HCPL PROCEDURE

ACCIDENT / INCIDENT CLASSIFICATION AND REPORTING PROCEDURE

MAIN AUTHOR	REVIEWER	APPROVER
Luke Hands Director of Health, Safety, Environment & Quality 27/07/2020	**Joe Bonner** Director 27/07/2020	**Mark Henry** Managing Director 27/07/2020

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ACCIDENT / INCIDENT CLASSIFICATION AND REPORTING

1 When should we use this Procedure?

1.1.1 The purpose of this procedure is to provide instruction and guidance on the reporting and investigation of workplace Health, Safety and Environmental incidents. It describes the activities, tasks and required actions to be carried out in order to support:

- A culture of openness where workplace incidents are reported freely.
- Identification of cause in a transparent, fair and just manner according to established best practice.
- Identification, documentation and tracking of improvement actions through to implementation.
- A process that drives continual improvement and shared learning.

1.1.2 The document also defines the roles and responsibilities for performing these activities, tasks, and required actions along with consistent incident classification categorisation to be used when reporting workplace incidents to internal stakeholders.

2 Who does this procedure apply to?

2.1.1 This procedure applies to all Henry Construction Projects Limited (Henry) employees, visitors, agency staff and contractors (under our control). Contractors providing services to the Company shall comply with this procedure.

2.1.2 The following documentation should be read in accordance with this procedure:

HCPL Classification and Reporting Guidance Note

3 Who is Responsible for this Procedure?

Director of Health Safety Environment & Quality	Overall Responsibility for the Incident Reporting process, chairing the SHES performance committee and approval of Detailed Investigations Approval of Investigations, appointment of independent investigation teams and approval of extensions to investigation timeframes.
HSQE Leadership Team	Form the Independent review panel and maintain an effective incident reporting process and system.
Project Safety Advisor/ Manager	Primary responsibility for the implementation of the reporting and review process within individual projects. In addition, provides trending and analysis to assist in managing risks and developing improvement plans. Also conducts statutory reporting where applicable.
Managing Director	Responsible for ensuring adequate arrangements are in place for compliance with the requirements of this procedure within the operating unit, approval of Level 2 Investigations.
Project/Site Manager	Responsible for initial reporting, categorisation, and severity assessments, leading Level 1 investigations, internal escalation within the business unit and compliance with client processes where applicable.
Supervisor	Responsibility for initial incident management and response within the project.

4 Incident Classification and Reporting

4.1 Initial Reporting

4.1.1 Reporting arrangements shall be made known to all employees, contingent workers and contractors during inductions and within work instructions.

4.1.2 All accidents and incidents must be reported immediately to the relevant Manager or supervisor for the works/activity taking place.

4.1.3 The Company has a set timescale for the reporting of accidents and incidents.

Within 1 hours of the incident being reported to line management initial details must be communicated to management.

Within 1 day the initial incident report form must be completed and logged onto the Henry accident and incident reporting form by the Project / Site Manager.

Within 2 weeks a detailed investigation report shall be completed if required.

4.1.4 Extensions to this timescale must be agreed by the Henry Health & Safety Director

Where necessary the Site Supervisor / Site Manager will follow the relevant Client notification and escalation process in tandem with this Henry process. Client reporting timescales that differ to the above shall also be adhered to in all cases.

4.1.5 A fatality or serious injury (any injury involving the removal of the injured person from site by ambulance) shall be reported **immediately** to the Managing Director and HSQE Director.

4.1.6 Hazards, unsafe acts and unsafe conditions that do not cause and accident or incident should be reported. This report should give enough information to allow the company to identify the location of the event, fix any residual issues and close out the issue raised.

4.1.7 Hard copies of reports must be completed on site to capture relevant information.

4.1.8 All Enforcement Agency visits must be immediately reported to the HSQE Director.

4.2 Incident Classification and Statutory Reporting

4.2.1 All incidents will be classified and investigated on the basis of actual and potential outcome in order to understand the full potential consequences. This is carried out using the tables in Appendix 1.

4.2.2 This Actual (A) and Potential (P) scale extends from 1 to 5 with level 5 incidents the most severe.

4.2.3 For all incidents an initial review will be undertaken by the HSQE Director

4.2.4 The project safety advisor/manager shall be responsible for all statutory reporting, e.g. those incidents reportable under RIDDOR. This should be done following consultation with the HSQE Director. A copy of the F2508 report should be saved with the investigation report.

4.2.5 Where there is ambiguity as to whether an incident is “work related” and/or a reportable incident in line with RIDDOR, a documented assessment will be submitted to the HSQE Director.

4.2.6 The HSQE Director will give confirmation as to whether the incident is to be classed as work related or reported in line with the above.

