

Section 10

# Managing Incidents



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## Section Introduction

This section explains the practice of managing workplace incidents. It's important that you understand the reporting and investigation processes for incidents so that lessons can be learnt to prevent reoccurrence.

The steps for managing incidents effectively for health and safety are:



**Step 1** – deals with reporting and recording incidents, for example the procedure to follow and the timescales for reporting. **A summary of the process for managing incidents is attached to this document and can be displayed on the relevant notice boards within the workplace.**

**Step 2** – explains the incident process and provides guidance on how to close them out effectively to prevent reoccurrence.

**Step 3** – outlines the process for reporting and investigating all incidents which may culminate in an executive incident review.

**Step 4** – explains the importance of identifying learnings from incidents and ensuring that these are recorded on SpheraCloud and actioned to avoid future similar incidents.

**Step 5** – provides advice on managing and reporting visits from an enforcing body such as the Health and Safety Executive (HSE)



# Step 1 – Incident Reporting and Escalation

## Timely Reporting of the Incident

Good communications are essential for the effective reporting of workplace incidents. Report all incidents to your line manager as soon as possible. This may not be possible if the incident occurs during out of hours, so in this case report the incident to the duty manager at the earliest opportunity. Under normal circumstances this **MUST** not exceed 24 hours after the incident has occurred.

Essential facts about the incident must be noted:



- When did it occur, (including time of day)?

- What happened?



- Where did it occur?



- Who was involved, (including any witnesses)?

- What plant, equipment or substances were involved?



- Photos (help establish the incident's true nature and the environment in which it occurred)

## General Data Protection Regulations

The personal information submitted will be used for statutory reporting and investigations and to plan, control and monitor protective and preventive measures by Health and Safety teams, line and senior management.

## Timescales for Incident Escalation, Reporting and Investigation

The principal tool used throughout this process is SpheraCloud, Thames Water's online system for reporting and investigating incidents. If you haven't already done so, ensure that you and your team members receive training from your health and safety advisor.

**The table on the next page sets out the timescales for reporting and investigating incidents:**

Incidents are classified in the following categories and must be carefully recorded and reported as follows:	Line manager	Inform SHW manager / advisor	Inform head of department / heads of SHW	Inform business unit executive	Inform Occupational Health	Record incident on SpheraCloud	Send LTI Home Safe counter re-set	Submit Incident Executive Report (IET)	Submit Lost Time & significant Incident Report (LTI)	Complete incident investigation	Complete Executive Incident Review	Complete lessons learnt
Low / Medium near miss/Service Strikes no injury	1 hr.	1 hr.	-	-	-	24 hr.	-	-	-	14 days	-	-
High near miss / Service strikes / Dangerous Occurrence no injury	1 hr.	1 hr.	1 hr.	1 hr.	-	24 hr.	-	48hr.	-	14 days	21 days	21 days
First aid injury, non-lost time	1 hr.	1 hr.	-	-	-	24 hr.	-	-	-	14 days	-	-
Lost Time Injuries	1 hr.	1 hr.	1 hr.	-	1 hr.	24 hr.	24 hr.	48 hr.	24 hr.	14 days	21 days	21 days
Injury Reportable under RIDDOR including specified injuries	1 hr.	1 hr.	1 hr.	1 hr.	1 hr.	24 hr.	24 hr.	48 hr.	24 hr.	14 days	21 days	21 days
Absenteeism from SAD cases	1	1	1	-	1	-	-	48 hr.	-	14 days	28 days	

**Note:** Managers must notify Occupational Health directly and within 1 hour of any work-related injury. Occupational Health will contact the injured party to carry out a health assessment and offer support. For all lost time injuries, complete the Lost Time 'Home Safe' Counter template, [SHE 34](#), and send it to [safetyhealthandwellbeing@thameswater.co.uk](mailto:safetyhealthandwellbeing@thameswater.co.uk) within 24 hours.



