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HELA

Evaluation of the Template Policy for the Selection of Workplace Accidents, Dangerous Occurrences and Work- Related Ill Health for investigation by Local Authorities

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Issue

1. To produce new Section 18 guidance for the selection of workplace accidents, dangerous occurrences and work-related ill health for investigation by local authorities.

Timing

2. Incident selection guidance is required for 2009/10 to enable LAs to meet their Section 18 requirements in 2011; compliment the new LAC67/1 Rev3 Priority Planning and priority planning guidance and develop alignment with relevant HSE and LBRO work streams.

Recommendation

3. HELA recommends the Incident Selection Criteria is adopted subsequent to –
 - (i) Simplification and amalgamation of proformas (Annex D)
 - (ii) Q&A section to assist users understanding of criteria (Annex E)
 - (iii) Further discussion with HSE to ensure incident selection alignment between FOD and LAs

Background

4. In 2006 HSE commissioned Greenstreet Berman Ltd to undertake a research report titled "Evaluation of EPS and Enforcement action. "The research identified a lack of consistency in areas of enforcement between HSE and local authorities. One area specifically highlighted was incident selection and investigation. The research found

inconsistency in the type and the way local authorities investigated incidents. Whilst generally there were incident selection criteria procedures in place the research found, there was disparity between LA procedures and sometimes no justification for selection of particular incidents. Ordinarily, there was disparity between local authorities and HSE incident selection procedures.

5. In 2006 HELA formed a Task and Finish group to recommend improvements to its current incident selection criteria guidance LAC 22/13. In practice selection criteria varied amongst LAs and with that of FOD. Through Jane Bride, Partnership Liaison Officer, the task and finish group produced a draft common Incident Selection Criteria Framework complete with templates and proformas to assist transparency and accountability (Annex A). The selection criteria were closely aligned with that of FOD and aimed at assisting compliance with Section 18. Following HELA approval a cross-section of local authorities from across Great Britain were invited to participate in the rolling trial. Sixty authorities volunteered.
6. At its October 2008 meeting HELA agreed to clear the guidance via the online web community. Difficulties in securing resource and gathering sufficient evaluation feedback from LAs delayed recommendations.

Evaluation

7. The trial involved 60 volunteer local authorities. A questionnaire was sent out (Annex B) and responses obtained from 40% (25) volunteer local authorities. The majority of local authority categories were represented namely - London Boroughs, Metropolitan Districts, Urban and Industrial, Suburban, Resort and Retirement, Rural, Welsh Urban and Welsh Rural. Overall feedback was positive and Annex C provides an evaluation report and synopsis of the results. Some partnership management teams also provided informal feedback.

Main Findings

8. Overall the procedure was well received by local authorities. Positive feedback included -
 - The procedure brought consistency which was welcomed
 - Enabled effective and efficient targeting of resources
 - In a lot of cases the number of incidents for investigation was reduced
 - The style and format enabled LA regulatory services to justify a decision which was particularly helpful when dealing with 'local pressures.'
9. Some local authorities have adopted the template and are continuing to use it at the time of writing.
10. No particular size or category of local authority was strongly critical of the procedure however, a few negative comments were received. Main concerns centred around the need for the procedure to be shortened and the fear that the requirement of managers to make initial decisions on the selection of incidents would produce unnecessary burdens on them. Further clarification on points of process and terminology was highlighted.

11. Some local authorities were investigating above the benchmark and found no use for the procedure.

Argument

12. The procedure enables LAs to efficiently and effectively target their interventions within local circumstances. In some cases investigations were significantly reduced. It will be clear that any resource released by this procedure should be directed towards other partnership activity. At the time of writing, some LAs continue use the procedure and proformas.
13. Templates and draft proformas to document decisions were welcomed as a means to justify decisions by health and safety regulatory services. Further refinement was needed to minimise administrative burdens. In response to comments, trial appendices Investigation Selection Form (Annex A (Appendix B) and the Decision Recording Form (Annex A (Appendix D) have been simplified and amalgamated into a single proforma (Annex D).
14. Some LAs raised concern that the procedure required senior officers\managers to review and select incidents. To ensure appropriate governance and consistency it is vital appropriate management levels are responsible for the selection of incidents. It is acknowledged that management can delegate authority to others within their LA. In line with Hampton principles, appropriate management responsibility and oversight of the process should be in place to ensure consistent and targeted reactive interventions to ensure maximum reduction in burdens on resources and business. These changes will also help to ensure LA resource is targeted towards dealing with risk and businesses are less likely to be contacted in circumstances where no further action will be taken.
15. Some responses requested further clarification on procedural aspects and terminology. A question and answer section has been drafted to accompany the template to aid understanding (Annex E).
16. Feedback received from some LAs indicated that they were selecting incidents over and above the benchmark set by the criteria. Work currently ongoing within HSE to review risk indicators and targeting in accordance with requirements set out in the BRE's report "Improving outcomes from Health and Safety" will inevitably shape the risk profile interventions of FOD and LAs. As a result future criteria may well be reviewed within FOD and LAs to enable a 'shift' to target areas of most need.

