Incident & Near Miss Reporting Standard

(SHEMS-STD-GR-011)

Contents

1 Introduction 3
2 Scope 3
3 Definitions and Acronyms 3
3.1 Major Incident Reporting 4
3.2 First Alert and Don't Walk By Reporting 5
3.3 Classification 7
3.4 Incident Categorisation of Persons Involved 7
4. Legal Privilege 7
5 Incident Investigations & Reports 7
5.1 Investigation Reports 8
5.2 Accuracy and Quality of Reports 8
5.3 Investigation Team 8
5.4 Collecting Evidence 9
5.5 Investigation Process 9
5.6 Taking Witness Statements 11
5.7 Collecting the evidence 12
5.8 Lessons Learnt Communication 13
5.9 Repeat Incidents 13
5.10 Training and Awareness 13
6 Metrics 13
6.1 Frequency and Severity Rates 13
6.2 Accident Incident Rate (AIR) 13
6.3 Accident Frequency Rate (AFR) 13
6.4 All Accident Incident Rates (AAIR) 14
6.5 All Environmental Incident Rates (AEIR) 14
7. Risk & Impact Matrix 14
8. Environmental Incidents 16
9. References & Forms 16

1 Introduction

This purpose of this standard is to define a consistent process for the reporting and management of all Safety, Health & Environmental (SHE) Incidents and Near Misses.

This standard requires that:

All Incidents and Near Misses occurring throughout Unitas operations are reported and that the reporting is timely, accurate, consistent and shared with the relevant regulator as appropriate.

Legal privilege (or equivalent in the relevant legal jurisdiction) shall be considered at the earliest opportunity prior to investigation of incidents/near misses and enforcing authority visits.

2 Scope

The scope of the Unitas Safety, Health & Environmental Management System (SHEMS) covers all persons, workplaces and operations by or on behalf of the Unitas Business.

Unitas SHEMS (SHEMS-STD-GR-003) provides guidance and signposting for the compliance, implementation, monitoring, audit and review of our systems, demonstrating continual improvement and achievement of the business objectives.

3 Definitions and Acronyms

AAIR Recordable Case	A work-related injury resulting in lost time for Unitas and Subcontractors employees. (not including the day of the incident)
AEIR Recordable Environmental Case	Any incident that results in harm to the environment.
Dangerous Occurrence	Any occurrence which arises out, of, or in connection with, work and is of a class specified in Schedule 2 of RIDDOR and requires notification to the Health and Safety Executive (HSE).
Disease	An occupational disease specified in Schedule 2 of RIDDOR (AAIR Recordable) and requires notification to the HSE.
First Aid Case	Regardless of who provides the care, first aid treatments on site or depots.
High Potential (HiPo)	Any incident or Near Miss that is identified with a “red” severity/ risk level as defined in the SHE Risk & Impact Matrix
Incident	An incident is any occurrence, event or series of events that results in a fatality, injury, illness to any person, damage to or loss of property, equipment, material, the environment or business reputation.
Lost Time Incident (LTI)	Unitas shall begin counting “lost time” days on the day after the injury occurred or the illness began and each calendar day until the individual returns to work in some capacity.
Near Miss	Any occurrence without loss or consequence that had the potential to cause harm to people, property, equipment, material or the environment.
Repeat Incident	Any incident including injury incidents, near misses or environmental incidents that have occurred previously.
RIDDOR incident	As defined within the UK Reporting of Injuries and Dangerous Occurrences Regulations, any work-related: • Dangerous Occurrence • Incident resulting in a major specified injury • Incident resulting in an over 7 day absence • Reportable Injuries • Occupational Diseases

