



Title: **CYPES Incident Reporting and Investigation Policy**

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This policy is an updated version of the previous Accident Reporting Policy

1. Overview

In line with best practice, the Department of Children, Young People, Education & Skills requires all sites to formally report centrally:

- Notifiable incidents to the Department. (See below for a definition of a 'notifiable incident')
- Incidents of violence and aggression against staff by residents, students, pupils, adults and members of public where injury or distress has occurred.
- Employee related incidents which do not fall into the notifiable criteria, but where injury has occurred.
- Near misses where somewhere could have been badly hurt, or significant damage could have been caused
- Safety Observations where unsafe behaviours, hazards or good practices have been noticed

In addition, any incident or near misses which are not severe enough to be notifiable should be recorded internally on a site register.

2. Scope

This policy applies to:

Incidents occurring to all students, pupils, residents, people on work experience and employees on CYPES premises or while under Department supervision (e.g. visits / activities on & off island). It also applies to visitors, parents, contractors or any members of the public.

3. Responsibilities and distribution

This policy is available on Gov.je and must be made accessible to all CYPES employees. The aim of this Policy 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.

4. Policy/Standards

All employees who are required to report or / and investigate incidents must be made fully aware of the reporting procedures and understand when incidents should be investigated, by whom, and the investigation process.

5. Further information and related documents

[Incident Reporting and Investigation Minimum Standard](#)

[Violence and Aggression Minimum Standard](#)

6. Recommendations and Guidelines

6.1 Definitions

Incidents are unplanned, undesired events that adversely affect the completion of a task or endanger the safety of people, or the environment.

Near-Misses are unplanned undesired events where no damage was caused and no personal injury sustained, but where, given a slight shift in time or position, damage or injury could easily have occurred.

Safety Observations are potential inappropriate or unsafe behaviours or hazardous conditions that could lead to an incident. They can also be used positively to report good practise that has been observed.

CYPES Notifiable Incidents are incidents which results in:

- death or major injury
- 24 hrs hospitalisation or
- more than three (3) days absence from school or work
- An incident (lawful or unlawful) on any CYPES controlled premises or at a CYPES controlled activity, requiring an ambulance call out or treatment at the Accident and Emergency section of a hospital.

An episode of any existing medical condition occurring should also be reported if it meets the criteria above.

Incidents of violence and aggression are any incident, in which an employee is abused, including verbally, threatened, or assaulted in circumstances arising out of the course of their employment which causes injury or distress.

7. Reporting Incidents

7.1 Reporting Incidents centrally

All incidents listed below must be reported centrally using the online system

- **Notifiable incidents**
- **Incidents of violence and aggression against staff by residents, service users, pupils, adults and members of public, where injury or distress has occurred.**
- **Employee related incidents which do not fall into the notifiable criteria, but where injury has occurred.**
- **Near misses where someone could have been badly hurt, or significant damage could have been caused.**
- **Safety Observations where an unsafe behaviour, a hazards or good practices have been noticed**

When reporting Incidents centrally, children's names or initials **must not** be documented on the forms. If known, the URN or UPN numbers can be used or more generic terms such as 'pupil' or young person.

7.2 Reporting Incidents Internally

Incidents that do not fall into the notifiable category, including less severe incidents of violence and aggression against an employee, where injury or distress has not occurred, must be recorded on the site's internal incident register, and must be available for inspection on request as part of the audit process.

As a minimum this record should include:

- The date and time the incident occurred.
- The location of the incident.
- A brief description of the incident.
- Details of the employee involved.

Consideration should also be given to the frequency of less severe incidents of violence and aggression as over a period of time if they occur recurrently, the severity may not change, but the impact could.

7.3 Information reported on other systems

In some cases, information about incidents will need to be reported on more than one system, if they involve a child / young person and an employee. For example, if an employee was injured by a young person / pupil in their care, displaying challenging behaviours, it must be reported centrally or in house (depending on the severity) as an employee related incident, but further information may need to be recorded specific to the pupil or young person on the relevant management Information system in use by the directorate.

Examples of Management Information Systems in use:

SIMS – used to record pupil personal data including information about incidents they are linked to.

