Planning and Regulatory Services
Health and Safety Enforcement Procedures

Selection of Incidents for Investigation

1. Purpose of this document

1.1. To provide a proportionate, transparent and targeted procedure for the selection of incidents for investigation.

1.2. To fulfil Argyll and Bute Council's duty to make adequate arrangements for enforcement under Section 18 of the 1974 Act.

2. Scope of this document

2.1. This procedures applies to the screening and selection of incidents up to the point that a decision to investigate is made.

2.2. In this procedure:

2.2.1. "incident" means any matter reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 ("RIDDOR"). Incident includes accidents, injuries, fatalities and dangerous occurrences.

2.2.2. "reportable" means reportable within the meaning of RIDDOR.

2.3. Appendix A summarises the procedure set out in this document.

3. Performance standards

3.1. Make the decision, forward the incident for next action and ensure it is recorded appropriately within:

- one hour of the receipt of the notification of a fatal
- 3 working days of receipt for a major injury, occupational disease, dangerous occurrence, or other serious incident
- 5 working days of receipt of all other incidents

4. How incidents are notified

4.1. The majority of RIDDOR reports are made using the on-line reporting system at www.hse.gov.uk/riddor. A minority of reports are made using manual F2508 forms sent directly to the Council. Some incidents will be reported directly by telephone or email, or as complaints, or come to the notice of the Council during routine visits to premises.

4.2. Where a report is received directly by telephone or email, the reporter shall be advised to make the report through the on-line RIDDOR reporting system.

4.3. However received, reports of fatalities and multiple serious injuries shall be considered as a matter of priority.

4.4. Where a manual F2508 report is received, the case officer shall be responsible for entering the details at www.hse.gov.uk/riddor.

4.5. ***Monitoring the RIDDOR database***

4.5.1. The Lead EHO (Health & Safety and Service Support) ("the Lead EHO") shall be responsible for checking the RIDDOR database daily for new reports. In their absence, the Area Environmental Health Managers shall co-operate in monitoring the database.

4.5.2. Unallocated reports on the RIDDOR database shall be checked to determine whether they fall to the Council as enforcing authority. Those that do shall be accepted. Those that do not shall be re-allocated to the correct enforcing authority.

4.5.3. Once accepted, the RIDDOR report shall be saved in PDF format and downloaded for consideration.

5. Selection of incidents for investigation

5.1. All incidents received shall be considered by the Area Environmental Health Manager (or in their absence, the Regulatory Services Manager) to determine, in accordance with this procedure, which incidents are to be investigated.

5.2. A Decision Recording Form (HELA-f06) shall be completed in all cases.

5.3. Mandatory investigations

5.3.1. The following defined major incidents shall always be investigated:

- Fatalities of any person arising out of or in connection with work activities, excepting suicides and deaths from natural causes.
- Injuries to any person, irrespective of cause, that meet the following conditions:
  - Amputation of digit(s) past the first joint;
  - Amputation of hand/arm or foot/leg;
  - Serious multiple injuries (more than one bone, not including wrist or ankle);
  - Crush injuries leading to internal organ damage, e.g. ruptured spleen;
  - Head injuries involving loss of consciousness;

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

- RIDDOR-defined major injuries arising from working in a confined space or an electrical incident.
- Reportable occupational diseases, excepting those arising from circumstances which have already been investigated.
- Serious breach of health and safety law including incidents likely to give rise to serious public concern where, in accordance with the Enforcement Management Model, the national enforcement expectation would determine a notice or a prosecution.
- Incidents likely to give rise to serious concern. This is intended to reflect the public interest. Non-injury dangerous occurrences with the potential for directly causing the death of anyone or major injuries to a number of people are typical of this category.

5.4. ***Non-investigation of a mandatory incident***

5.4.1. There may be grounds for not investigating mandatory incidents. These include:

- Where an investigation is impractical, e.g. key witnesses or key evidence is no longer available;
- Where there were/are no reasonably practicable precautions available to prevent the incident or its recurrence;
- Where an investigation would mean the Council would be acting ultra vires;
- Where there is a conflict of interest between the Council as a regulator and as a duty-holder, in which case the HSE shall be notified;
- Inadequate resources due to other priorities.

5.4.2. The Regulatory Services Manager shall decide whether or not a mandatory incident is not to be investigated. The Area Environmental Health Manager shall submit a Decision Recording Form (Form HELA-F06) for consideration by the Regulatory Services Manager.

5.5. ***Discretionary investigations***

5.5.1. The Area Environmental Health Manager may determine that an incident not falling within the criteria for mandatory investigation should nevertheless be investigated when taking into account the following factors:

- The incident arises from a high-risk activity as defined in Annex A of the National Code;
- The incident arises from an activity which has been identified by Argyll and Bute Council as a local inspection priority;
- The duty-holder has a poor health and safety record or there has been a history of similar events;
- The incident has the potential for high media interest;
- Failure to investigate the incident could result in reputational risk through inaction or perceived inaction;
- The incident may give rise to complaints;
- The incident has been identified as being useful for enhancing sector good practice or technical knowledge;
- The investigation would be beneficial for the training and development of inspectors as identified through the review of competence process.

5.5.2. In any case where a discretionary investigation is instructed, the Area Environmental Health Manager shall complete the relevant part of the Decision Recording Form (Form HELA-F06).

6. Case records and documentation

6.1. An Accident Report case shall be created in Uniform for all incidents received.

6.2. Accident Report cases shall be maintained by the case officer in accordance with the relevant Uniform Data Standard.

6.3. All case documentation identifying the injured person shall be classified *Protect - Personal* and kept secure by the case officer.

6.4. All case documents shall be stored in Civica and linked to the Uniform Accident Report case record.

7. References

7.1. The Health and Safety at Work etc. Act 1974

7.2. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

7.3. *The National Local Authority Enforcement Code – Health and Safety at Work, England, Scotland and Wales*, HSE, May 2013

7.4. LAC 22/13 (rev1), *Incident Selection Criteria Guidance*, HSE, 29/02/2012

7.5. Enforcement Policy Statement, HSE41 (rev1), HSE 2009

7.6. *Work-related Deaths, a Protocol for Liaison*, Misc733, HSE 2006

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APPENDIX A – Selection of Incidents Flow Chart