	• Gas Incidents • Failure of a structure
Potential RIDDOR	As defined within the RIDDOR Regulations and involving Unitas and/ or supply chain partner where one of the above RIDDOR is likely.
Work-related Accident	An accident is deemed work-related if it happens 'out of connection with work'. The fact there is an accident at work premises does not, in itself, mean that the accident is work related – the work activity itself must contribute to the accident. An accident is ' work related' if any of the following played a significant role: • The way the work was supervised. • Any machinery, plant, substances or equipment used for the work. • The condition of the site or premises where the accident happened.
Reportable Environmental Incident	Any incident as a result of Unitas and/or supply chain partner work activities that results in: • Damage or danger to the natural environment • Pollution to water or land • Poaching or illegal fishing – by member of workforce or supply chain • Dead fish.
Driver and Vehicle Standards Agency (DVSA)	Any action from the DVSA threatening prosecution or other action following an alleged contravention of any legislation including the issue or threat of issue of enforcement notices.
Police and Enforcement Bodies	Issue or threat of issue of enforcement notices (HSE, EA, Police, HM Customs and Local Authority etc.). Any action from the police or other enforcement body threatening prosecution or other action for alleged contravention of any legislation.
Road Traffic Collision (RTC)	Any RTC involving any of the following as a result of our work activities: • A Unitas employee • A member of a supply chain partner • A member of the public
Other	Service delivery failures: • Major disruption of service provision resulting in significant effects to the general public and likely to attract media attention. Examples are major road delays; tunnel or bridge closures; excavations; railway closures or major damage to third party property. • Any event arising out of Unitas activities that is likely to give rise to public concern and adversely affect the reputation of the company.
First Alert	Reporting process to inform the relevant areas of the business in line with this standard

3.1 Major Incident Reporting

If the incident/ accident is a Major Incident as described below, please report immediately in accordance with the Major Incident Response Plan Standard (SHEMS-STD-GR-013).

The range of incidents likely to be immediately classified or subsequently escalate into a Major Incident is diverse and may or may not be a safety, health or environmental event (SHE) related.

Examples of Major Incident are:

- Accidents and incidents involving fatalities, serious injuries or a notifiable disease, including those where a member of the public is seriously injured or fatally injured;

- Road traffic accident or vehicle fire with serious injuries or fatal injuries (involving either employees or public);
- Incidents involving a catastrophic event arising from third party intervention such as terrorist/ activist groups, including a bomb/ explosion or any incident which may attract media attention;
- A premise/ construction site fire;
- An incident affecting the safe operation of the railway;
- Any oil, fuel or chemical spillage, which may affect the public and/ or impact Unitas reputation;
- An act of pollution that requires external support;
- Issues that are a direct result of an accident/ incident e.g. when damage is caused by a scaffold collapse which could attract both media and protest group attention.
- Any incident that could have significant consequences affecting the business or the public.

3.2 First Alert and Don't Walk By Reporting

To increase the visibility of awareness of incidents and to build upon the good practice in areas of the business, Unitas has introduced a first alert process. Any accident, incident, near miss or safety observation that meets the following criteria must be reported as a First Alert. Please note that this is in addition to any other reporting requirements described in this standard.

The SHE Manager/ Advisors ensure that all Incidents and Near Misses are recorded within 24 hours of the incident or Near Miss occurring.

A First Alert Incident is classified as (see Section 3 for definitions);

- A fatality to any employee, contractor or member of the public
- RIDDOR reportable injury or incident
- A potential RIDDOR reportable injury or incident
- HiPo (High Potential Incident)
- A reportable Environmental Incident
- A repeat Incident
- A DVSA Intervention
- A police Incident
- An unexpected and unforeseen discovery of (suspected) asbestos containing materials
- An Enforcing Authority Visit

As a minimum, a phone call shall be made immediately from the injured person to their line manager to report any of the above incidents, The line manager must then inform the SHE Team as soon as possible (must be within 1 hour of the incident). The SHE Team will ensure that the relevant tracker is populated and information distributed to the below personnel within 1 hour of being notified of the incident;