Mosaic – used to record children's personal data including information about incidents they are linked to.

MyConcern – a safeguarding management system where safeguarding incidents are recorded.

Nova – used to record children's personal data including information about incidents they are linked to.

8. Management of Incidents

All incidents should be reported locally to the responsible person, for example, Head Teacher, Registered Manager, Department Manager, or in their absence, another responsible officer.

This person must make sure that:

- when necessary, the emergency services have been contacted.
- the injured person and others affected by the accident have received the appropriate treatment and support from a qualified First Aider
- The area where the incident occurred is immediately made safe, for example by shutting-down equipment, cordoning off danger areas, putting up warning signs etc.
- If the incident fulfils the criteria to be reported centrally, this should be done as soon as possible, or within a maximum of 24 hours of the incident occurring

Notifications of all incidents reported centrally will automatically be sent to the Incident Manager of the relevant location. They are required to add some further information and decide whether an investigation is

required. If an investigation is necessary, the Incident Manager will either delegate it to an Investigation Lead or undertake the investigation themselves. (Incident Managers and Investigation Leads are predetermined on the reporting system)

9. Investigation

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

Investigations are undertaken to prevent future incidents occurring, not to apportion blame.

The three main causes of incidents are:

- **Immediate causes** – exposure to hazardous substance, slips trips and falls.
- **Underlying causes** - unsafe acts or unsafe conditions.
- **Root (organisational)** – these are often management, planning or organisational failures such as lack of training, no risk assessment, inadequate procedures or poor workplace design

There are 4 key steps to the investigation process:

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 that can be collected during incident investigations is detailed in Appendix B

Step 2 - Analysing the information

The analysis of the information should start 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 (see appendix E) 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

Step 4 - The action plan and its implementation

An action plan provides a simple method of recording any 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. Control measures required should be prioritised by risk in the action plan. The action plan should include a requirement for any relevant risk assessment or systems of work in place to be reviewed and updated. Where required, additional training should also be provided. Actions plans should be reviewed regularly until all actions have been completed. There is an action plan example at the bottom of appendix C

10. 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.

For information about Incident Investigation training email CYPESHandSCentral@gov.ie

11. Safeguarding the Wellbeing of Staff

The Head of / School / Department / Centre / Section has a duty to ensure, on behalf of the employer, so far as is reasonably practicable, that the health, safety and welfare at work of employees and the health and safety of others is safeguarded by:

- following up and investigating all incidents of unacceptable behaviour and where necessary identifying and implementing recommendations for improvement, with staff or other staff representatives
- assessing the risks to employees and others (including the risk of reasonably foreseeable violence) and implement steps to reduce these risks
- providing adequate information, instruction, training and supervision
- monitoring and reviewing arrangements put in place to reduce the risks and to ensure they are effective
- establishing transparent processes to acknowledge the hazardous nature of any foreseeable incidents, and implement adequate control measures
- ensuring staff are aware of how to report and record incidents (making them aware of this policy)
 - in the event of an incident where injuries have occurred, ensuring that staff are referred for medical treatment and also referred to the occupational health service if necessary
- providing support and direct staff to external support and advice services following any incident
- carrying out regular (at least annually) reviews of risk assessments and procedures to ensure they remain adequate and relevant

12. Data Protection

When reporting incidents formally online, childrens names or initials are not to be recorded on the form. If the child's URN is known this can be used. When asked to record the name of the person involved on the form, then 'pupil' or 'young person' should be used in place of a name. If further information is required centrally, contact will be made with the incident reporter, or the incident manager of the area. All personal incident information about the children will be recorded on their specific management system.

Copies of the Accident Record and / or any other completed formal documentation are not permitted to be shared with any person(s) or Parties without consultation with CYPES Head of Governance.

12.1 Analysis of data

The online incident reporting platform is a Corporate tool, however all Incident data is analysed by the CYPES Governance team. Any trends or spikes identified, for example a rise in incidents of violence and aggression, or several incidents being reported involving a specific piece of equipment, will be discussed with the relevant area before being escalated to senior management teams.