Presentation

17. As toolkit operational guidance to support the new Section 18 standard there is unlikely to be parliamentary or ministerial interest. Communications with LAs will be managed through the LAU HELEX, LAU and local authority communication media and via partnership management teams.

Costs and Benefits

18. There will be some costs to LAs of modifications to internal procedures and recoding systems.

Financial/Resource Implications for HSE

19. None expected except for those indicated in the LAU plan of work.

Environmental Implications

20. None.

Other Implications

21. Close monitoring and discussion following future developments with HSE's planned work stream for the selection of incidents. Monitoring of LBRO work stream on local authority regulatory risk rating.

Action

22. LAU to manage communication of new Section 18 toolkit on incident selection criteria.

Contact

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Trial Template – NOT FOR GENERAL DISTRIBUTION

Template Policy on the Selection Criteria for the Investigation of Workplace Accidents, Dangerous Occurrences and Work-Related Ill Health

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1.0 PURPOSE

To provide a common, transparent procedure for local authorities on the selection of RIDDOR notifications for investigation. The procedure forms part of the Section 18 Standard which ensures a proportionate, transparent and targeted approach to the selection and investigation of incidents. Local Authorities who do not choose to adopt the procedure should have in place, at the very minimum, an equivalent procedure, which mirrors or enhances the selection criteria below. The procedure does not aim to increase the number of investigations local authorities conduct but to reflect local authority circumstances in incident selection whilst ensuring a consistent approach with HSE FOD.

2.0 SCOPE

The policy covers the handling of all notified incidents received by the local authority whether reportable or not.

A further policy has been developed which deals with the Management of Investigations and which is entitled "Policy on the Management of Health and Safety Investigations". The two policies should be referred to in conjunction with each other.

The scope of the procedure does not extend to circumstances where local authorities in another regulatory capacity e.g. planning, highways, are best placed to deal with breaches of the law.

3.0 STATEMENT OF POLICY

3.1 It is the policy of the local authority to select incidents for investigation with reference to the Health and Safety Executive's Enforcement Policy Statement. When deciding which incidents to investigate and the level of resource to be allocated to the investigation, account will be taken of the:

- severity and scale of potential of potential or actual harm;
- seriousness of any potential breach of the law;
- duty holder's known past health and safety performance;
- enforcement priorities;
- practicality of achieving results
- wider relevance of the event including serious public concern.

3.2. In certain cases the local authority may decide not to investigate where

- there are no reasonably practicable precautions;
- it is impracticable to investigate or follow up;
- there are inadequate resources to investigate or follow up.
(refer also to paragraph 8.1 for further considerations). For any mandatory incident that is not investigated a Decision Recording Form (DRF) must be filled out by the

Head of Service and counter signed by a senior manager...Refer to section 8.2 for a copy of this form.

- 3.3. The local authority will in accordance with its duty under Section 18, allocate sufficient time and resources for reactive work to investigate accidents, dangerous occurrences and causes of occupational ill health.
- 3.4. Not every incident reported to the local authority will require investigation (please see HSE's Policy Statement on the Enforcement of the Health and Safety at Work Act 1974, Section 3). The criteria for selecting incidents that we may consider suitable for further investigation are detailed in the following sections: -

4.0. PROCEDURE WITH NOTIFIED INCIDENT:-

- 4.1 Incidents relating to accidents, dangerous occurrences and occupational ill health will come to the local authority's attention either formally through the Reporting of Injuries, Deaths and Dangerous Occurrences Regulations 1995 (RIDDOR) procedures or informally through complaints, Officer visits or enquiries from Solicitors acting on behalf of an injured party etc. Local authorities should ensure they follow the Investigation Selection Process Flow Chart (Appendix A).
- 4.2 Where the Incident Control Centre (ICC) is used:-
 - check the ICC daily reports page each day and accept correctly allocated incidents or reallocate as appropriate using the relevant enforcing authority guidance
 - redirect to the ICC RIDDOR notifications received by post or fax which are normally handled by the ICC but which have been erroneously sent directly to the local authority.
- 4.3 Where the ICC is not used ensure that the incident is dealt with by the right enforcing authority by:-
 - checking, if necessary, the Enforcing Authority Regulations 1998. .
 - checking the incident occurred within the area of the local authority.
 - passing the incident, where appropriate, to another enforcing authority.

N.B

LAs should ensure they report all incidents reported directly to them to the ICC via telephone, e-mail or fax.

- 4.4 Not every notification made to a local authority will require investigation. The criteria for selecting incidents for investigation should target effort at the more significant events, but not so as to distort the overall balance of resources between preventative and reactive work.