# Step 2 – Incident Investigation and Close Out

## Definitions

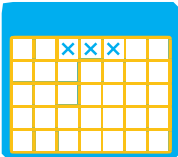
### Injury



An incident that occurs from a work-related activity and requires first aid treatment. To be work related, there must have been something wrong with:

- The way in which the work activity was being carried out, including how the work was organised, how the work was supervised or how the work was being performed.
- The site, equipment, plant, tools, substances or materials used in the activity.
- The condition of the premises, including the structure or fabric of the building, the external areas forming part of the premises
- e.g. the ground conditions, the access platforms, the condition or design of floors, stairs and lighting where the work was taking place.
- The people, in relation to their training, competence or way in which they were carrying out the task that contributed to the incident.

### Lost time injury



An injury that causes a person to be off from work for more than one day (shift) – this does not include the day of the incident.

If the individual attend GP/ Hospital for advice following a first aid injury and then returns to work the same day or the next day this will not be counted unless they are certified unfit for work.

### Records Only



In some cases, an investigated incident shows that it was not caused by a work-related activity or the injured person aggravated a pre-existing injury. However, there may be some learning to share from it. Public road-related vehicle incidents will also be changed to the records only area for future information after the investigation is completed.

### Near miss



An incident (event), which occurred but did not lead to an injury that needed first aid or caused loss.

### Safety observations



An unsafe act or condition where an object or situation is observed and can be challenged or resolved in order to prevent an incident occurring that could lead to loss. For example, identifying a damage cable.

### Service strike



Damage to an underground or over ground service such as electricity cables, gas pipelines, buried electrical cables, water pipes, telecommunication cables, etc.

### Good practice



Actions, practices and behaviours that have been observed to go beyond expected standards and requirements also help to improve the effectiveness and efficiency of processes.

### Definitions of severity

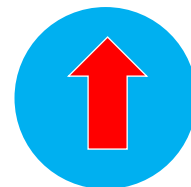


See next page for definitions of severity of Near Misses and Safety Observations.

## Near Miss and Safety Observation Severity

### HIGH

Findings which expose the business, or individuals to serious risk if left un-addressed and/or have an urgent compliance, process, systems or customer implication



Conditions or behaviours which could lead to incidents that:

- Present a serious or imminent risk of major injury or ill health e.g. unguarded dangerous machinery, uncontained chemical leak, missing safety structures.
- Have a potential for major/severe damage, harm or loss.
- Are reportable or immediately reportable to the enforcing agency.

### Serious breach of legislation, regulatory requirements or a corporate policy which:

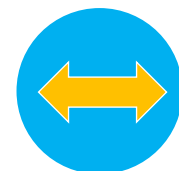
- Are likely to lead to formal action by the enforcing agency.
- Are very likely to lead to informal action by the enforcing agency.
- Are very likely to have a major adverse impact on the customer.

Serious management or system failures, which require immediate remedial action.

Serious customer impact if left unattended.

### MEDIUM

Findings of an administrative/operational nature which expose the business or individuals to moderate risk if left un-addressed, and/or do not have an urgent compliance, process, systems or customer implication.



Conditions or behaviours which could lead to incidents that:

- Present a general risk of injury or ill-health e.g. contained chemical leak, damaged safety structures.
- Have a potential for moderate damage, harm or loss.
- Involve non-reportable lost time.

Minor breach of legislation, regulatory requirements or a corporate policy which:

- Are very unlikely to lead to formal action by the enforcing agency.
- Are unlikely to lead to informal action by the enforcing agency.
- Are unlikely to have a major adverse impact on the customer.

General management or system failures.

### LOW

Findings of any nature which expose the business or individuals to low risk if left un-addressed, and/or have opportunities to improve effectiveness and efficiency of the process.



Any condition or behaviour which presents a low risk of injury or ill-health.

Conditions or behaviours which could lead to incidents that:

- Present a low risk of injury or ill-health e.g. faulty fire panel, trip hazard, first aid kit missing.
- Have a potential for minor damage, harm or loss.
- Would not require local first-aid treatment.

Suggestions for compliance, process, systems or customer improvements. - Conditions or behaviours which could lead to incidents that:

- Present a general risk of injury or ill-health.
- Have a potential for moderate damage, harm or loss.
- Involve non-reportable lost time.