Form: “Work Related” Incident Assessment Form

4.3 Informing Relevant Stakeholders

4.3.1 Details of all reported incidents will be recorded for trending and analysis.

4.3.2 A weekly summary of all incidents will be circulated within the Company in the form of Incident briefing packs.

4.3.3 For all incidents requiring a detailed investigation a HSQE Alert will be created using the appropriate colour coded template and circulated across the Business.

4.4 Conduct Investigation

4.4.1 All investigations shall commence promptly, within no more than one day of the occurrence and be carried out by an investigation team as described in Appendix 1.

4.4.2 A log of incident investigator competencies shall be identified.

4.4.3 Level 1 Investigations shall be recorded by the Investigation Lead. The following forms shall be used for detailed investigations:

Form: HCPL Incident Investigation Report

4.4.4 For all minor incidents the investigation will be led by a Line Manager, supported by a trained investigator. The investigation report will be reviewed by the HSQE Director.

4.5 Detailed Investigations

4.5.1 For all Detailed investigations, (Category 3A/P and above) the investigation shall be led by a manager external to the immediate employing department and supported by a HSQE trained investigator. A full report will be submitted within two weeks.

4.5.2 Subject matter experts may be appointed to the incident investigation team when deemed necessary in order to carryout assessments, technical advice or provide feedback on learning points.

4.5.3 The investigation shall identify root causes, but the method used should be commensurate with the level of actual or potential outcome.

4.5.4 The full and final investigation report must be approved by the Managing Director and HSQE Director.

4.6 Review Incident Investigation

4.7.1 Investigation findings shall be set out in the form of immediate, underlying and root causation. Findings will be accompanied by recommendations for action discussed with, and agreed by, the action holders and line managers if necessary.

4.7.2 Incident trends will be the subject of periodic review which will also include reviewing the effectiveness of the actions taken following accidents and incidents and the wider management systems to ensure they remain fit for purpose.

4.7.3 Where required, the HSQE Director shall ensure arrangements are in place to assist and provide records to relevant regulatory bodies (Police, HSE, ORR, Environment Agency) upon request. Any such documents released will be copied prior to issue and a register retained.

4.7 Manage Actions and Communicate Learning Opportunities

4.8.1 The Lead Investigator shall ensure that all actions identified during the investigation process are allocated to the responsible person.

4.8.2 Actions arising from all incidents will be completed and tracked to closure.

4.8.3 The HSQE Director will ensure that any evidence submitted is sufficient to demonstrate that the action has been suitably carried out.

4.8 Post-Incident Evaluation

4.8.1 Incident data will be analysed by HSQE Director to identify the underlying trends emerging from incidents in order to review annual plans to ensure the plans focus on the correct areas. A Significant Incident Review shall take place following submission of the final report following any detailed incident investigation

4.9 Data Protection and Legal Privilege

4.9.1 Due to Data Protection legislation, copies of incident report forms, incident investigation reports etc. shall be controlled so as to prevent unauthorised access. Management shall be responsible for maintaining confidentiality of completed reports.

4.9.2 Legal privilege may be placed on such documents and, in such event, report holders may change as advised by legal teams.

4.9.3 Copies of legally privileged incident reports should not be issued to any other third party without authorisation from the HSQE Director.

4.10 Post Incident Response

4.10.1 For cause Drug and Alcohol testing can be undertaken following any incident, but in particular:

- Where human error or impaired judgement appear to be a primary causal factor.
- Where employees are involved in repeat or multiple incidents.
- Where incidents occur during safety critical operations such as those involving heavy machinery, electricity, lifting equipment or work at height.
- Where an individual's behaviour prior / post incident indicates that they may be under the influence of drugs and/or alcohol.
- Where the incident appears likely to be categorised as a 4A / 4P or above.

Where multiple personnel are involved in an incident D&A testing will be conducted with all parties.

4.11 Serious Breaches of Health & Safety Standards

4.11.1 On some occasions, following the completion of an investigation into an incident, disciplinary action may be deemed necessary. In particular where breaches of work instructions, HSQE procedures or supervisory duties have occurred. Disciplinary action aims to remedy unacceptable behaviour and promote acceptable levels of performance. Enforcing standards can however also lead to disciplinary sanctions and even dismissal.

4.12.2 Accident/incident investigations and disciplinary investigations will occur in series, with the accident incident report being passed on to HR to consider disciplinary proceedings.

Note: In certain circumstances, and for more serious incidents (level 3A and above), it may be appropriate to include a HR representative in the investigation team.