Appendix A

Incident Type and Investigation Level

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

Catastrophic	Major	Moderate	Minor	Insignificant	Near Miss
<p>The most serious types of incidents resulting in:</p> <ul style="list-style-type: none"> • Serious injury, permanent incapacity, loss of limb, fatality • Severe damage to property, environment, long-term loss of services. 	<p>The most serious types of incidents resulting in:</p> <ul style="list-style-type: none"> • Major injury, multiple injuries, long term ill health • Damage to property, short-term loss of services, significant effect on property or environment. 	<p>Any incident which results in:</p> <ul style="list-style-type: none"> • Fractures, sprain, strain, laceration, ill health • Moderate damage to property, environment, interruption to services. <p><i>* Laceration implies a torn or jagged wound</i></p>	<p>Any incident which results in:</p> <ul style="list-style-type: none"> • Cut, bruise, basic first aid treatment required • Minor impact to services, property or environment. 	<p>Any incident which results in:</p> <ul style="list-style-type: none"> • Minimal injury (no first aid needed) • No repairs required, minimal impact to services, property or environment. 	<p>Any incident which results in:</p> <ul style="list-style-type: none"> • No harm or damage to property or environment but had the potential to cause harm or damage.
<p>Full investigation required- Investigation will be required by the Health & Safety Team (with Manager or Head Teachers support).</p>	<p>Investigation will be required by the Health & Safety Team with Manager or Head Teachers support</p>	<p>Investigation will be required by Managers or Head Teachers (with support from the Health and Safety Team if required).</p>	<p>Manager or Head Teacher to complete initial investigation to learn lessons and prevent reoccurrence.</p>	<p>Manager or Head Teacher to complete initial investigation to learn lessons and prevent reoccurrence.</p>	<p>Manager or Head Teacher to complete initial investigation to learn lessons and prevent reoccurrence.</p>

Incident investigation Types of Evidence that could be used

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?

The amount of evidence required will be dependent on the level of investigation. Lower level investigations may only require one or two different types of evidence.

Appendix C

Example Incident Investigation template used for more complex investigations

(There is a lower level investigation form option with drop down questions on Connect H&S)

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 your Health and Safety Team [Contacts for Health and Safety](#)

Section 1: Overview

Name of Injured/affected or impacted Person(s)	<i>Fred White</i>
Manager carrying out investigation	<i>Joe Blue</i>
Date of Incident	<i>12/03/2023</i>
Date of Investigation	<i>14/03/2023</i>
Initial Incident Severity (from Connect H&S system)	<i>Moderate</i>
Was the severity on Connect H&S correct?	<i>Yes</i>
If no what is the actual severity of the incident?	<i>N/A.</i>
Type of potential RIDDOR reportable incident?	<i>Yes the incident resulted in an employee sustain a fractured leg and wrist</i>

Section 2: Investigation Information Gathering

<p>1. Where and when did the incident happen? Include building and room. For outside areas consider aerial map with site of incident marked.</p> <p><i>The incident happened at St Aubin School in the main corridor on the ground floor just outside reception.</i></p>
<p>2. Who was injured/ suffered ill health or was otherwise involved with the incident?</p> <p><i>Sandra Green and Fred White from the housekeeping team were both involved in the incident. Fred White sustained the injuries.</i></p>
<p>3. Were there any witnesses to this incident? <i>Choose an item.</i> (If yes, enter names below)</p> <p><i>Another colleague Jack Brown was a witness to the incident</i></p>
<p>4. How did the incident happen? (Be as detailed as possible)</p> <p>(What activities were being carried out at the time and any equipment involved including make, model, serial no)</p> <p><i>Sandra Green was mopping the floors in the corridor, Sandra was new to the St Aubin School housekeeping team, she had not completed her induction yet and had not seen the house keeping safe operating procedures or risk assessments. Sandra was given a mop the floors to wash the main corridors by her supervisor Fred White, and then he went off to check one of the classrooms. When he walked back into the corridor from the classroom he slipped on the wet floor and fell over. There were no first aiders on site as it was after school and only teachers are trained as first aiders. Jack Brown another member of the site team witnessed the accident and called an ambulance.</i></p>