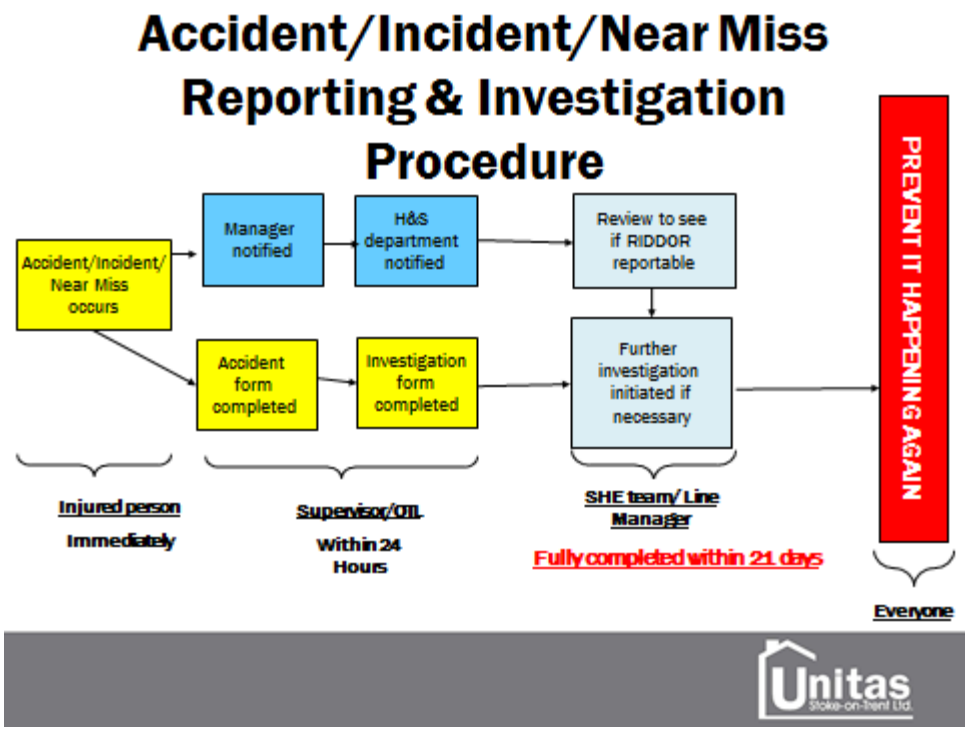
- Director
- Senior Management Team
- Manager of Work Stream
- SHE Manager
- SHE Advisor
- Trade Union Representative

It is important that Unitas employees and contractors report Unsafe Acts and Unsafe Conditions and Best Practice Ideas. A "Don't Walk By" culture of reporting issues and ideas will reduce the risk of injury and ill health and create a positive SHE performance within Unitas and the supply chain. There is a dedicated direct email address to the SHE Team (sheteam@Unitas) which all employees can use when reporting issues and ideas. Full details need to be provided by the employee, together with a contact number, so that feedback can be made to the employee on the progress of the Don't Walk By reporting.

A record of the "Don't Walk By's will be reported within the issues register. The Line Manager of the employee reporting the Near Miss / "Don't Walk By" will be notified by the SHE Team and they will

then carry out any further investigation/actions that may be required. The results of the investigation will be fed back to the SHE Team and the employee using the Near Miss/Learning Event Form.

Figure 1 – Accident/Incident Reporting & Investigation Process



Prior to any external notification being made the SHE Manager/ Advisors and Operations Director shall:

- Review the content of the notification
- Consider engagement and consultation with the nominated Legal Team for guidance in respect of invoking legal privilege.

Table 1 below establishes minimum requirements for the timing of notifications.

Notification		Risk Classes		
From	**To**	**Low Risk**	**Medium Risk**	**High Risk**
Individual	Unitas Line Manager/Supervisor	Immediately/ As soon as possible	Immediately/ As soon as possible	Immediately/ As soon as possible
Unitas Line Manager/Supervisor	SHE Advisors	Within 24 hours	As soon as possible/ Within 1 hour	As soon as possible/ Within 1 hour
SHE advisor/Line Manager/Senior Management Team/ Supervisor	SHE Manager	Same day	Same day	As soon as possible/ Within 1 hour
SHE Manager	Director	Same day	Same day	As soon as possible/ Within 1 hour
Director	Unitas Board	Monthly	Same Day	As soon as possible/ Same day

3.3 Classification

Incidents and Near Misses are classified based on their actual severity which will determine the level of internal notification. Severity of the Incident or Near Miss is obtained by using the Unitas SHE Risk & Impact Matrix.

3.4 Incident Categorisation of Persons Involved

Incidents and Near Misses are categorised based on the contractual relationship and influence as regarding the individuals involved.

Table 2: Categories of persons Involved

Employees Anyone on the Unitas payroll plus; • Contracted staff • Agency Personnel • Personnel on secondment to/ from Unitas
Sub-Contractors Contractors and Subcontractors working under the supervision of Unitas. This includes contractors and subcontractors working under client issued contracts where Unitas is named and/ or appointed by the Operations Director.
Those not at Work Sometimes referred to as “members of the public”.
Site Visitors Those visiting sites who will not be carrying out work on site eg those attending meetings, accompanied visitors viewing aspects of work, those on educational visits, head office staff collecting or delivering post, potential purchasers (residential) or potential occupiers etc.…

4. Legal Privilege

Legal privilege (or equivalent in the relevant legal jurisdiction) is important. Documentation or correspondence which is not legally privileged may be disclosed in legal proceedings. The Director and legal Counsel shall agree such status as appropriate and share with the investigation and communication teams as soon as possible. Upon legal notification, they will decide whether legal advice is necessary and communication sent accordingly.