5 Document References

5.1 External References

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

HSG 48 - Reducing error and influencing behaviour

HSG 245 - Investigating Accidents and Incidents

Environmental Permitting Regulations

6 Definitions & Abbreviations

Incident	An unplanned event that does not result in injury, but causes damage to property, or has enough significant risk to merit recording.
Accident	An accident is a separate, identifiable, incident, which causes physical injury. This specifically includes acts of non-consensual violence to people at work. Injuries themselves, e.g. 'feeling a sharp twinge', are not accidents. There must be an identifiable external event that causes the injury, e.g. a falling object striking someone. Cumulative exposures to hazards, which eventually cause injury (e.g. repetitive lifting), are not classed as 'accidents'.
Enforcement Agency Visit	A visit to a site or yard/depot from one of the Enforcing Authorities (e.g. Environment Agency/SEPA, HSE/HSA / ORR, Local Authority, Natural England, Scottish Natural Heritage etc.)
Environmental Incident	A failure to implement adequate environmental controls that has resulted in pollution of water, air or land, damage to wildlife and ecosystems (habitats) or nuisance to a local community.
Work Related	An event is 'work-related' if any of the following played a significant role: ■ the way the work was carried out ■ any machinery, plant, substances or equipment used for the work or ■ the condition of the site or premises where the event happened The fact that there is an event at work premises does not, in itself, mean that it is work-related – the work activity itself must contribute to the accident, incident or ill health.
Lost Time Incident (LTI)	An employee, contractor or agency person who sustains a work related injury that results in them being unfit for work for one or more days following the incident. The day of the event is not counted. Any days the injured person would not normally have been expected to work, such as shifts, weekends, rest days or holidays are included.
Medical Treatment Injury	A work related incident that results in injury to an employee, contractor or agency person where a medical professional has provided care recognised as above first aid (for example the provision of an injection, stitches or prescription of medication other than over the counter medicines).
Specified Injury	Work Related injuries specified within RIDDOR as requiring reporting to the HSE. These include (but are not limited to) fractures (other than to fingers, thumbs and toes), amputation and loss of consciousness caused by head injury or asphyxia.
Dangerous Occurrence	An event which arises out of or in connection with work and is one of a number of specific reportable event types as defined in RIDDOR.

Reportable Disease	Occupational diseases specified within RIDDOR which are likely to have been caused or made worse by work. These include but are not limited to carpal tunnel syndrome, occupational dermatitis, hand-arm vibration syndrome and any occupational cancer.
Property Damage	An event that results in damaging any property, plant or equipment (including 3rd party equipment).
Near Miss / Close Call (non-rail / rail)	An event that, while not causing harm, has the potential to cause injury or ill health.

7 Revision History

Revision	Status Code	Date	Revision Description
C01	A1	July 2020	Issued for review.

8 Authorisation

Author		**Luke Hands** Director of Health, Safety, Environment & Quality	July 2020
Reviewer		**Joe Bonner** Director	July 2020
Approver		**Mark Henry** Managing Director	July 2020

Appendix 1 – Company HSE incident Classification

Use the tables in this section to make an assessment of the actual outcome of the incident. If multiple applicable consequences are listed, the event will be categorised based upon the most serious consequence. Following this, make an assessment of the potential outcome by determining the most serious easily foreseeable consequence.

Note: Consequences may involve employees, contractors or members of the public/visitors.

Actual Consequence / Reasonably Foreseeable Consequence	Actual	Potential
④ Fatality ④ Terminal ill health, eg, occupational cancer, asbestosis etc. ④ Environmental Incident Category 5 ④ Service Damage Category 5 ④ Rail Sector Incident (Major)	Category 5A	Category 5P
④ Permanent Disability, loss of sight, disfigurement etc ④ RIDDOR Specified Injury / Dangerous Occurrence ④ Reportable diseases under RIDDOR not falling into category 5 ④ Environmental Incident Category 4 ④ Service Damage Category 4	Category 4A	Category 4P
④ RIDDOR Lost Time Injury (over 7 days) ④ Work related health issue requiring time off work ④ Environmental Incident Category 3 ④ Service Damage Category 3 ④ Rail Sector Incident (Minor)	Category 3A	Category 3P
④ Medical treatment ④ Lost Time Injury (under 7 days) ④ Work related health issue requiring physiotherapy or counselling, but no time off work ④ Environmental Incident Category 2 ④ Service Damage Category 2	Category 2A	Category 2P
④ First Aid Treatment ④ No Treatment required ④ Damage / loss caused ④ Close Call ④ Near Miss (Non-rail) ④ Work related minor health issue ④ Environmental Incident Category 1 ④ Service Damage Category 1	Category 1A	Category 1P

Using the above tables determine appropriate action and investigation level. Always conduct an investigation in line with whichever actual or potential was most serious.