## Establishing Competence to Conduct an Incident Investigation

It's important that all workplace incidents are subject to thorough investigation in order to identify the root causes and prevent a reoccurrence. Managers must ensure that this is done effectively, either by themselves or a nominated person within their team who has done "Incident Investigation Training". They must understand how to complete the investigation forms currently within SpheraCloud. A user guide on how to complete these investigation forms is available from the SpheraCloud library.



You will need to complete four control questions (on SpheraCloud) for low and medium severity health and safety near misses and non-lost time injuries. And for high severity health and safety near misses, lost time injuries and service strikes, you'll need to complete a more detailed investigation form.

**Taking the time to do this accurately and thoroughly can help prevent someone from being harmed in the future. It must be completed correctly as it may be used later in litigation.**

## Deciding the Level of Investigation and Setting Up the Investigation Team



The level of investigation (in terms of time and resources) should always be proportionate to the severity of the event and the likelihood of it recurring. When conducting an investigation, you may need to draw on the appropriate skills, knowledge and expertise of others. For example, when investigating an electrical incident, it would be necessary to contact an authorising engineer for assistance.

In relation to dangerous occurrences and major injuries it is essential that you get the help and advice of your local safety health and wellbeing advisor who will assist managers responsible for taking the lead in these investigations.

## Information gathering

At the beginning of the investigation you will need to collect all the information that you can about the incident. This will involve collecting basic information about the events that led up to the incident and the circumstances surrounding it. Establish at this early stage whether or not the incident actually occurred by asking such questions as: was it immediately reported to the line management, and was it witnessed that the incident



arose out of, or in connection with, a work-related activity. If there was an injury, find out if the injured person has any existing injuries that may have been aggravated by the incident.

To help you decide if the incident arose out of, or in connection with work, ask the following questions:

- Was there something wrong with the way in which the work activity was being carried out including, how the work was organised, how the work was supervised or how the work was being performed.
- Was there something wrong with the site, equipment, plant, tools, substances or materials used in the activity?
- Was there something wrong with the condition of the premises including the structure, or fabric of the building, the external areas forming part of the premises e.g. the ground conditions, the access platforms, the condition or design of floors, stairs and lighting where the work was taking place.
- Was something wrong in relation to the people carrying out the task that contributed to the incident, for example, their training or competence or the way in which they were carrying out the task.

It's important to assess each control question thoroughly to find out the potential cause of the incident and which category it falls into for the root cause analysis. It will also help to get these answers before you start to enter the information on SpheraCloud. Remember, where an answer is given negatively, you must add notes and, where possible, an action to ensure it is prevented in the future.

If the event was a lost time incident, a high-risk near miss, or a service strike, you will need to do considerably more to identify the causes. Your local Safety, Health and Wellbeing advisor will assist you with this.

Each of the key questions below has a number of subsidiary questions which should be considered (where they are relevant) to the incident. It is important to remember that this is a prompt for you to aid your thought process and there may be other questions which arise, as the investigation progresses during the information gathering phase.



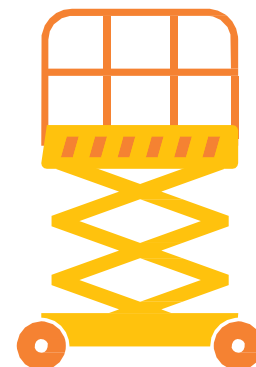
## Was There Anything About the Condition of the Workplace that Contributed to the Incident?

- Was access to the workplace suitable?
- Was the access and egress being used?
- Was the workplace suitable for the task?
- Was there sufficient space?
- Was the workplace being used as intended?
- Were people segregated from hazardous processes?
- Was the work environment (lighting, temperature, ventilation) suitable?
- Did the ergonomics of the workstation suit the person using it?
- Was the work area clean and tidy (routine cleaning, ways of dealing with spills)?
- Were weather conditions adequate?
- Were the noise levels within acceptable levels?
- Were the appropriate warning signs in place?
- Were contractors provided with adequate information about access and the hazards in the workplace?