If legal advice is necessary, all advice given by a Legal Advisor or an external law firm must be followed, i.e. advice relating to correspondence, instructions on reports and communications with interested parties (including the HSE and the EA).

When Legal Privilege has been invoked, no investigation report shall be issued without having been reviewed and approved by the legal advisor and authorised by the Director.

Many incidents require the involvement of an insurance department. The insurance department will then decide whether a law firm needs to be appointed.

5 Incident Investigations & Reports

Investigations are carried out at the earliest opportunity in order to deal with Incidents (accidents, incidents, fires, property and vehicle/equipment damage including near misses) efficiently; to

understand their causation; review/implement corrective actions where appropriate; to share lessons learnt and prevent recurrence throughout the business.

The internal investigation team shall assist the authorities as appropriate. If the regulatory authorities are also investigating the Incident, the team shall automatically seek legal assistance.

5.1 Investigation Reports

Investigations are completed in accordance with Section 5 within the Standard at the earliest opportunity in order to understand the cause of the incident, implement corrective actions and share lessons learnt efficiently.

The Preliminary Accident Investigation Report Form, (SHEMS-FOR-GR-053) should be completed and forwarded to the SHE Team within 24 hours. Where the investigation is escalated a SHE Investigation Report Form (SHEMS-FOR-GR-433) will be completed within 21 days of the incident or near miss occurring. All relevant documentation linked to the investigation (witness statements, timelines, training records etc.) will be stored in a confidential folder with restricted access.

5.2 Accuracy and Quality of Reports

The comprehensiveness of the investigation and appropriateness of the corrective actions together with administrative completeness will be checked by the SHE Manager/ Advisor before the investigation is submitted for review as below:-

Incident Type	Incident Category	Reviewed By
A	Major Incident	Director
B	RIDDORS	Head of Service
C	Non-RIDDOR	SHE Manager

Closure of corrective actions and recommendations will be tracked using the incident tracker by the SHE Team. The corrective actions will be closed out by the responsible line managers and the investigation action will not be closed until it has been agreed by the responsible person identified in the table above.

5.3 Investigation Team

Investigations of High Potential Incidents, Near Misses and incidents require root cause investigation and analysis at a level relevant to the injury and /or damage.

Incidents or Near-Misses that occur frequently or have a high learning value may require a higher level of investigation than that indicated by the potential consequences.

The Investigation team is determined by the SHE Manager and relevant Operational Management/ Head of Service as appropriate. The investigation team will include; members of the site team, task competent personnel and senior management with support from the SHE team.

Incidents and near misses with actual or **potential Low and Medium Severity/Impact** shall have the incident investigated by;

- Operations Team Leader: e.g. Supervisor, Manager, Section Leader or other individual with sufficient experience, credibility and authority to understand the processes and contributing circumstances of the incident
- SHE Advisor
- Workforce Safety Representative as required.
- Witnesses to the incident as appropriate to the investigation team

Incidents and near misses with actual or **potential High Severity/Impact** shall have the incident investigated by;

- A Line Manager with the appropriate competence and level of seniority within the organisation and holding the necessary skills to conduct the investigation e.g. Operations Manager, SHE Manager/SHE Advisor as appropriate.
- A SHE Manager/Adviser to offer advice and guidance on the Incident investigation; to facilitate the investigation process and the root cause analysis methodology.
- A Person with thorough knowledge of activities and equipment e.g. supervisor, team leader
- A Supervisor or individual who recorded the injury so as to explain what happened in relation to the Risk Assessment and SSOW.
- Someone who can provide specialist technical advice.