Appendix 2 – Guidance on Writing Incident Reports

Part A – Memory Jogger for Writing Reports

1. Be clear about the facts relating to the incident. Don't hide facts, don't speculate and don't exaggerate. Consider all relevant facts including lighting, timing, PPE, barriers, signage, risk assessments, briefings and verbal warnings and advice.
2. Consider the duty of the employee to take care of their own health and safety and the Company's duty to ensure a safe workplace so far as reasonably practicable.
3. If there are matters which are important but not relevant to the incident incorporate them as learnings in a separate communication stream.
4. Carry out the most appropriate root cause analysis in line with Company policies and procedures which identifies immediate, underlying and root causes. Identify relevant documents and witness statements which support the conclusions. If you have any concerns discuss your approach with your health and safety adviser.
5. Consider the context of actions and whether they are appropriate taking into account locally understood customs and behaviours for example non-verbal communication in a noisy environment may be well understood and regularly practised whereas in a quiet environment it may be rarely used and understood and therefore inappropriate.
6. Set out relevant background, in particular, issues of training, role requirements and experience and policies and procedures. Most areas of the Company are strong in terms of training (whether courses, learning briefs, team meetings or other forms) and it may be that people have forgotten training they have had.
7. We should always look to enhance processes however if the current process is satisfactory or adequate say so and give reasons why. Make it clear that the suggested enhancements build on appropriate arrangements. If a suggested enhancement is appropriate but not a relevant cause of the incident state that or move the suggestion to a different, more appropriate communication.
8. Consider whether there are constructive rather than negative ways to view information e.g. the Company's awareness and preparedness to deal with an issue may be a good thing even if it hasn't prevented an incident occurring.
9. Use verbal communication to discuss issues and gain understanding during the writing of the report.
10. Ensure the investigation and report is progressed promptly. Company procedures set out timelines however in some special cases more time may be needed to do a proper root cause analysis. If so, make sure stakeholders are aware that more time is needed and ensure proper communication processes are established. Generally, it will be appropriate to produced factual interim briefs setting out progress.
11. Speak to the lawyer supporting the incident if you have any questions.
12. The Incident Report must be kept confidential. Mark it as a draft preferably using version control. Once it is final mark it as FINAL.

The report should be headed "Strictly Private and Confidential. Subject to Legal Professional Privilege" at the top of each page. The report should only be distributed to the group writing it. The distribution list should be agreed once the report is in final form.

Appendix 3 – Examples of types and Categories of Environmental Incidents

Table 1: Air – dust smoke, fumes, gases, odour

Category	Examples
5	Release of toxic substances to air, and public health warnings and information have to be issued. Intervention from Regulatory – prosecution likely *Note: this would also be classified as a Health & Safety incident*
4	Significant quantities of gas being emitted off-site (<1km from site), but no public health or warnings required. Release of >300kg of F-Gas (HFC, PFC, SF_6) Intervention from Regulatory Authority – possible prosecution
3	Significant quantities of dust being emitted off-site (likely to cause a nuisance) resulting from: ■ Failure to implement effective air pollution control measures. ■ Failure to have/ comply with, an Environmental Permit (or exemption) for crushers etc. Significant quantities of dark smoke being emitted off site (likely to cause a nuisance) from vehicles, plant and/ or equipment. Significant odour being emitted off site (likely to cause a nuisance) resulting from failure to implement effective air pollution control measures. Release of >30kg of F-Gas (HFC, PFC, SF_6) Intervention from the Regulatory Authority
2	Minor quantities of dust being emitted off-site (may cause a nuisance) resulting from: ■ Failure to implement effective air pollution control measures. ■ Failure to comply with an Environmental Permit (or exemption) for crushers etc. Minor quantities of dark smoke being emitted off site (may cause a nuisance) from vehicles, plant and/ or equipment (except small amounts of dark smoke on start - up) resulting from failure to carry out daily checks. Minor odour being emitted off site (may cause a nuisance). Release of >3kg of F-Gas (HFC, PFC, SF_6)
1	A **near miss** that could have resulted in any of the above – for example: Failure to implement effective air pollution control measures with no dust being emitted off-site yet. Failure to comply with an Environmental Permit (or exemption) for crushers etc., with no dust being emitted off-site yet. Nearly starting work without an Environmental Permit for crushers etc. in place but someone realising and those works being postponed until the Permit is in place. Plant or equipment breakdown emitting dark smoke on site and spotted, turned off immediately and maintenance arranged. Odour identified on site and controls put in place to prevent it. Release of <3kg of F-Gas (HFC, PFC, SF_6)