Supporting documents/items included in this investigation:

- Photographs
- CCTV or video/audio files
- Plans
- Physical evidence e.g. whole of damaged parts of equipment, samples of substances, clothing or footwear
- Manufacturers/suppliers user guides
- Results of tests e.g. dust or noise monitoring
- Health surveillance records
- Best practice guidance e.g. trade association or Health and Safety Executive guidance
- Other (Please state)

5. Was there a risk assessment and/or standard operating procedure (SOP) for the task?

Yes

No

5.1 Did the risk assessment/SOP cover all aspects of the task?

Yes

No

5.2 Was it being followed?

Yes

No

5.3 Supporting documents/items included in this investigation:

- Risk assessment(s) e.g. COSHH, Manual Handling, LOLER
- Standard Operating Procedures

Give Details:

There was a safe operating procedure (SOP) in place for the task and also a risk assessment (RA), but they give conflicting information. Both documents had not been reviewed for several years. The SOP did not say to put wet floor signs in place after washing the floor, even though the RA said that this is an existing control. The RA and SOP were not being followed by the housekeeper as they have not been shared with her.

6. Was there anything unusual or different about the working conditions at the time of the incident? *Choose an item. e.g. weather, open day, change to a standard working practice, etc. (if yes, provide details below)*

No

7. What injuries or ill health effects, if any, were caused?

Fred White fractured both his right leg and right wrist (he is left handed)

8. Was maintenance, cleaning or housekeeping sufficient? *Choose an item. (if not, provide details below, such as Maintenance, cleaning and other records)*

No there was also no wet floor signs being used to warn others of the slippery wet floor.

9. Was a lack of competency/training a factor in this incident? *Choose an item. (if so, provide details below such as training records, acknowledgement of SOPs, etc)*

Yes, the housekeeper doing the mopping was new and had not completed her induction. She had not seen any of the RA's or SOP's for the tasks she was completing.

10. Did the workplace layout influence the incident? *Choose an item.* (if so, provide details below such as maintenance, routine/non-routine work being completed, etc)
No

11. Was safety equipment and/or personal protective equipment provided?
There was wet floor signage available in a cupboard but the cupboard door was locked and the new housekeeper did not have a key

12.1 Was the equipment suitable for the task and being used correctly *Choose an item.*? (If not, provide details below)
The equipment provided was suitable but not all of it was easily accessible