5.4 Collecting Evidence

Investigation Evidence to be collected as a minimum:

- Incident Report (PAIR & BI 510 Form)
- Witness statements
- Photographs of incident scene
- Training records of Injured Person (IP), and others directly involved
- Plant and Maintenance records of equipment involved
- Site/premises inspections
- Risk Assessments/ SSOW/Method Statements

The investigation process allows Unitas to:

- Gain an understanding of how and why things went wrong
- Gain an understanding of the way individuals are exposed to uncontrolled hazards
- Review the actual risk assessment/safe system of work and the incident environment; review ways of working at the time of the incident and whether short cuts had been introduced by the workers?
- The culture of the workforce - are rules regularly ignored?
- Identify deficiencies and opportunities for improvement within SHEMS. Share and communicate lessons learnt

5.5 Investigation Process

The investigation is designed to establish the causes (ref; HSG245 Investigating accidents and incidents):

- **Immediate (primary) cause** - most obvious reason why an incident/near miss occurred e.g. scaffold rail missing, individual slipped.
- **underlying cause -** unsafe acts and unsafe conditions; less obvious system failure or behavioural/organisational reasons for an incident/near miss happening e.g. lack of pre start equipment checks; hazards not adequately assessed via suitable and sufficient risk/impact assessment or operation pressure took priority.
- **Root cause -** an initiating event or failing from which other causes or failings spring. Root causes are generally management, planning or organisation failings eg failure to identify training needs and assess competence; low priority given to risk assessments etc.

Investigations shall be conducted with the purpose of incident prevention not to apportion blame. Only after the investigation is complete is it appropriate to consider if an individual(s) acted inappropriately. This may include condoned unsafe acts and conditions.

It is likely that the incident investigation may highlight opportunities for improvement in the management system; training; behavioural culture and supervision. Investigations that conclude that the sole root cause of the incident was individual/ work error are rarely acceptable or constructive.

There are often a number of underlying causes that underpin "human error" that created the environment in which human errors were inevitable eg inadequate training and supervision; poor equipment design; lack of management planning; poor attitude and awareness to safety, health and environmental requirements etc

The investigation shall include an analysis of all the information available, e.g. previous audits; inspections; equipment inspections/ service records; witness statements; risk assessments; processes; safe systems of work (SSOW) and training requirements/records etc. This will enable an objective review to be undertaken and to identify what went wrong; decide what corrective actions are required and to monitor their effectiveness to eliminate recurrence.

It is important that investigations and reporting are open, honest and objective. It is important to concentrate on the facts and documented information/evidence rather than gossip and preconceived ideas. Be wary of blaming individuals and ensure that when completing and presenting your findings, you have considered all the information - be factual.

To understand what went wrong and why, consider the 5 basic "why's"

"Why's" Investigations can start with the immediate cause and asking a series of 'Why' questions, ending with the root cause eg

Primary Cause	- Individual slipped on oil on floor
Why	- Inadequate maintenance
	- lack of housekeeping checks
	- lack of employee awareness to clean up
	- lack of supervision and maintenance
	- inadequate SHE management
Root Cause	- Management not committed to effective SHE delivery.

And/or

Problem Statement: You are on your way home from work and your car stops in the middle of the road.

1. Why did your car stop?

– Because it ran out of petrol.

2. Why did it run out of petrol?

– Because I didn't buy any petrol on my way to work.

3. Why didn't you buy any petrol this morning?

– Because I didn't have any money.

4. Why didn't you have any money?

– Because I lost it all last night in a poker game.

5. Why did you lose your money in last night's poker game?
– Because I'm not very good at "bluffing" when I don't have a good hand.

When reviewing a Major Incident or serious incident the 5 why's can be used in the Domino Theory (an alternate and more specific investigation process) The Domino Theory (as shown below) provides a structured investigation process, again, by asking questions to identify the:

- Unsafe Act or Unsafe condition
- Precursor reasons for the Unsafe Act/Condition
- Line Management deficiencies
- Weak decisions

Why? Through such techniques interested parties were able to learn and understand the root cause of Major Incidents e.g. Kings Cross Station Fire; the Herald of Free Enterprise disaster etc, These were both examples of collective management and individual employee failings where management had failed to recognise, and act on, previous failings within their Safety and Health Management Systems.