Table 2 Archaeology & Heritage

Category	Examples
5	Wilful destruction of archaeological remains or Scheduled Ancient Monument. Intervention from Regulatory Authority – prosecution likely
4	Destruction of archaeological remains resulting from failure to implement the Written Scheme of Investigation e.g. failure to have an archaeologist present for watching brief. Intervention from the Regulatory Authority – prosecution possible
3	Significant damage to archaeological remains resulting from failure to implement the Written Scheme of Investigation e.g. failure to have an archaeologist present for watching brief. Damage to a Scheduled Ancient Monument resulting from; ■ Failure to comply with the Scheduled Monument Agreement ■ Failure to report unexpected archaeological finds and finds have been damaged. ■ Failure to have a burials licence. ■ Failure to comply with a burials licence causing significant damage to remains. Destruction of, or significant damage to, non-listed built heritage before it has been assessed, evaluated and recorded (Written Scheme of Investigation). Intervention from the Regulatory Authority.
2	Minor damage to archaeological remains resulting from; ■ Failure to implement the Specific Written Scheme of Investigation e.g. failure to have archaeologist present for watching brief. ■ Failure to comply with Scheduled Monument Agreement (including method statement) but no damage caused. ■ Failure to report unexpected archaeological finds and finds have not been damaged. ■ Failure to comply with a burials licence and minor damage or no damage to remains. Minor damage to non-listed built heritage before it has been assessed, evaluated and recorded (Written Scheme of Investigation).
1	A near miss that could have resulted in any of the above – for example; ■ Failure to implement archaeological works and protection measures given in the Written Scheme of Investigation but no damage caused. ■ Failure to implement planned non-listed built heritage control measures given in the Written Scheme of Investigation but no damage caused. ■ Nearly starting excavation that requires an archaeological watching brief but realising the archaeologist is not present and delaying the excavation until the archaeologist is present. ■ Nearly starting work without a Site-Specific Written Scheme of Investigation/ burials licence in place but someone realising and those works being postponed until it is in place.

Note: Unexpected archaeological finds are not an incident unless we fail to stop work.

Table 3 Contaminated Land

Category	Examples
5	Spreading significant contamination to a previously uncontaminated area off-site presenting danger to health of the public. Intervention from Regulatory Authority – prosecution likely *Note: This would also be categorised as a Health and Safety Incident*
4	Spreading significant contamination to a previously uncontaminated area off-site resulting from failure to implement the contaminated land controls. Intervention from the Regulatory Authority – possible prosecution
3	Spreading significant contamination to a previously uncontaminated area on site resulting from failure to implement the contaminated land controls. Failure to have an Environmental Permit (or exemption) for treatment of contaminated soils. Failure to comply with an Environmental Permit (or exemption) for treatment of contaminated soils resulting in significant harm or damage. Intervention from Regulatory Authority.
2	Failure to comply with an Environmental Permit (or exemption) for treatment of contaminated soils resulting in minor, or no, harm or damage. Spreading minor contamination to a previously uncontaminated area resulting from failure to implement the contaminated land controls.
1	A near miss that could have resulted in any of the above – for example: ■ Failure to implement contaminated land controls but no harm or damage caused. ■ Failure of containment measures that has not yet caused pollution Nearly starting work without an Environmental Permit in place but someone realising and those works being postponed until the Permit is in place.

Note: Unexpected contamination is not an incident unless we fail to stop work, identifies the nature and extent of the contamination and updates the risk assessments and mitigation measures.

Table 4 Ecology

Category	Examples
5	Total loss or extensive damage or smothering to designated habitat, which adversely affects its long-term conservation status. Intervention from Regulatory Authority - Prosecution likely
4	Total loss or extensive damage or smothering to non-designated habitat, which adversely affects its long-term conservation status Intervention from Regulatory Authority - Civil Sanction/ Prosecution likely

3	Damage to a nesting bird, protected species, fish or nest or habitat protected by law Removal of, or damage to, a tree/hedge protected by a Tree Preservation Order Spreading an invasive species to a previously unaffected area off-site. Failure to have protected species licence or fisheries byelaw consent. Failure to comply with protected species licence or fisheries byelaw consent (including conditions) resulting in harm or damage. Intervention from Regulatory Authority
2	Spreading an invasive species to a previously unaffected area on-site. Removal of a tree or hedge that should not have been removed Damage to a tree or hedge that should have been protected Damage to an undesignated wildlife site Failure to comply with protected species licence or fisheries byelaw consent (including conditions) resulting in no harm or damage. Failure to have ecologist undertake watching brief where one was required but no harm or damage caused.
1	A near miss that could have resulted in any of the above – for example: ■ Failure to implement ecological control measures as required by the Works Information but no harm or damage caused e.g. protected area/ species or invasive species not fenced off ■ Works encroaching on a wildlife site which could cause damage ■ Work about to be undertaken near a nesting bird due to lack of pre-start survey Nearly starting work without protected species licence/ fisheries byelaw consent in place but someone realising and those works being postponed until it is in place.

Note: Unexpected ecological discoveries are not an incident unless we have failed to stop work.

