'investigation level' can be amended by to reflect the department's management structure and responsibilities.

Risk	Investigation level
Minimum	Relevant supervisor to look at the circumstances and try to learn lessons to prevent a reoccurrence
Low	Relevant supervisor or line manager to identify all causes to prevent recurrence and learn lessons
Medium	More detailed and will involve H&S adviser and employee representatives
High	Team based carried out under the supervision of senior management

Source: [Investigating accidents and incidents A workbook for employers, unions, safety representatives and safety professionals HSG 245 \(UK HSE\)](#)

## Appendix B

### Incident Investigation – Types of Evidence

#### Direct Observations

Information from your own direct observation of the site of the accident.

Take photographs to aid observations.

- Layout of premises
- Equipment/machinery/tools/vehicles e.g. make/model/type/status/guards/power status
- Presence (or absence) of articles or substances e.g. slings, chemicals
- General conditions and housekeeping
- Other person(s) & activities present
- Reconstruction of incident
- Measurements and plans
- Position of injured person/witnesses at time of the accident
- Presence of CCTV cameras

#### People to speak to

Information from:

- Injured person
- Direct witnesses
- First aider
- Other persons associated with the incident who have relevant information to give – usually become more apparent as the investigation progresses

#### Documents

Information from relevant documents:

- Accident report form
- First aider report
- E-mail(s)
- Risk assessments
- COSHH assessments
- Manual handling assessments
- Staff training records
- Monitoring records e.g. dust/noise
- Maintenance/test results
- Records of user checks
- Previous accident reports
- Health & Safety Executive (HSE) guidance
- Other best practice guidance
- Minutes of meetings
- Safe operating procedures
- Manufacturer's instructions
- Witness Statements

#### Analysis

- Assess what you find
- Check reliability and accuracy
- Identify and resolve differences
- Identify gaps in evidence

**Do you have a clear picture of what happened and why?**

## Appendix C “5 Whys” Technique

The following illustrates a simple use of the “5 Whys” technique.



## Appendix D

This form can be used as a template and can be amended to suit the department's own circumstances.

### Incident Investigation Form

This form should be signed by the person leading the incident investigation. If you require any assistance in completing this form please contact the Safety, Health & Wellbeing Team

#### Section 1: Overview

<b>Name of Injured Person(s)</b>		<b>Date of Incident</b>	
<b>Manager carrying out investigation</b>		<b>Date of Investigation</b>	
<b>Incident Severity (from SHE Assure Form)</b>	<b>Catastrophic</b>		<input type="checkbox"/>
	<b>Major</b>		<input type="checkbox"/>
	<b>Moderate</b>		<input type="checkbox"/>
	<b>Minor</b>		<input type="checkbox"/>
	<b>Insignificant</b>		<input type="checkbox"/>
	<b>Near miss</b>		<input type="checkbox"/>
<b>Was the severity on the SHE Assure form correct?</b>	Yes <input type="checkbox"/>		No <input type="checkbox"/>
<b>If no what is the actual severity of the incident?</b>	<b>Catastrophic</b>		<input type="checkbox"/>
	<b>Major</b>		<input type="checkbox"/>
	<b>Moderate</b>		<input type="checkbox"/>
	<b>Minor</b>		<input type="checkbox"/>
	<b>Insignificant</b>		<input type="checkbox"/>
	<b>Near miss</b>		<input type="checkbox"/>

#### Section 2: Investigation Information Gathering

<p><b>1. Where and when did the incident happen?</b> Include building and room. For outside areas consider aerial map with site of incident marked.</p>	
<p><b>2. Who was injured/ suffered ill health or was otherwise involved with the incident?</b> Include name, staff or student number if known, length of service, status e.g. staff, student, contractor</p>	
<p><b>3. Were there any witnesses to this incident?</b></p>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>3.1 Have witness statements been taken?</b></p>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>Supporting documents included in this investigation:  <input type="checkbox"/> witness statements - Name(s)  <input type="checkbox"/> Other (Please state)</p>	
<p><b>4. How did the incident happen? (Be as detailed as possible)</b> (What activities were being carried out at the time and any equipment involved including make, model, serial no)</p>	
<p>Supporting documents/items included in this investigation:  <input type="checkbox"/> Photographs  <input type="checkbox"/> CCTV or video/audio files  <input type="checkbox"/> Plans  <input type="checkbox"/> Physical evidence e.g. whole of damaged parts of equipment, samples of substances, clothing or footwear  <input type="checkbox"/> Manufacturers/suppliers user guides  <input type="checkbox"/> Results of tests e.g. dust or noise monitoring</p>	

## Appendix D

<input type="checkbox"/> Health surveillance records <input type="checkbox"/> Best practice guidance e.g. trade association or Health and Safety Executive guidance <input type="checkbox"/> Other (Please state)			
<b>5. Why did the incident happen? (Use the Five Why's technique to identify root causes)</b>			
<b>6. Was there a risk assessment and/or safe operating procedure (SOP) for the task?</b>		Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>6.1 Did the risk assessment/SOP cover all aspects of the task?</b>		Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>6.2 Was it being followed?</b>		Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>6.3 Supporting documents/items included in this investigation:</b>  <input type="checkbox"/> Risk assessment(s) e.g. COSHH, Manual Handling, LOLER <input type="checkbox"/> Safe operating procedures  Give Details:			
<b>7. Was there anything unusual or different about the working conditions at the time of the incident? e.g. weather, open day etc.</b>			
Yes <input type="checkbox"/>		No <input type="checkbox"/>	
<b>Give details:</b>			
<b>8. What injuries or ill health effects, if any, were caused?</b>			
<b>9. Was maintenance, cleaning or housekeeping sufficient?</b>			
Yes <input type="checkbox"/>		No <input type="checkbox"/>	
<b>9.1 If not, explain why not:</b>			
Supporting documents/ items included in this investigation: <input type="checkbox"/> Maintenance Records <input type="checkbox"/> Other (Please state) <input type="checkbox"/> Cleaning records Give Details:			
<b>10. Was a lack of competency/training a factor in this incident?</b>			
Yes <input type="checkbox"/>		No <input type="checkbox"/>	

## Appendix D

<b>10.1 Give details:</b>	
Supporting documents/items included in this investigation: <input type="checkbox"/> Training records <input type="checkbox"/> Other (Please state) Email communication. Work order CI Fire	
<b>11. Did the workplace layout influence the incident?</b>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>11.1 How did the workplace influence the incident?</b> e.g. maintenance, routine/non-routine work being completed	
<b>12. Was safety equipment and/or personal protective equipment provided? N/A</b>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>12.1 Was the equipment suitable for the task and being used correctly? N/A</b>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Give details:</b>	
<b>12.2 Was PPE used during the task? N/A</b>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>12.3 Was PPE compatible with other PPE used? N/A</b>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>13. Are you aware of any similar incidents?</b>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Give details:</b>	
<b>14. Is there any other information not detailed above that is relevant to this incident?</b>	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Give details:</b>	

## Appendix E

### Action Plan

No	Description	Allocated to	Target Date	Comments	Task Complete		Date Completed
					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
1					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
3					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
4					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
5					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
					Yes <input type="checkbox"/>	No <input type="checkbox"/>	