- 4.5. All incidents received are to be considered by the Team Leader (Senior\Principal EHO or appropriate person **responsible** for allocation) who will decide what incidents are to be investigated based on the criteria outlined in Sections 6.0 and 7.0. The Team Leader will allocate incidents to be investigated to appropriate field staff.
- 4.6 It is recommended that all administrative staff who may initially handle these notifications are competent with the key aspects of this policy so that urgent notifications such as fatalities are brought to the Team Leaders attention as a matter of priority.
- 4.7 If the Incident is selected for investigation the Team Leader should record the selection decision together with the investigation objectives and allocate the investigation to an appropriate field officer. An Investigation Selection recording form is attached at Appendix B.

5.0 INVESTIGATION OF INCIDENTS WHERE INITIAL REPORTS DO NOT PROVIDE ENOUGH INFORMATION FOR INVESTIGATION DECISION

If the information provided on an incident does not provide enough information on which to base a decision to investigate or evident facts require further analysis the Team Leader should ensure further information is obtained from the relevant party i.e. duty holder, injured party, either by letter, telephone etc. A standard letter is attached at Appendix C for this purpose.

6.0 MANDATORY INVESTIGATIONS

The following defined major incidents should always be investigated:

6.1 Fatal Accidents

All fatalities as a result of an accident arising out of or in connection with work activities, whether it is to an employee or a member of the public. This excludes suicides or deaths from natural causes. See HELA circular 22/16 for HSE's consideration into work related Road Traffic Incidents [DN: Check: circular]

6.2 Major Injuries

The following RIDDOR defined major injuries to all persons including non-employees, irrespective of the cause

- All amputations of digit(s) past the first joint;
- Amputation of hand/arm or foot/leg;
- Serious multiple fractures (more than one bone, not including wrist and ankle);
- Crush injuries leading to major organ damage (e.g. ruptured spleen)
- Head injuries involving loss of consciousness

- Burns and scalds greater than 10% of the surface area of the body;
- Permanent blinding of one or both eyes;
- Any degree of scalping
- Asphyxiations

6.3 Occupational Diseases

All reports of cases of occupational disease which meet the criteria of report ability under RIDDOR, except those arising from circumstances/ have already been investigated.

6.4 RIDDOR injuries highlighted by Programmed Directed Inspections (Strategic Priorities) as set out by the HSE Board e.g. 2007/2008 FIT3 required incidents.

6.5 **Where a serious non-compliance appears to be the cause of an incident.** Where a serious non-compliance appears to be the cause of the incident and is likely to have involved a serious breach of health and safety law. A serious breach of the law is one where the enforcement expectation using the Enforcement Management Module (EMM) would determine as requiring a Notice or Prosecution;

6.6 **All incidents likely to give rise to serious concern.** This reflects the views of the public at large not just those of an individual. Consider in particular:

- Incidents involving children, vulnerable adults and multiple casualties where the outcome or potential outcome is serious.
- Dangerous Occurrences with the potential for directly causing the death of anyone or major injuries to a number of people.

7.0 DISCRETIONARY INVESTIGATIONS:-

Those incidents not falling into the above criteria for mandatory investigation may be investigated at the local authority's discretion when taking into account the following factors;

- 7.1 Any other incident which relates to the Health and Safety Executive's Strategic Priority which has not caused a RIDDOR defined major injury, or one which arises from a specific health and safety initiative that may be contained within the Local Authorities Service Plan or Local Area Agreement.
- 7.2 The poor health and safety track record of the duty holder and whether or not there has been a history of similar events;
- 7.3 The incident has the potential for high public profile/media attention or has received considerable media attention leading to reputational risk through inaction/perceived inaction.

- 7.4. Any incident that has been identified as being useful for -
- (i) enhancing sector good practice\technical knowledge or
 - (ii) training and developing staff as recognised from any Regulators' Development Needs Analysis (DNA) Tool discussions.