Table 5 Groundwater

Category	Examples
5	Release into the lower aquifer of any substance that is harmful to human health and public health warnings and information have to be issued. Intervention from Regulatory Authorities – prosecution likely *Note: this would also be classified as a Health & Safety incident*
4	Release into the lower aquifer of any substance that is harmful to human health (where not done in accordance with a consent e.g. discharge consent or groundwater authorisation). Intervention from Regulatory Authorities – Penalties/ Prosecution possible

3	Release of any substance other than clean and clear water into groundwater including all types of oil, chemicals, detergents. Significant impacts on groundwater levels caused by dewatering (e.g. on neighbouring abstractions). Failure to have consent (e.g. groundwater abstraction licence, environmental permit for discharge to groundwater). Failure to comply with consent (including conditions) resulting in significant harm or damage (e.g. groundwater abstraction licence, environmental permit for discharge to groundwater). Intervention from the Environment Agency, including receipt of a notice. Failure to respond to a notice issued by the Environment Agency.
2	Minor impacts on groundwater levels caused by dewatering (e.g. on neighbouring abstractions). Failure to comply with consent (including conditions) resulting in minor or no harm or damage (e.g. groundwater abstraction licence, environmental permit for discharge to groundwater).
1	A near miss that could have resulted in any of the above – for example: ■ Failure to implement planned groundwater protection measures as required by the Contract Environmental Management Plan(s) but no harm or damage caused. Nearly starting work without a consent in place but someone realising and those works being postponed until the consent is in place (e.g. groundwater abstraction licence, environmental permit for discharge to groundwater).

Note: If oils or chemicals have entered surface water categorise as "Surface Water". If oils or chemicals have not entered groundwater or surface water categorise as "Oils and Chemicals".

Table 6 Noise & Vibration

Category	Examples
5	Vibration causing in significant harm or damage resulting in serious injury to site personnel or a member of the public. *Note: this would also be classified as a Health & Safety incident*
4	Intervention from the Regulatory Authority that has stopped critical works.

3	Failure to have Section 61 consent/ dispensation/ variation for the works (except where the relevant local authority does not require it). If Section 61 consent in place: Material breach of Section 61 consent/ dispensation/ variation (including working hours, method etc. in consent application and any conditions set by the local authority) Failure to use Best Practicable Means to control noise resulting in high likelihood of complaints. Failure to use Best Practicable Means to control vibration resulting in significant harm or damage. If a Section 61 is not required: Working outside permitted hours without permission from the local authority Failure to comply with a Section 60 notice issued by the local authority. Intervention from the local authority in response to a failure to manage construction noise and vibration.
2	Failure to comply with Section 61 consent/ dispensation/ variation that is unlikely to result in prosecution. Failure to use Best Practicable Means to control noise resulting in minor harm or damage. Failure to use Best Practicable Means to control vibration resulting in minor harm or damage. If Section 61 consent in place: Failure to immediately notify the local authority of an overrun. *Note* – an overrun is only an incident if the local authority was not notified.
1	A near miss that could have resulted in any of the above – for example: ■ Nearly starting work without a Section 61 consent/ variation/ dispensation in place but someone realising and those works being postponed until the consent is in place. ■ An item of plant about to be used that is not included in the Section 61 consent/ variation/ dispensation but someone realising and not using the plant Breach of agreed vibration levels in the Contractor's Vibration Control and Mitigation Plan but no damage caused.

Table 7 Oils & Chemicals

Category	Examples
5	Oil and chemical spills or leaks off-site (>200 litres) that cause pollution or contamination of soil or ground and have entered foul sewer. Intervention by Regulatory Authorities
4	Oil and chemical spills or leaks on-site or off-site (>200 litres) that cause pollution or contamination of soil or ground but have not polluted surface or groundwater or gone down a drain.

3	Oil and chemical spills or leaks off-site (<200 litres) that cause pollution or contamination of soil or ground but have not polluted surface or groundwater or gone down a drain. Intervention from Regulatory Authority regarding oil and chemical storage. Oil storage that is not bunded or in drip trays (in accordance with the Control of Pollution (Oil Storage) (England) Regulations) and presents a major pollution risk.
2	Oil and chemical spills or leaks on-site (<200 litres) that cause pollution or contamination of soil or ground but have not polluted surface or groundwater or gone down a drain Oil storage that is not bunded or in drip trays (in accordance with the Control of Pollution (Oil Storage) (England) Regulations) and presents a minor pollution risk.
1	A near miss that could have resulted in any of the above – for example: ■ Oil or chemical spill or leak contained entirely on concrete hardstanding that is entirely within the site boundary. Failure to implement planned controls for oil and chemical storage and handling but no spill has occurred e.g. no drip trays in use.

Note: If oils or chemicals have entered surface water categorise as "Surface Water". If oils or chemicals have entered groundwater categorise as "Groundwater".