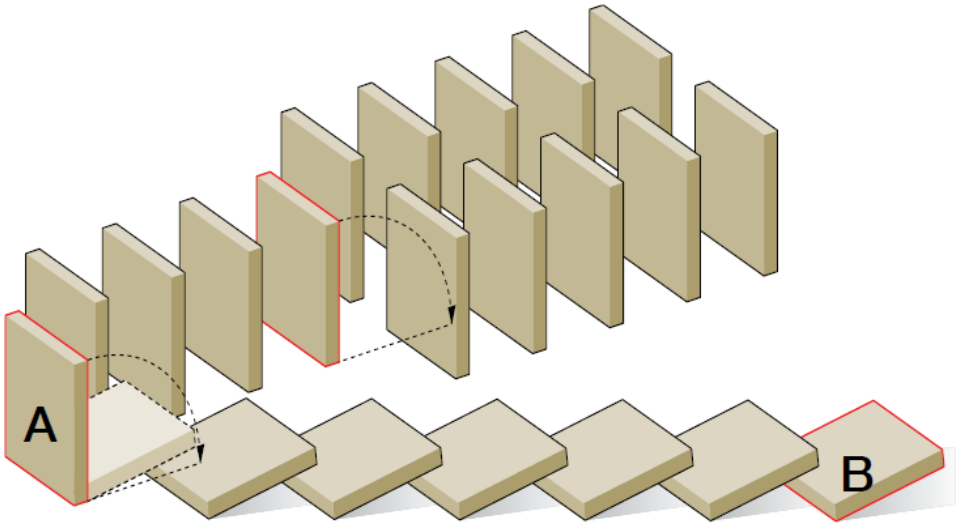


Figure 1 Sequence of dominos (Domino effect) copied from HSG245

5.6 Taking Witness Statements

Witness statements should normally be taken as soon as possible to ensure that:

- the events are still fresh in the mind of the witness;
- the evidence is recorded before the witness has had an opportunity to discuss their evidence with others.

All witnesses shall be treated with courtesy and every attempt should be made to put witnesses at their ease. It is preferable to speak to witnesses in a private area so that there is a more relaxed environment. At the outset you should explain to the witness that the primary aim of taking a statement from them is to find out what happened.

All statements shall be written and signed. Witness statements shall be written so that they are concise and to the point, reflecting on the direct knowledge of the witness. As far as is possible, you should record the witness's own words.

It may be helpful to take notes before beginning to write the statement. Once the statement has been completed you should read it over to the witness before it is signed. If there are any alterations to the statement then these should be initialled by the witness.

The statement shall include the witness's home address and telephone number so that you can contact the witnesses as necessary. An additional chaperone and support is required where the witness provider is under 18. Please refer to your HR/ SHE Manager for guidance.

5.7 Collecting the evidence

Discovering what happened can involve quite a bit of detective work. The investigating team members must be precise and establish the facts as best as they can.

There may be a lack of information and uncertainties. The team must consider everything that might have contributed to the incident. Taking photographs at the scene are to be recommended - these provide a great insight to the investigation and never change the scene details.

Electronic photographs are now accepted in disputes. *If possible*, ensure the camera records the date and time on the photograph.

Describe the chain of events leading up to, and immediately after, the incident. Record such factors in chronological order, if possible. Work out the chain of events by talking to the injured person, eye witnesses, line managers, SHE representatives and fellow workers to find out what happened and who did what. In particular, note the position of those injured both immediately before and after the adverse event. Be objective and, as far as possible, avoid apportioning guilt, assigning responsibility or making snap judgements on the probable causes.

Note any equipment involved.

Plant and equipment that had a direct bearing on the adverse event must be identified clearly - obtain the details from the nameplate attached to the equipment. Note all the details available eg the manufacturer, model type, model number, machine number, year of manufacture and any modifications made to the equipment. Note the position of the machinery controls immediately after the adverse event. Also obtain details of last service and inspections including PAT (portable appliance testing) as appropriate.

Was the risk known? If so, why wasn't it controlled? If not, why not?

The investigation shall identify if the source/cause of the incident and its potential consequences were known and whether this information was communicated to those who needed to know. All information and feedback provided from the injured person, witness, supervisor or other members of the workforce shall be recorded.

The existence of a written risk assessment and Safe Systems of Work/Method Statement for the process or task that led to the incident shall be reviewed and retained with the report. This will assist with establishing whether the documented controls had been effectively implemented.

Were there additional operational pressures that led to a deviation from standard documented work practice?

- Was the work that led to the incident planned in consideration of risk, resource and timely?
- Were the standards of supervision and on-site monitoring of working practices as described within Unitas' standards and Safe Systems of Work?
- Was the injured person adequately trained, qualified and competent for the work prior to the incident?
- Were the documented requirements too onerous and ignored/ omitted because they wre too difficult and time-consuming?