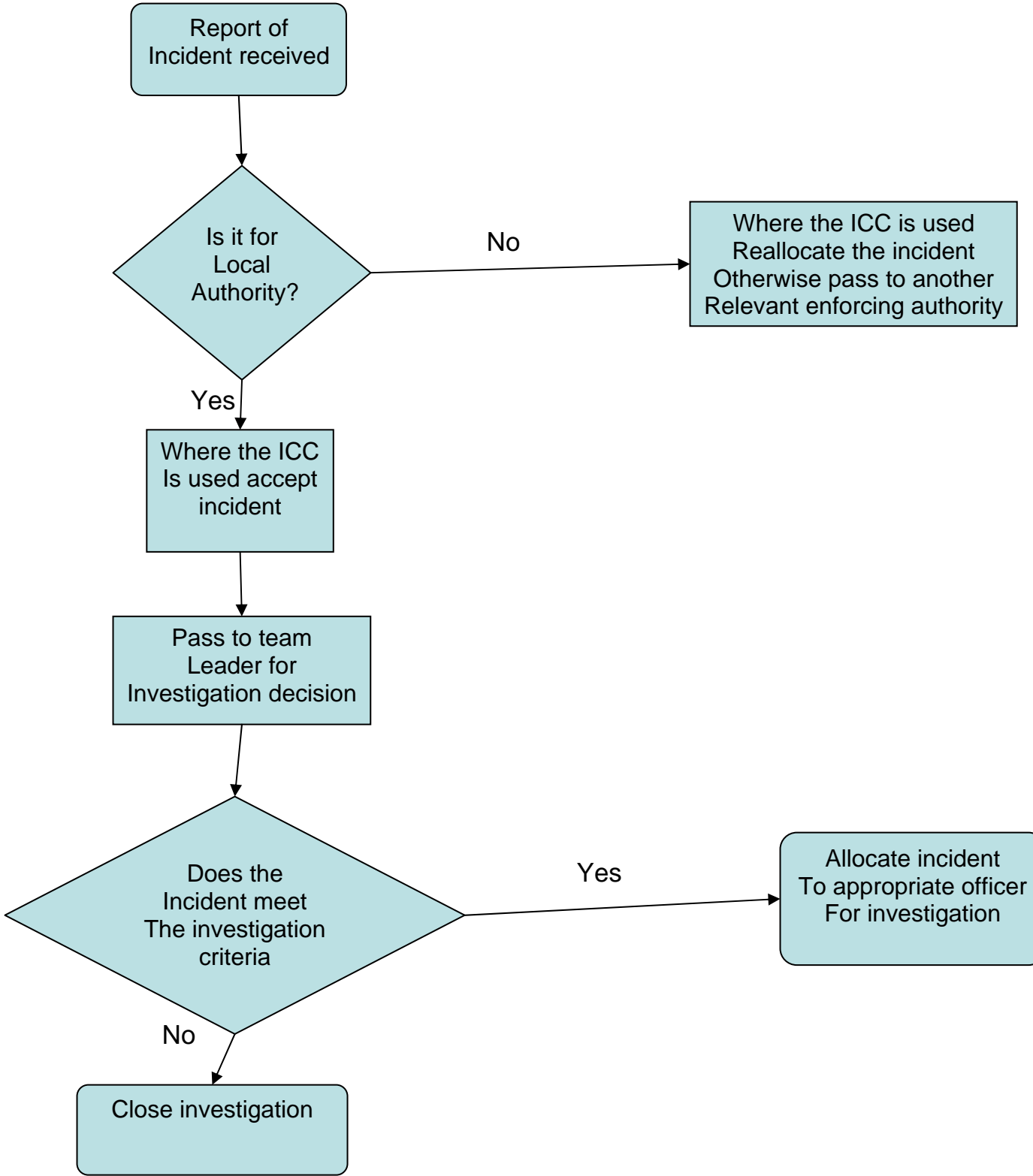
8.0 NON –INVESTIGATION OF A MANDATORY INCIDENT:-

8.1 The grounds for not investigating incidents that would normally be investigated will include;

- Those incidents reported that do not meet the criteria for investigation as detailed above;
- The Impracticality of an investigation, e.g. unavailability of key witness (es), key evidence is no longer available.
- No reasonably practicable precautions available to prevent the incident\accident or its recurrence;
- Investigating the accident will mean the Local Authority will be acting ultra vires.
- There is a conflict of interest between the LA as a regulator and duty holder.
- Inadequate resources due to other priorities;

8.2. Remember that for any mandatory investigation that is not investigated, a Decision Recording Form (DRF) (Appendix D) must be filled out by the Head of Service and counter signed by a senior manager explaining the reasons for non-investigation

Appendix A



**Appendix B
Investigation Selection Form
(To Be Attached To The RIDDOR)**

QUALIFYING CRITERIA FOR INVESTIGATION	<i>NOTES</i> e.g. On Selection, for Investigating Officer
(A) DEFINED CIRCUMSTANCES	
Fatality arising out of or in connection with work	
Amputation of digit past first joint	
Amputation of arm/leg	
Serious multiple fractures (> one bone, not including wrist or ankle)	
Crush injuries leading to internal organ damage	
Head injuries involving loss of consciousness	
Burns and scalds greater than 10% of body area	
Permanent blinding of one or both eyes	
Any degree of scalping	
Asphyxiations	
RIDDOR injuries defined by Strategic Programmes set out by the HSE Board. For current FIT 3 this is:	
Workplace transport incidents	
All Electrical incidents	
Falls from heights	
All incidents arising from working in a confined space	
Diseases & Dangerous Occurrences:	
All RIDDOR reportable diseases (except those already investigated)	
All RIDDOR reportable dangerous occurrences (except as above)	
(B) CIRCUMSTANCES ALLOWING DISCRETION	
Public concern (public at large not just an individual)	
Serious breach of H&S law (warranting notice or prosecution)	
Incidents relating to inspection programme	
Incident involving plant or processes which could enhance knowledge	
Training of inspectors	
Complaint criteria	
Deviation from criteria – note reason(s).	
DISQUALIFYING CRITERIA	
Does not meet qualifying criteria above	
Inadequate resources – this must be referred to line manager	
Impracticability of investigation	
No reasonably practicable precautions available for risk reduction	
<ul style="list-style-type: none"> • Referred to line manager ? 	
DECISION – INVESTIGATE ?	Yes/No

INVESTIGATING OFFICER

DATE.....