Table 8 Surface Water

Category	Examples
5	Release into surface water of any polluting substance (including all types of oil, silt, chemicals and detergents) resulting in significant damage to wildlife and external authorities required to assist with clean-up. Intervention by Regulatory Authority – prosecution likely
4	Release into surface water of any polluting substance (including all types of oil, silt, chemicals and detergents) resulting in some damage to wildlife Intervention by Regulatory Authority – prosecution likely

3	Release of any substance other than clean and clear water into surface water (or drain that leads to surface water or where the outfall is unknown) including all types of oil, chemicals, detergents. Failure to have consent for works affecting surface water (e.g. discharge consent, flood defence consent, marine licensing consent). Failure to comply with consent (including conditions) resulting in significant harm or damage (e.g. discharge consent, flood defence consent, marine licensing consent). Intervention from Regulatory Authority, including receipt of a notice. Significant impact on surface water levels e.g. caused by dewatering. Stopping or significantly affecting the flow of a watercourse without consent.
2	Release of any substance other than clean and clear water (including all types of oil, silt, chemicals, detergents) into drain that leads to foul sewer i.e. to a sewage treatment works. Failure to comply with consent (including conditions) resulting in minor or no harm or damage (e.g. discharge consent, flood defence consent, marine licensing consent). Minor impacts on surface water levels e.g. caused by dewatering. Minor effect on the flow of a watercourse.
1	A near miss that could have resulted in any of the above – for example: Not using biodegradable hydraulic oils in plant and equipment working over or near water. Failure to implement planned surface water control measures as required by the Works Information, but no harm or damage caused. Nearly starting work without a consent in place but someone realising and those works being postponed until the consent is in place.

Note:

Impacts on surface water may not be evident on site – may be in river/ canal/ dock/ lake downstream or in a drain running off site.

If oils or chemicals have entered groundwater categorise as "Groundwater". If oils or chemicals have ***not*** *entered groundwater or surface water categorise as "Oils and Chemicals".*

Table 9: Waste

Category	Examples
5	Fly-tipping of a significant quantity of hazardous material by Henry vehicle causing pollution requiring specialist clean up and resulting in prosecution and long term impact on reputation.
4	Fly-tipping of a significant quantity of non-hazardous material by Henry vehicle resulting in prosecution and long term impact on reputation.
3	Failure to have Environmental Permit (or exemption) for depositing, storing or treating waste (including excavated material) on site. Failure to comply with Environmental Permit (or exemption) for depositing, storing or treating waste on site, resulting in significant harm or damage. Waste sent to a recycling or disposal site/ facility that are not permitted by the Environment Agency to accept that type of waste. Using a waste carrier that is not registered as a waste carrier with the Environment Agency. Failure to have Waste Transfer Note / written Waste Information / Hazardous Waste Consignment Note. Failure to have an up-to-date Site Waste Management Plan, or to comply with it, resulting in significant harm or damage. Intervention from the Environment Agency.
2	Failure to comply with Environmental Permit or exemption for depositing, storing or treating waste (including excavated material) on site, resulting in minor or no damage. Failure to handle and store excavated material in accordance with soil management controls resulting in minor or no harm or damage. Failure to segregate wastes that must be separated by law (e.g. hazardous waste and waste electrical and electronic equipment) Failure to register as a Hazardous Waste Producer (unless exempt). Failure to have up-to-date Site Waste Management Plan, or to comply with it, resulting in minor harm or damage. Failure to a) minimise, b) reuse and recycle excavated material.
1	A near miss that could have resulted in any of the above – for example: ■ Failure to have up-to-date Site Waste Management Plan, or to comply with it, no harm or damage caused. Nearly starting work without an Environmental Permit in place but someone realising and those works being postponed until the Permit is in place.

Appendix 4 – Categories of Service Damage

Category	Utility	Financial / Reputation
5	■ HV Electrical Cable ■ High Pressure Gas Main (>7bar)	■ >10000 Residential Properties affected ■ >£1mil damages
4	■ Intermediate Gas Main (2bar – 7 bar) ■ Water Main (8" and above)	■ £100k – 1m damages
3	■ Water Main (Below 8") ■ Medium Pressure Gas Main (75mbar and 2 bar)	■ Residential / Commercial Properties affected ■ £10k – 100k damages
2	■ Low Pressure Gas Service ■ LV Electrical Cable ■ Street Lighting Cable / Furniture	■ Residential / Commercial properties affected
1	■ Sewer ■ Water Service ■ Telecoms Cable, including TV ■ Road Sensors (Midas) ■ Drainage ■ Signalling Cables (Rail) ■ Fibre Optic Cable	■ Less than 5 residential properties affected

N.B in the event of service damage the above categories are classified for Overhead and Underground Services.

Appendix 5 – Guidance for a Successful Investigation

Purpose
The aim of any investigation is to:

- **establish the facts of what happened**
- **analyse why things happened as they did**
- **identify the true root cause(s)**
- **disseminate learning across Henry**

Good investigations will lead to fewer accidents/failures, and help achieve improvements on the contract and across the business.

The visible engagement and interest of senior managers at appropriate stages of the investigation process, and especially in understanding and applying the lessons learnt, will enhance its chances of helping to achieve a Never Harm Culture.