- A lack of planning may mean that some tasks are not done; are done too late or are done in the wrong order;
- High production targets and piecework may result in safety measures being degraded and employees working at too fast a pace**.**
- Was maintenance and cleaning adequate?

5.8 Lessons Learnt - Communication

The communication of incidents and subsequent lessons learnt must be managed to ensure the circumstances for legal privilege (or equivalent in the relevant legal jurisdiction) are maintained.

Internal and external communications of incidents and lessons learnt will be through SHE Bulletins or alerts which will only be issued by the SHE Team.

5.9 Repeat Incidents

Anyone identifying a repeat incident should advise the SHE Manager/Advisor who shall review and evaluate the need for additional resources to complete an investigation review so as to understand why the initial corrective action has not been effective.

5.10 Training and Awareness

The Unitas SHE Manager/Advisor will identify and ensure that any training needs are fulfilled in accordance with this standard by reviewing the training requirements for Unitas employees within the business.

6 Metrics

6.1 Frequency and Severity Rates

Frequency and severity rates are a normalised measure of performance and is a means of collecting appropriate data to calculate frequency and incident rate using the Health & Safety Executive (HSE) national accident incident rate (AIR) and accident frequency rate (AFR) The data is based on the number of accidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and calculated using the HSE formulae.

These calculations are based on the monthly headcounts provided by the business.

6.2 Accident Incident Rate (AIR)

The AIR is the sum of all fatalities and major specified injuries plus >7 day injuries (as per RIDDOR definitions) over a rolling 12 month period multiplied by 100,000 and divided by the average number of employees for the same 12 month rolling period.

$$AIR = \frac{\text{No of fatalities + RIDDORs Major Specified Injuries +>7 RIDDOR injuries X 100,000}}{\text{No of employees over a12 month rolling period}}$$

6.3 Accident Frequency Rate (AFR)

The AFR is the AIR rate divided by 2,163 (the number of hours a person works in a year – according to the Labour Force Survey).

AFR = AIR/2,163

6.4 All Accident Incident Rates (AAIR)

The AAIR is the sum of all personal injury incidents resulting in lost time other than on the day of the incident/injury (i.e. all fatalities and LTI's) over a rolling 12 month period, multiplied by 100,000 and divided by the average number of employees for the same 12 month rolling period.

$$AAIR = \frac{\text{No of PI incidents (fatalities + all types of LTIs) X 100,000}}{\text{No of employees over 12 month rolling period}}$$

6.5 Environmental Incident Rates (EIR)

The EIR is the sum of all thirteen types of Environmental Incidents (as listed in Section 8) where harm has occurred, over a rolling 12 months period, multiplied by 100,000 and divided by the average number of employees for the same 12 months rolling period.

$$EIR = \frac{\text{total of the13 types of Environmental Incidents X 100,000}}{\text{No of employees over 12 month rolling period}}$$

7. Risk & Impact Matrix

People – Occupational Injury	Environmental	Reputation	Asset Damage	HIGH – MEDIUM - LOW						
Single Fatality or multiple fatalities	Immediate long term catastrophic harm	Localised, long term	Extensive damage. >£250,000	F	F1	F2	F3	F4	F5	F6
Multiple Injuries/RIDDOR, permanent injury or disability	Immediate long term harm	Localised, long term impact but un-manageable	Major damage. £100,000-£250,000	E	E1	E2	E3	E4	E5	E6
Single RIDDOR or lost time incident	Limited short term harm	Localised, long term impact but un-manageable	Significant damage. £50,000-£100,000	D	D1	D2	D3	D4	D5	D6
Medical Treatment case with/or restricted work case	Minor harm	Localised, short term impact	Minor Damage £10,000-£50,000	C	C1	C2	C3	C4	C5	C6
First Aid	Minimal harm	Localised, temporary impact	Minimal damage up to £10,000	B	B1	B2	B3	B4	B5	B6
No injury or ill health	No harm	No impact	No asset damage	A	A1	A2	A3	A4	A5	A6
					1	2	3	4	5	6
					Likelihood					

1 = Improbable (unlikely)

2 = Remote (doubtful)

3 = Rare (occasional)

4 = Probable (Likely)

5 = Frequent (Regular)

6 = Certain (Definite)