## Did the Equipment, Substances, or Materials Being Used or Generated Contribute to the Incident?

- Was the most suitable plant / equipment available for the job?
- Was the plant / equipment suited to the person using it?
- Was the plant / equipment being used suited to the job?
- Had the plant / equipment been chosen or modified so that safety improvements could be made if necessary?
- Was the plant / equipment in working order and had it been adequately maintained?
- Was there a routine maintenance programme?
- Was there a procedure for repair when a defect was discovered?
- Was the plant / equipment being used properly?
- Were there adequate controls or guards for safe use of the equipment?
- Were the controls / guards fitted maintained and properly used?
- Were the controls well laid out and easy to understand?
- Were the most suitable materials / substances available for the job?
- Were the correct materials being used?
- Did the materials meet specifications?
- Were the materials / substances used suitable for the job and the person?
- Were the materials or substances being properly used?
- Was exposure to hazardous materials and by-products adequately controlled?
- If the need for PPE had not been identified
- was it safe to do the job without PPE?
- If necessary, was suitable PPE available?
- If necessary, was the correct PPE used?
- If the correct PPE
- was used, was it used correctly?





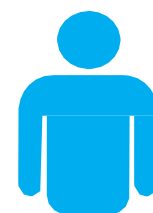
## Did the Procedures, Instruction, or Information (or Lack of Them) Contribute to the Incident?

- Were there safe working procedures and instructions available for the tasks?
- Were safe working procedures and instructions up to date, accurate, realistic and adequate?
- Did any safe working procedures etc. deal with the circumstances of the incident?
- If there were any safe working procedures etc. were the correct ones followed?
- Were they provided and readily available (including for contractors)?
- Were safe working procedures etc. regularly inspected?
- Was the level of supervision adequate, including for contractors?
- Were the training needs for this activity identified?
- 
- If there were safe working procedures or instructions, were they used as part of the training?
- Were contractors working in accordance with agreed method statements and safe systems of work?
- Were contractors informed of the safe working procedures they should adopt?



## Was There Anything About the People Involved that Contributed to the Incident?

- Were the people involved suited to the job?
- Was the health of people who could be affected monitored?
- Were the people performing the work as expected?
- Were workers, employed by contractors, suitable and competent?
- Was the event free of human failings?
- Were all rules, policies and procedures followed?
- Was the incident the result of any slips or lapses caused by: fatigue due to excessive working hours, lack of breaks, boredom, distraction, etc.
- Was the incident the result of too much pressure or time constraints?
- Was the incident the result of any slips or lapses caused by drugs or alcohol, etc.?
- Was the person's emotional state a contributing factor?



## Analysis of the Data



Any data gathered (**from observations, interviews and documentation**) must be analysed to identify the causes of the incident. It is usually the case that any incident can be attributed to a variety of causes, and careful consideration of the data will enable you to establish the root cause.

For example, if an employee had been injured by a belt conveyor, observation of the scene might reveal that guarding had been removed. Interviews might reveal that it had been removed to help with cleaning and had not been replaced. Checking the specification might reveal that the equipment was not designed for the materials it was being used to transport, resulting in the need for constant cleaning.

## Identifying Suitable Risk Control Measures

Analysis of the incident will reveal that risk control measures either failed or did not interrupt the chain of events leading to the incident, because they were not in place.

During this phase of the investigation it is necessary to draw up a list of risk control measures, which would prevent a similar occurrence. It may be helpful to discuss this with your local Safety, Health and Wellbeing Advisor. Continuing with the hypothetical example given above, suitable alternative control measures might involve including the belt conveyor on a maintenance schedule and training the operators to identify a particular type of defect.





## Step 3 – Significant Incident/illness Executive Reporting and Review

### Reporting

As per the escalation table on page 3 and the process flow on page 12 for all lost time injuries, the Lost Time '[Home Safe' Counter template, SHE 34](#), must be completed within 24 hours of it being notified as lost time. Report all significant incidents to the Thames Water Executive Team within 48 hours of the incident occurring. Managers in conjunction with the local Safety, Health and Wellbeing Advisor must complete and submit an [Incident Executive Report template, SHE 35](#).