TEAM LEADER

DATE.....

Note: RIDDOR defined major injury – fracture other than to fingers, thumbs or toes; amputation; dislocation of shoulder, hip, knee or spine; loss of sight (temporary or permanent); chemical or hot metal burn or penetrating injury to eye; injury from electric shock/burn leading to unconsciousness or resuscitation or hospital stay of >24 hours; any other injury leading to hypo/hyperthermia or unconsciousness or resuscitation or hospital stay of >24 hours.

Appendix C

Letters requesting further information from IP (Injured Person).

Dear Sir\Madam,

YOUR INJURY

Enclosed is a copy of information that has recently been provided to this local authority under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR form 2508).

The Council requires further information on which to decide if further investigation is needed. Please check the RIDDOR 2508 form for accuracy and provide the information indicated on the two attached pages **within the next 14 days.**

If you have any questions please do not hesitate to contact me.

Yours faithfully

Enclosed:

A copy of the RIDDOR Report received by the Council

Return Envelope

6. Had you been told of the results of a risk assessment for the activity? If so, can you recall what they were?

7. If you have returned to work, has anything changed, e.g. new precautions?

8. Please say if the information provided on the report of injury form is correct and if not provide the amended details here. Please confirm your injuries and how long you are likely to remain off work if you have not already returned.

Signed:

Letter requesting further information from Employer.

Dear Sirs,

INJURED PERSON:

DATE OF INJURY:

Please find enclosed a copy of the information, which you have provided to this local authority regarding the above incident. The incident has been selected for further enquiries.

The enclosed sheet contains details of the information, which we require as part of these enquiries. **Please return the completed questionnaire to me within the next 14 days. Failure to reply within the timescale may result in a visit to your premises by a Health and Safety Officer to make further enquires.**

If you have any questions please do not hesitate to contact me on

Yours faithfully

Reference:

Injured Person's Name:

FURTHER INFORMATION REQUIRED FOR LOCAL AUTHORITY INVESTIGATION

1. What were the circumstances of the accident?

2. How did the accident happen?

3. Why did the accident happen?

4. How does the accident affect the significant findings of your Risk Assessment for this task (as required by Regulation 3 of the Management of Health and Safety at work Regulations 1999);

5. What action has been taken to reduce the risk of a recurrence of such an accident?

6. Where any photographs taken or sketches made of the scene of the injury? If so, please provide copies.

7. What are the names and addresses of any witnesses to the injury or other persons who may be able to assist in the investigation?

8. Were any written statements taken from these witnesses? If so please provide copies.

Appendix D

Template Decision Recording Form

Decision Recording Form Recording decisions not to investigate a RIDDOR incident

Part A - Reason for Officer line manager not selecting incident for investigation *(please tick appropriate box(es))*

1. Following consideration of HSE's HSWA Section 3 policy

Tick box if additional papers are available
(See HSWA Section 3 policy - Recording decisions not to investigate)

2. Decision making factor is relevant:

Investigation is impractical

No reasonably practicable precautions are available for risk reduction

Inadequate resources available or other developing priorities
(Note: Notify Senior Manager of provisional decision to request approval at Part D)

Inspector Line Manager initials Date

Part B – Officer line manager decision to cancel investigation

Incident meets selection criteria and selected but investigation does not proceed due to inadequate resources or other developing priorities.
(Note: Notify Senior Manager of provisional decision to request approval at Part D)

Officer Line Manager initials Date

Part C - Officer line manager decision on receipt of additional information

Where decision 'Not Inv' remains unchanged due to inadequate resources
(Note: Notify Senior Manager of provisional decision and request approval at Part D)

Where decision changed to 'investigate' give name of investigating officer

Line Manager initials Date

Part D - Senior manager consideration of inspector line manager's decision on inadequate resources/other developing priorities *(please tick appropriate box)*

Decision not to investigate approved

Incident to be investigated (specify action below)

Action to be taken:

Senior Manager initials Date

ANNEX B – Evaluation Questionnaire

For the purposes of evaluation, all replies will be treated as confidential and anonymised.