8. Environmental Incidents

	Incident Category	Description	Reporting Trigger
1	Unauthorised discharge to a surface water drain or controlled waste	For example discharges to ditch, stream, dyke, river, canal, pond, lake, reservoir, estuary, coastal waters and groundwater. This includes water contaminated with mud, silt, fuel, oil, chemicals etc.	Any discharges of this type could result in enforcement action and should be reported, whatever the volume is involved.
2	Unauthorised discharge to a foul drain	For example discharges of substances other than sewage (e.g. concrete washout, commissioning, flushing effluent, groundwater) that are not covered by a temporary trade effluent consent or discharge of sewage directly to a public foul sewer without agreement.	Any discharges of this type could result in enforcement action and should be reported, whatever the volume is involved.
3	Unauthorised waste activity, including unauthorised escape of waste	Including treatment, use, storage or disposal (including fly-tipping) eg crushing activities undertaken without a permit or exemption; sending waste to a facility that is not permitted to accept it; using crushed demolition waste on site without an exemption or application of the WRAP recycled aggregate quality protocol. Also, waste escaping from a site, depot or vehicle.	Any instances of this type could result in enforcement action and should be reported.
4	Unauthorised water abstraction or impoundment	Extraction of water from a river or other water body without a licence or impoundment of water without a licence.	Any instances of this type could result in enforcement action and should be reported.
5	Unauthorised discharge to air	For example dust, fumes, odour or smoke.	Any release of dust, fumes or smoke that is persistent (i.e. not dark exhaust fumes that occur only on start-up of plant/machinery) or that result in a complaint from the public, client or Environmental Health Officer must be reported.
6	Unauthorised discharge to ground	Including gas, oil, diesel, petrol, hydraulic oil, chemicals, paints, solvents, concrete washout etc.…	If action needs to be taken on site to contain or respond to the spill to prevent pollution (i.e. deploying a spill kit or digging our contamination for disposal) it must be reported.
7	Damage/blockage of watercourse	For example to a stream, river, canal, drainage ditch or dyke. Includes blockages that may be caused, for example, by scaffolding suspended over a watercourse.	Any damage to the banks or bed of a watercourse or any blockage that results in localised flooding (particularly to adjacent properties) must be reported as this could result in enforcement action.
8	Damage to wildlife, trees	Damage that occurs accidently	Damage to any protected species,

	and habitat	(i.e. not planned removal of shrubs etc.)	habitat or feature e.g. protected hedgerow(s); tree(s) with a TPO (Tree Preservation Order); great crested newt pond; live bird's nest etc. could result in enforcement action and must be reported.
9	Damage to archaeology	Including listed buildings and buried archaeology.	Any damage to listed buildings or finds of unknown archaeology must be reported to ensure relevant expertise is brought in.
10	Nuisance	Including noise, dust, vibration, odour, fumes, smoke, mud on rods, traffic, parking, vermin, standing water, site run-off etc	Any of these issues that are persistent (i.e. not dark exhaust fumes that occur only on start-up of plant/machinery) or that result in a complaint from the public, client or Environmental Health Officer must be reported.
11	Breach of a permit, notice or licence condition	For example, breach of permit/licence conditions of a Unitas-operated waste facility; breach of the conditions of a temporary trade effluent consent; discharge permit or Section 61 agreement etc	Any breach must be reported as this could result in enforcement action.
12	Allowing the spread of an invasive non-native species	Including Japanese knotweed, Himalayan balsam rhododendron, killer shrimp, zebra mussel and American signal crayfish etc.…	Where known invasive species have been allowed to spread as a result of Unitas' actions and cannot be contained and mitigated then this must be reported as it could result in enforcement action.
13	Timber or timber based products not purchased	Timber or timber based products purchased/obtained from an illegally harvested source.	Where a merchant, supplier or manufacturer is unable to demonstrate that they are fully compliant with the requirements of the Timber Regulations or where a timber or timber based product does not have a chain of custody certificate from a credible, independent certificate scheme (such as that run by the Programme for the Endorsement of Forest Certification (PEFC) or the Forestry Stewardship Council (FSC)) then it must be reported.

9. References & Forms

PAIR Form (SHEMS-FOR-GR-053)
BI510 – (SHEMS-FOR-GR-431)
Witness Statement (SHEMS-FOR-GR-057)
Learning Event/Near Miss Report– (SHEMS-FOR-GR-043)
SHE Investigation Report – (SHEMS-FOR-GR-433)
Monthly Head Count Form (SHEMS-FOR-GR-115)
Major Incident Response Plan Standard (SHEMS-STD-GR-013)