12.2 Was PPE used during the task? *Yes the housekeeper was wearing gloves and an apron.*

12.3 Was PPE compatible with other PPE used? *yes*

12. Are you aware of any similar incidents? *Choose an item.* If so, provide details below)
None known

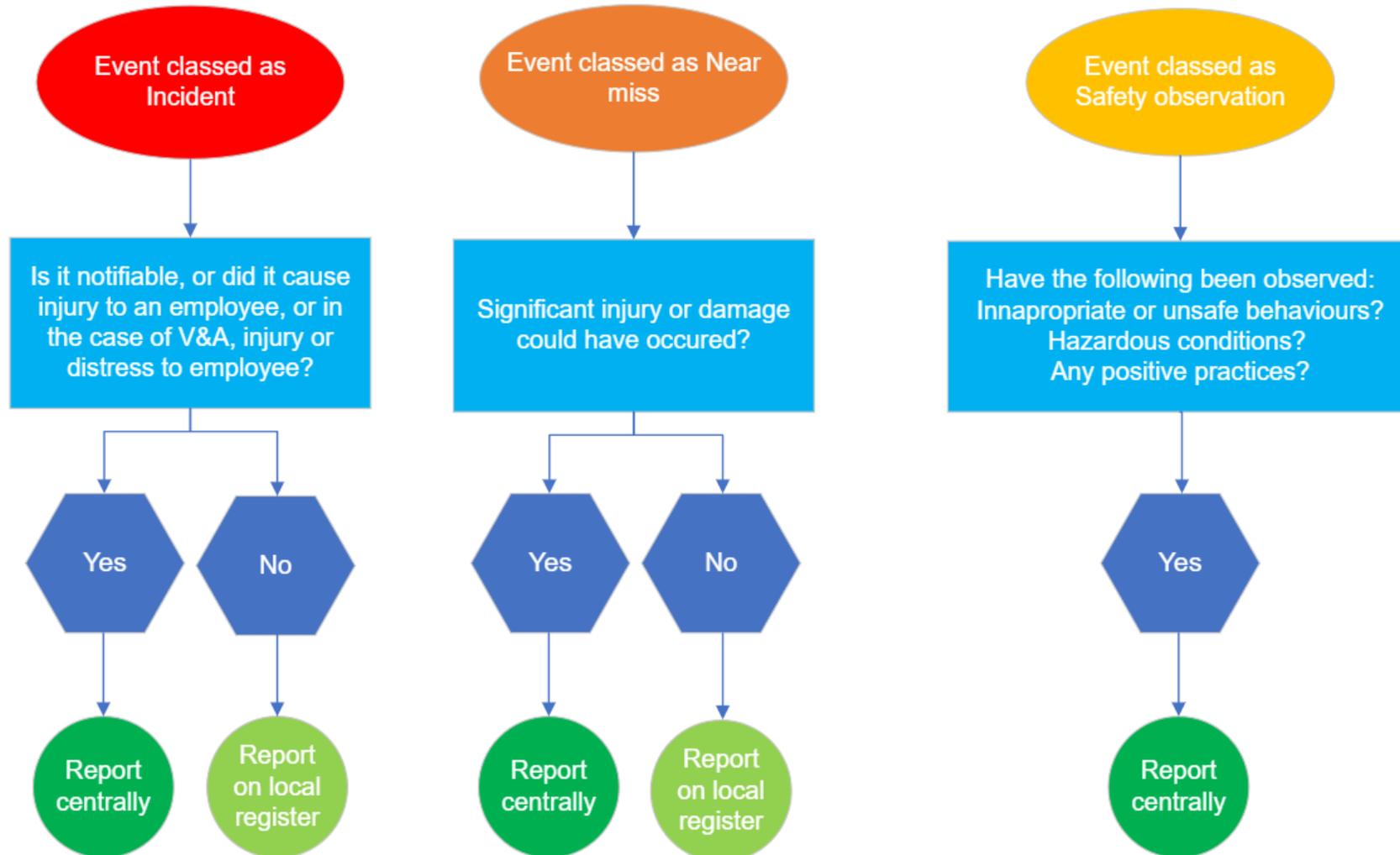
13. Is there any other information not detailed above that is relevant to this incident? *Choose an item.* If so, provide details below)
The times for the housekeeping staff to come in and clean the school had changed recently to later in the evening, without consultation with the team and this was causing some problems for the team as there was less time to complete the tasks

Example of basic action plan

Actions	Person Responsible	Date completed
1. Update procedures to ensure staff complete induction process prior to starting operational work,	Housekeeping manager	Procedures have been updated to say will complete induction prior to becoming operational 17/03/2023
2. Review all relevant and update all relevant Risk assessments and Safe Operating procedure COSHH assessments are	Housekeeping manager in conjunction with housekeeping team	Ongoing
3. Risk assessments and Safe operating procedure to be shared with relevant staff	Housekeeping manager	
4. Relocate storage of all safety signage so it is easily accessible to staff	Housekeeping manager and school site manager	
5. Ensure SG completes her training	Housekeeping manager	SG has now completed her induction training 15/03/2023
6. Assess need for first aiders and train staff if required.	Housekeeping manager	Two members of the team will take on role of first aiders and have booked on FAW training in May 17/03/2023

7. Working times to be reviewed in consultation with staff	Housekeeping manager in conjunction with housekeeping team	Working times have been reviewed and an earlier start has been agreed allowing more time to complete all the cleaning tasks 18/03/2023
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Incident/Accident Flowchart



'5 Why's' Technique

The following illustrates a simple use of the "5 Why's" technique.