Send the completed forms to: [safetyhealthandwellbeing@thameswater.co.uk](mailto:safetyhealthandwellbeing@thameswater.co.uk) within the given timescales via your Safety, Health and Wellbeing Advisor.

### Review - work-related lost time injury

All cases of work-related lost time injury or illness must be reported, investigated and have an Executive Incident / Illness Review (EIR) undertaken. Also, service strikes of high voltage or high-pressurised gas mains must also have an EIR.

The EIR should be conducted by a member of the senior management team and a Safety, Health and Wellbeing Manager. As part of the review the [EIR template, SHE 36](#), should be completed and presented at the review.

All non-lost time injuries and low voltage service strikes will be reviewed at a local level with a relevant senior manager and the Health, Safety and Wellbeing Advisor for that area.

All must take place within 21 days of the incident occurring. Upload the EIR to SpheraCloud and send it to [safetyhealthandwellbeing@thameswater.co.uk](mailto:safetyhealthandwellbeing@thameswater.co.uk).

### Review - work-related lost time illness

All cases of work-related lost time illness must be reported, investigated and have an Executive Illness Review (EIR) undertaken. A clinical judgement will be made as to whether cases are work-related.

For all cases of Stress, Anxiety and Depression (SAD), a Stress risk assessment should be completed by the Line Manager. The Line Manager and employee guides to stress should be reviewed to support the Risk Assessment. These guides and the Risk Assessment template are located on the [OH SharePoint portal](#).

If cases are work-related as decided by the Occupational Health team, the Occupational Health team will inform the Line Manager and the HSSW manager for the area.

The HSSW Manager for the area will request that an Executive Illness Review template is completed by the Line Manager.

An Executive Illness Review meeting should be set up within 28 days. The review meeting should be attended by the Line Manager, OH advisor, HR advisor, ML4 and HSSW Manager for the area.

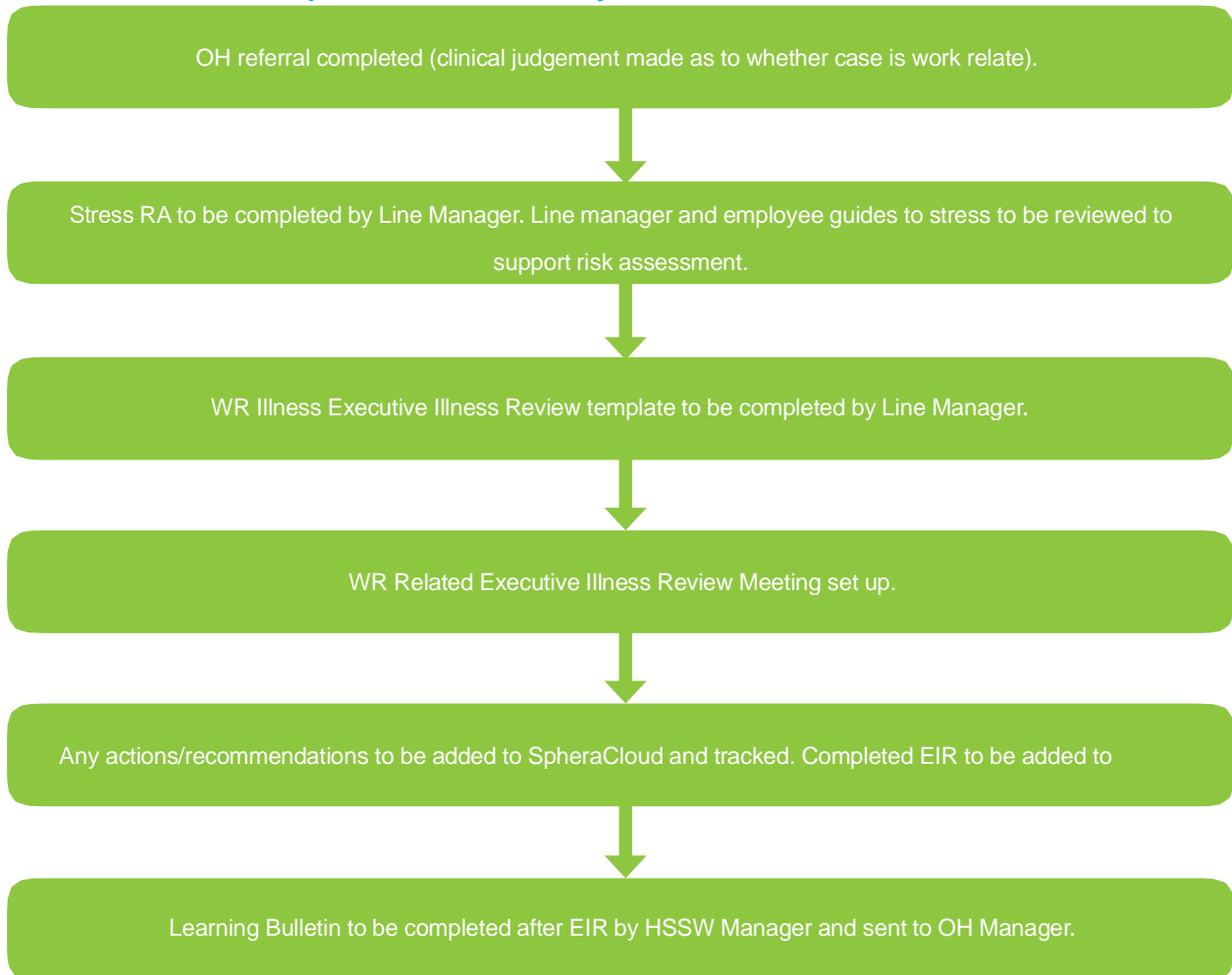
Please note: If the case significantly involves the Line Manager the review should be undertaken and completed by the next level up.