QUESTIONNAIRE FOR EVALUATION OF INCIDENT SELECTION TEMPLATE

- 1. Name and Job Title:**
- 2. Local Authority:**
- 3. Contact details:**
- 4. Number of Officers who deal with health and safety:**
- 5. Number of Officers involved in the trial:**
- 6. Number of reported incidents received in trial period:**
- 7. Number of categories of incidents selected for investigation using the procedure e.g. falls from height, slips and trips etc:**
- 8. Did you find the procedure useful and if so why? Please also give reasons if you did not find it useful.**
- 9. Did it make Incident Selection easier for you?**
- 10. Did Officers use the tools provided in the appendices and if so how many times?**
- 11. What did you like/dislike about the procedure?**
- 12. What improvements would you make to the procedure/documentation?**
- 13. During the trial period, did you have to justify any of your decisions and if so did the procedure make this easier for you?**
- 14. Please give any general comments on the procedure:**

WHEN YOU HAVE COMPLETED THIS QUESTIONNAIRE PLEASE EMAIL IT TO ME AT EITHER jane.bride@stevenage.gov.uk OR jane.bride@hse.gsi.gov.uk.

THANK YOU!

ANNEX C – Evaluation Report for Trial of Incident Selection Criteria Template

EVALUATION OF TEMPLATE POLICY ON THE SELECTION CRITERIA FOR THE INVESTIGATION OF WORKPLACE ACCIDENTS, DANGEROUS OCCURRENCES AND WORK-RELATED ILL HEALTH – PROJECT REPORT.

Executive Summary

Findings from research commissioned by HSE highlighted the need to produce an incident selection criteria for local authorities to improve consistency and focus resources appropriately. With the introduction of the Section 18 Standard the new procedure would form a fundamental part of priority planning benchmarking. A draft Incident Selection Criteria was trailed across a representative section of local authorities. The draft procedure was well received subsequent to a minor clarifications and amendments to reduce length.

Aims and Objectives

The aim of the project was to trial, evaluate and produce a template incident selection criteria for local authorities, which would provide a Section 18 benchmark standard taking in to account local area circumstances.

The objectives of the project were to provide –

- A standard Section 18 benchmark criteria to base incident selection activity and procedures targeting resources appropriately;
- Clear concise guidance on the nature and types of incidents to be selected to aid inter authority and HSE\LA consistency and;
- A transparent procedure that provides regulators some local flexibility in decision making and a mechanism by which investigation decisions are justified locally within a management accountable framework.

Background.

In 2006, HSE commissioned Greenstreet Berman Ltd to undertake a research report titled “Evaluation of EPS and Enforcement action “The research identified a lack of consistency in areas of enforcement between HSE and local authorities. One area specifically highlighted was incident selection and investigation. The research found inconsistency in the type and the way local authorities investigated incidents. Whilst generally there were incident selection criteria procedures in place the research found, there was disparity between LA procedures and sometimes no justification for selection of particular incidents. Ordinarily, there was disparity between local authorities and HSE incident selection procedures.

At its meeting on 31st March 2006 HELA formed a Task and Finish group to look at local authority proactive and reactive interventions. In accordance with Hampton principles, one of the aims of the group was to produce a common Incident Selection Criteria Framework, aligned with HSE, which would ensure consistency and effective targeting amongst local authority regulators (revising guidance LAC 22/13). The framework should also contain

draft template letters and other proforma to assist local authorities. A draft Incident Selection Criteria was trialled on a cross-section of local authorities throughout Great Britain. Sixty authorities volunteered to take part in the rolling trial that took place between September and December 2008.

Incident Selection Criteria Template Policy

The template policy aims to provide new guidance for local authorities to comply with part of their requirements of Section 18 “Making it Happen”. For those authorities with good procedures already in place, it further provides a benchmark against which they can review or integrate into existing arrangements.

Based on existing good practice the procedure does not ask for any action over and above what should already be in place. In line with current practice, the template procedure aims to give greater flexibility upon which to base selection decisions and provides a framework to clearly justify decisions.

Evaluation.

The trial involved 60 volunteer local authorities. A questionnaire was sent out and responses obtained from 40% (25) of volunteer authorities. Some partnership management teams also provided informal feedback.

Main Findings

The procedure was well received and authorities acknowledged that consistency is an important factor in working more efficiently. Other positive feedback received was as follows:

- Incident Selection was made easier and targeted their resources more effectively.
- The number of incidents for investigation was significantly reduced.
- The style and format of the proforma was appreciated and enabled them to provide a justification for intervention/non-intervention. Triallists found this approach particularly helpful when working within the local political arena.

The negative comments received stated that:

- Three authorities found the procedure too lengthy and cumbersome.
- Some authorities noted the procedure required managers to make initial decisions on the selection of incidents to be investigated. It was felt Managers would not have time to do this and would burden them given other areas of work for which they were responsible.