 <p>Why did the worker injure himself?</p>	 <p>Because he fell from a ladder</p>	<p>Why did the PE teacher hurt her back?</p> <p><i>Because she was moving heavy sports equipment</i></p>
 <p>Why did he fall from a ladder?</p>	 <p>Because he was not holding onto the ladder and overbalanced backwards</p>	<p>Why was she moving heavy sports equipment manually?</p> <p><i>Because she wasn't using the equipment that had been provided</i></p>
 <p>Why was he not holding onto the ladder?</p>	 <p>Because he was using both hands to remove a large section of guttering</p>	<p>Why wasn't she using the equipment provided?</p> <p><i>Because she didn't know how to use it</i></p>
 <p>Why was he using both hands to remove the guttering?</p>	<p>Because the system of work for gutter replacement was flawed so it was not possible for the worker to maintain three points of contact with the ladder</p>	<p>Why did she not know how to use it?</p> <p><i>Because she had never received any training showing her how to use the equipment</i></p>
 <p>Why was there a flawed system of work in place?</p>	 <p>Because the job had not been properly planned in advance</p>	<p>Why had she not been trained?</p> <p><i>Training had not been added to the training matrix and there was no RA in place identifying training as a control measure</i></p>

CHANGE HISTORY

Version	Date Issued	Issued by	Reason for Change
	8th February 2008	Head of Governance	<i>First issue</i>
0.1	5 th November 2013	Head of Governance	<i>Removed the requirement for schools to return internal incident registers</i>
0.2	2 nd December 2014	Head of Governance	<i>Policy reduced in length; simplified accident form included</i>
0.3	27 th January 2016	Head of Governance	<i>Policy name updated from 'Accident Reporting Policy' policy amended to reflect the Department's new name; details of Department contacts updated; inclusion of Accident and Incident Reporting Process flowchart and removal of Accident Record form</i>
0.4		Head of Facilities	<i>Policy amended to reflect departments name change, additions resident & residential manager to reflect Children's Service, author now changed to Head of Facilities Management from Head of Governance</i>
0.5		Head of Facilities	<i>Policy amended to include information about reporting incidents of abuse against staff by adults and made relevant to all CYPES sites. Section 7 added 'Safeguarding the Wellbeing of our Staff'</i>
0.6		Health and Safety Manager	<ul style="list-style-type: none"> • <i>Policy Template and title changed, investigation added to title to reflect added information. Author changed to H&S Manager and review date added.</i> • <i>Section 6.1- Incident, and near miss and safety observations definitions added and V&A definition amended.</i> • <i>Section 7.1 - Criteria for reporting centrally amended to include more employee related incidents where injury has occurred, and near miss incidents where someone could have been hurt or damage could have been caused</i> • <i>Section 7.2 List of minimum information required added for less severe incidents reported internally internally.</i> • <i>Section - 7.3 Reporting information on other systems added.</i> • <i>Section 8 - 'Management of incidents' added to replace sections 5 and 6 from original policy.</i> • <i>Section 9 - Investigation information added.</i> • <i>Section 10 - Training paragraph added.</i> • <i>Section 12.1 – Informaton about analysis of data added</i> • <i>Removed information about work experience and Trident to be added in a more specific policy</i> <p><i>Appendices added</i></p> <ul style="list-style-type: none"> • <i>Appendix A- Incident type and level of investigation table.</i> • <i>Appendix B- Incident Investigation, Types of Evidence table.</i> • <i>Appendix C – Incident Investigation Template.</i> • <i>Appendix D – Incident Flow Chart amended.</i> • <i>Appendix E – '5' Whys techniques.</i>

APPROVAL

ADDITIONAL INFORMATION

Consultation	Date	
Primary Schools	Presented at Education SLT in May 2023 and Policy was sent to key stakeholders from both primary and secondary schools May 2023	
Secondary Schools		
Further Education	Sent to key stakeholders in May 2023	
Jersey Youth Service	Sent to key stakeholders in May 2023	
Childrens Social Care	Sent to key stakeholders in May 2023	
Planned review date:	Distribution:	
April 2026	Policy will be available on CYPES Gov.Je. and Governance SharePoint site. Distributed to all CYPES by internal comms	
Associated policies and Minimum Standards	Name	Reference
	Violence and Aggression Minimum Standard	
	Incident Reporting and Investigation Minimum Standard	