Any actions or recommendations from the review should be added to SpheraCloud by the HSSW Manager or Line Manager for the area; this should be agreed at the review as well as timescales and responsibilities for completion. The actions added to SpheraCloud must not contain any personal or sensitive information relating to the individual.

The completed Executive Illness Review template should be sent to the OH advisor for the area and added to Cohort.

After the EIR takes place, a learning bulletin must be completed by the HSSW Manager for the area and sent to the OH Manager to ensure that any lessons learnt are captured and trends can be analysed.

## Work-related lost time illness - process flow summary



## Resulting Actions

As a result of the review, add any resulting actions **Individually** and associated documents to the existing incident record within SpheraCloud with the agreed timescales for completion.



## Step 4 – Learnings from the Incident

### Capturing the Required Actions and Learnings from the Incident

Identify any remedial actions required to prevent a recurrence of the event at this stage. It is absolutely essential to capture the learning from any incident and to ensure that they are applied in your own area and in other vulnerable areas of the business. Actions may range from providing appropriate training to maintaining or replacing plant or equipment. It is important to identify any company-wide actions, since an incident can have implications for the rest of the business as well.

### Communicating and Embedding Learnings

Identify any learnings from the reviews and share them across the business, in the form of a [Learning Bulletin, SHE 37](#). Send the Learning Bulletin to [safetyhealthandwellbeing@thameswater.co.uk](mailto:safetyhealthandwellbeing@thameswater.co.uk).



## Step 5 – Enforcement Authorities Visits



Thames Water will occasionally encounter representatives of the enforcing authorities i.e. the Health and Safety Executive, the Fire and Rescue Service, or the Local Environmental Health Officer. In many cases the contact will often follow a reportable incident or just be a routine visit. In all cases you will be acting on behalf of the company. Therefore, it is essential to be professional, polite and helpful.

Many enforcing authorities have the legal power to gain entry to premises, question persons under caution, and seize records and equipment as evidence. Consequently, make no attempt to obstruct them; however, it is reasonable to request that a Thames Water representative accompanies them while they are on our premises.

**Whenever contact occurs, follow the process set out below:**

### Planned visit

Inform your senior manager, the duty control manager and your local Safety, Health and Wellbeing Advisor of the visit's details. Review and discuss the correspondence, with your local Safety, Health and Wellbeing Advisor, before the visit, so any required preparation and planning is done in advance. On the day, you, the Safety, Health and Wellbeing Advisor, and in conjunction with the enforcing authority must agree on any

necessary action and record them on SpheraCloud. Keep all correspondence i.e. letters, notes from the meeting etc. locally, within the health and safety records file, and upload copies onto SpheraCloud.