Other findings were:

- Some local authorities liked it so much that since the trial are still continuing to use it.
- Some local authorities were investigating above the benchmark stipulated and were continuing to use their own criteria and procedures.
- All the responses received showed that there was no particular size or category of local authority that were strongly against using the procedure.

Discussion

The procedure made the selection of incidents easier and more targeted using resources more effectively. In some cases investigations were significantly reduced.

Where comments stated that the procedure was too lengthy and cumbersome, the amalgamation of the Investigation Selection Form (Annex B) and the Decision Recording Form (Annex D) would streamline administration. It was noted, proformas provided a means to justify intervention decisions in a local political arena.

In relation to a selection of incidents by a senior officer/manager, this is a crucial part of the procedure as it will ensure consistency in selection and therefore cannot be compromised. However, in using the procedure, it is intended that a manager can delegate the task to a competent person within their team and monitor the situation at suitable intervals to ensure the selection criteria are appropriately used. This is not considered an extra burden upon local authorities but a means to ensure - (i) efficiency in line with Hampton principles and (ii) no unreasonable burdens are placed on business.

Following the evaluation of the trial, HSE have decided to review its incident selection criteria. At the time of writing discussions are ongoing to ensure that any changes would be reflected in any future amendments to this criteria.

Recommendations

It is recommended that the Incident Selection Criteria be adopted subsequent to the following recommendations -

- Simplify the proformas and amalgamate Annex B and D.
- Q&A to assist explaining commonly asked questions
- Further discussion continues with HSE to ensure any future changes in incident selection criteria are considered in respect of this procedure.

Conclusion

Overall, the Incident Selection Criteria were well received. Further work is needed to reduce its length. The production of a Question and Answer section would assist usability and communication. When communicated further explanation on how the procedure assists local authorities to comply with Section 18 and how it could fit in with existing procedures would benefit promotion.

Jane Bride
Partnership Liaison Officer
Stevenage Borough Council

APPENDIX A – Results of Evaluation of Template Procedure for Incident Selection.

<u>Local Authorities (by Category)</u>	<u>Incidents reported</u>	<u>Incidents investigated</u>	<u>Types of incident</u>	<u>No. of Officers in trial</u>	<u>No. of Health and Safety Officers</u>
<u>London Authorities</u>					
LB Westminster	59	12	All categories	2	>5
LB Bexley	33	7	Storage;Catering;Retail;Residential	1	3
RB Kingston Upon Thames	50	20	Various	2	3
LB Southwark	9	4	Leisure; Catering; Retail	1	3
LB Barking and Dagenham				Not trialed but reviewed	
LB Sutton				Not trialed but reviewed	
<u>Metropolitan</u>					
Doncaster	39	13	>3 day; members of public; major injuries	3	8
<u>Urban and Industrial</u>					
Luton	44	19	All categories	5	5
Derwentside	7	2	Major injury; as training exercise (sec 7.4)	2	2
<u>Suburban</u>					
Babergh	15	0	No information provided	3	3
Mid Suffolk	8	1	No information provided	1.5	1.5

South Bedfordshire	17	10	All categories	5	5
Waverney	13	6	Retail; residential;Leisure	1	3
Stevenage	20	8	Leisure;retail; residential – major injuries;>3 day injuries	2	1
Welwyn Hatfield	40	2	Storage and Distribution; retail; residential;leisure	5	5
St Albans	29	3	Storage;retail;catering	1	1
Hertsmere				Not trialled but reviewed	2
Chester le Street	2	0	No investigations	3	3 (but FTE 0.65)
<u>Resort and Retirement</u>					
Christchurch	3	1	> 3 day injury	1	2
<u>Rural</u>					
Kerrier				1	1
Carrick				Not trialled but reviewed	3
<u>Welsh Urban</u>					
Merthyr Tydfil	4	2	Storage; Distribution; Retail		
Torfaen	39	2			
Vale of Glamorgan	13	4	Retail; Leisure; Recreational		
<u>Welsh Rural</u>					
Carmarthenshire	13	3	Retail; Leisure		

ANNEX D – Changes to original proformas –Investigation Selection Form and Decision Recording Form.

APPENDIX B – DECISION RECORDING FORM.

(To be completed by Manager or other nominated competent person and attached to RIDDOR form and case paperwork).

Incident Reference:
Name of IP:

Date:

(A)DECISION TO INVESTIGATE	
(1) Category of Incident (reference sections. mandatory fracture; strategic priority reportable etc)	
(2) Passed to Officer	
(3) Date	
(4) Further details/comments to assist investigating Officer:	
Signed:	
Position:	
(B) DECISION NOT TO INVESTIGATE MANDATORY INCIDENT: (To be completed by Manager <u>and</u> Head of Service/Director)	
Reasons:	Comments:
(1) Does not meet Criteria	
(2) Inadequate Resources	
(3) Insufficient evidence to pursue	
(4) Investigation would not result in an improvement in safety or reduction of risk	
Signed: Team Manager:	Date:
Head of Service:	Agree: Disagree:
	Date:
Further action required:	

Annex E – Questions and Answers (Frequently Asked Questions).