Initial Incident Statement
When an incident occurs there is likely to be limited, and sometimes conflicting, information given.

The first step for the investigator is quite simply to write down what happened and what were the consequences or potential consequences – keeping it simple and with no elaboration.

E.g. Fred fell off a ladder and broke his leg

This statement becomes the scope of the investigation and can stop investigators wandering into areas that are not relevant to this incident.

Evidence Gathering
Evidence and photos should be gathered at the time of the incident and held for the investigator(s).

In many cases it is also beneficial for the investigator(s) to visit the scene of the incident, build up a picture in their mind and perhaps spot items that may have had an influence on events.

Eye-Witness Accounts
Eye-witness accounts may or may not be accurate. We all unintentionally filter what we see through our own experience of the world. For something that has happened quickly there may be so much to assimilate in a short time that we corrupt the information, and may well be corrupted further by discussing what we have seen with other witnesses.

The recommended way to gather a witness account is to let them fully talk through what happened in their own words, before asking any questions or clarifications. The interviewer should jot down a series of bullet points, then talk through the sequence of events before starting to write a statement.

Follow correct interview practise – open questions and an open mind!

Visiting an Employee at Hospital or Home
If information is required from a person who is in hospital or at home, it is permissible to do so. However, you should make contact in advance and have their agreement to visit them. If they are uncomfortable for you to visit them at their home, you should suggest a neutral venue, such as a coffee shop or other meeting place. An independent person shall also attend, preferably with a HR background.

The employee has the right to refuse a visit, so be sure the initial request is couched in a constructive, non-blaming manner.

Timeline / Storyboard
Use the witness accounts and other available evidence to develop a timeline of the incident. Initially this will be the immediate sequence of events, but as the investigation progresses it will discover all the events that led up to the incident. Jot down questions as you think of them, adding to them as you evaluate the information.

For investigations into more serious incidents, the use of a storyboard with Post-its for each fact and question is recommended. These can be moved around as the investigation progresses and build up the full picture of what happened and the events leading up to the incident.

At this stage just gather the "what" – do not make the mistake of starting to guess at the "why".

As you start to build up a picture, more questions will spring to mind that need to be investigated.

Look into the areas of:

Technology – equipment & processes
Organisation – control & responsibility
People – competence & behaviours
Similar events that have occurred
Environment – weather and workplace
Timing – when things happened

Analysis of the Incident
Once it is believed that all the relevant information is known, it is time to start analysing why things happened as they did.

The starting point is the brief incident statement. You ask yourself why did this happen – but proceed in small steps, not big leaps. E.g. Why did Fred fall off the ladder?

Because he was not holding on.

Why not?

Because his hands were holding tools

Why?

This will go into multiple levels of "why" and "because" and there may be more than one "because" that needs to be followed up.

A useful technique for doing this is to use a large sheet of paper and write the incident statement at the top.

List each "because" below the statement, working down level by level until you get to the true root cause(s). The use of Post-its makes it easier to adapt and amend as you go.

You can check the logic of your analysis by working through the stages in reverse order, by asking at each stage "what was the consequence of this substandard condition?"

Recommendations - Once the root causes are known, the investigator should develop some recommendations for improvement to prevent similar incidents in the future. It is worth testing these with the people involved in the incident – do they agree that taking these actions will prevent a repeat occurrence.

Remember – there is no such thing as an accident in our workplace. Everything happens for a reason, and if we can identify the cause we can work towards eliminating it in the future.

Explanation of the Root Cause Analysis We use the following terminology in the analysis:

Immediate cause – what was the trigger that caused the incident

Contributory factors – did not of themselves cause the incident but may have influenced it

Underlying cause – why the immediate cause happened

Root cause – the fundamental reason(s) why this happened.

The investigation technique can be used for any type of incident/event/failure, but for ease of understanding we will use safety-related terminology.

Immediate Cause(s)
Unsafe acts – someone did something, either by mistake (error) or knowingly in breach of safe practise (violation).

Unsafe conditions – created either by ourselves or by others. We might know about the difficult/unsafe condition such as a steep embankment, or it might be unexpected such as a hole in the verge.

Contributory factors - these can be almost anything, hence we have given some examples overleaf.

Underlying Cause(s)
Unsafe behaviour – errors or violations

Unsafe planning – failure to think sufficiently about the job in hand

Unsafe organisation – failures at managerial level, rather than operational. Inadequate support for the task in hand.

There are likely to be several levels of underlying causes, but the focus must be on what directly contributed to the incident. You may well identify other issues that were not correct, but these should form a separate part of the investigation report i.e. other factors that did not directly contribute to the incident but need improvement.

Root Cause(s)
The root causes of virtually all incidents lie in two areas – the people and /or the supporting organisation.