### Unannounced visit

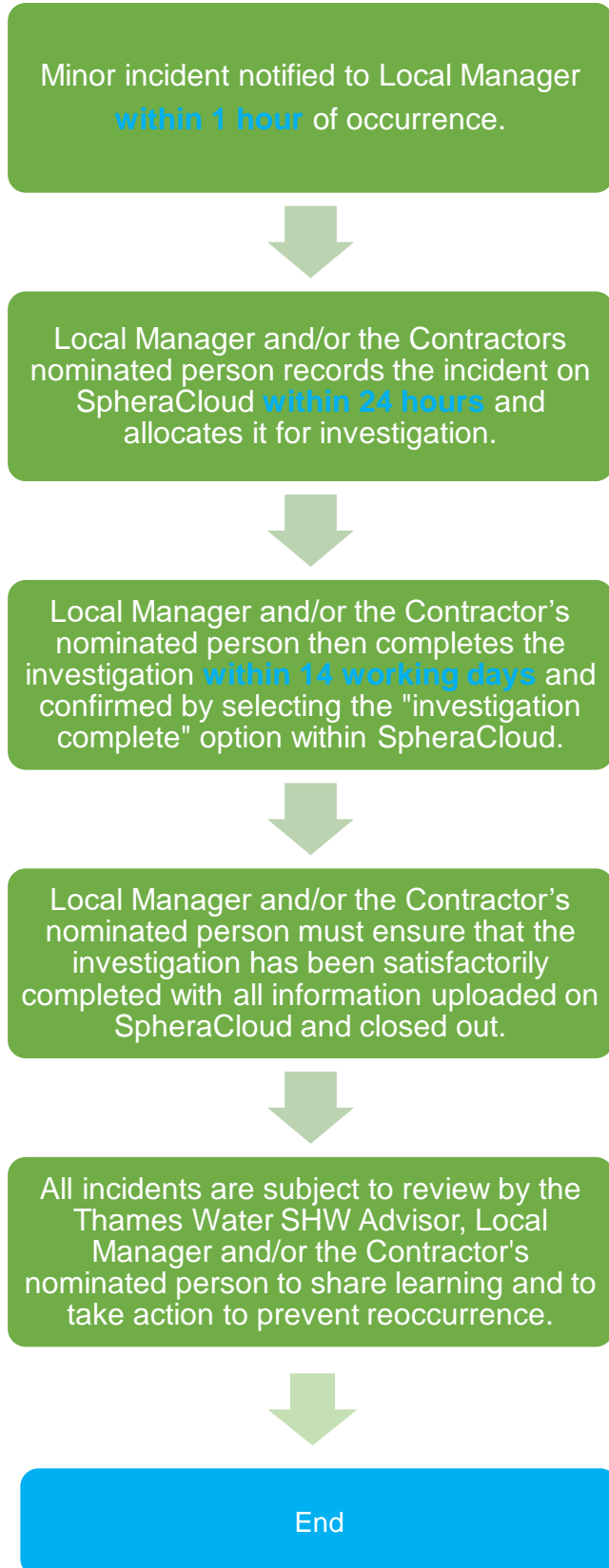
Inform your senior manager, the duty control manager and your local Safety, Health and Wellbeing Advisor (who will join you as soon as possible to help and assist you) that you are meeting with a representative

of one of the enforcing authorities. You, the Safety, Health and Wellbeing Advisor, and in conjunction with the enforcing authority must agree on any necessary action and record them on SpheraCloud. Keep all correspondence i.e. letters, notes from the meeting etc. locally, within the health and safety records file and upload copies onto SpheraCloud.

# Reporting Minor / Significant Incident Process Flow Summary

## Minor Incident Reporting

(non lost time injury, near miss low or medium including low or medium service strikes)



## Significant Incident Reporting

(major lost time injuries, dangerous occurrences and high near misses including service strikes)