INCIDENT SELECTION CRITERIA – FAQs

1) What is the purpose of the Incident Selection Criteria?

The Incident Selection Criteria is a tool to assist local authorities with selecting incidents for investigation and aims to bring about consistency and transparency both across local authorities and HSE. It will therefore make it easier for you to justify your decisions with incidents you choose to investigate or not. It forms part of “toolkit” to help you comply with Section 18 Standard – Make It Happen.

2) What are the selection criteria based on?

Based on key criteria to effectively target health and safety risks in the workplace. The criteria are based on those used by HSE and have been condensed from the RIDDOR criteria to ensure that resources are not wasted and are targeted effectively. The procedure will be reviewed to ensure that it remains relevant throughout the local authority regulatory environment.

3) Will it involve more work for us?

This is not the idea. In fact, it should mean less work for you as the incidents you select using the criteria will be ones which warrant further investigation and therefore you will not waste valuable resources on those that do not. The criteria give you the flexibility to prioritise incidents within a local context and justify your decisions.

4) The criteria for selection seem very strict and too prescriptive. What is the reason for this?

In the past, there has been great disparity between local authorities in the selection of incidents to investigate and between them and HSE. The criteria are based on those used by the HSE but flexibility has also been built into the template to take account of local needs and conditions. The procedure aims to provide a level of consistency and therefore a prescriptive element is necessary.

5) Why must a Team Leader consider incidents received, as this could be impractical at times?

Arrangements for the selection of incidents vary between local authorities. As a manager, it would be appropriate for a Team Leader or equivalent to ensure that the correct types of incident are selected consistently. If a Team Leader were to delegate the responsibility they should ensure the member of staff selected is competent to do so and understands the local authorities selection process. During potentially high profile incidents e.g. an emergency call out situation, Team Leaders who have delegated their task should be particularly mindful to monitor the situation as part of their management function to ensure that the template is being used as intended.

- 6) We already have a procedure in place that suits us and we have not had any problems using it so why change to this one?

The template is a tool to achieve consistency and a benchmark standard. If your local authority already uses a set of criteria which is at least equivalent to the template standard then there is no reason why you should not continue to use it. However if your procedure is not comparable you should use this template as a benchmark to review your policy and procedures.

- 7) The template seems rather cumbersome and long-winded and will take me a long time to adapt to using it.

The template has been trialled throughout large and small local authorities in Great Britain. Before introducing this template a consultative exercise was undertaken around the country of local authorities and the HSE from a practical, legal and enforcement point of view. Comments received were incorporated into the template and it has been reduced in size as much as possible to make it a user –friendly document. Like everything new, it may take a while to get used to but it will assist you in targeting resources more effectively and provide a sound base form which to justify your reactive interventions.

- 8) Under the section on Mandatory Investigations point 6.2, it only mentions multiple fractures to be investigated. What about single fractures like a broken arm or leg?

It is true that HSE will not necessarily investigate a single fracture but you may wish to look at this under maybe section 6.3 or 6.4 or bring it in under the section dealing with Discretionary Investigations. This is the idea of the template in that it not only fits what the HSE do but it also allows local authorities to use their discretion up to a point in deciding what to investigate.

- 9) What aspects of FIT 3 are included in the template?

All local authority FIT 3 areas are included (see Appendix D for details). Remember future priority programmes may well change the content in Appendix D.

- 10) What if we decide to continue as we are and not use this policy? Who will be checking up on us and what will happen if we don't?

The procedure is part of a toolkit to help local authorities to comply with the new Section 18 Standard – Making It Happen. As with other Section 18 Toolkits self-assessment and peer review processes will ensure local authorities and HSE Field Operations Division (FOD) are adhering to the standard. Partnership Management Teams within your regions will also be involved in encouraging compliance within their regions and where there is non-compliance, the local authority will be identified. Local authorities will be expected to review their existing procedures over the next year or so and then must be fully compliant by 2011.

11. Do I have to use all the proforma letters and forms within this procedure?

No you don't. As mentioned before, you can integrate this procedure with your own systems as long as they mirror these examples or are better and they fulfil the objectives of this procedure..

12. There still seem to be get out clauses within the procedure, which will allow local authorities to make excuses to not investigate an incident when they should e.g. inadequate resource. Surely this defeats the objectives of this exercise?

No, it doesn't. There will be times when authorities have to make a decision on priorities and where they are not fulfilling a statutory duty in that they cannot investigate a mandatory incident, then managers will have to make that decision and justify why they have done it. This is all part of accountability and the reason why managers must take responsibility for such a decision as part of their management function. Of course, this can be questioned if the reasons given are spurious. And remember that local authorities will be subject to self assessment and peer review on this.