16 Safety occurrence reporting and investigation

This chapter is split into two parts:

Part 1: Directive. This part provides direction that you **must** follow to help you comply with (keep to) health and safety law, Government policy and Defence policy.

Part 2: Guidance. This part provides the guidance and good practice that **should** be followed and will help you to keep to this policy.

Contents

Amendment record

This chapter has been reviewed by the Directorate of Defence Safety (DDS) together with relevant subject matter experts and key safety stakeholders. Any suggestions for amendments **should** in the first instance be directed to the Defence organisation's Safety Centre/Team Group Mailbox) and with their approval, sent to DDS at COO-DDS-GroupMailbox@mod.gov.uk.

Version No	Date Published	Text Affected	Authority
1.5	Oct 20	Interim update post-handover of policy from DSA to Dir HS&EP	Dir HS&EP
1.6	Aug 22	Review and update	Dir HS&EP
1.7	07 Sep 23	Release of two-part chapter structure.	DDS
1.8	14 Apr 25	Review and update	DDS

Terms and definitions

The following table sets out definitions of some of the key terms used in this chapter. The general safety terms and definitions are provided in the Master Glossary of Safety Terms and Definitions which can also be accessed on GOV.UK.

Accident	An event that results in injury, ill health or death to a person(s).
Dangerous occurrence	One of a number of specific, reportable adverse events which arise out of or in connection with work, as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
Hazard observation	A specific situation or set of circumstances which did not actually result in a safety occurrence but where the potential for a safety occurrence to occur in the future was identified.
Hospitalised	The term 'hospitalised' is being admitted to a hospital for more than 24 hours as an inpatient on the recommendation of a suitably qualified medical practitioner and kept there for treatment and is RIDDOR reportable.
Incident	An event which causes loss or damage to property, plant or equipment.
Near miss	An event that had the potential to cause injury, ill health or death to a person(s) or damage to property, plant or equipment, but no actual harm or damage occurred.
Notification	The urgent act of immediately informing those required of a serious safety occurrence - usually by telephone.
Occurrence	Refers to the terms Accident / Incident, Near Miss, Unsafe Act, Unsafe Condition and Dangerous Occurrence.
Reporting	The routine act of recording the details of all occurrences, regardless of whether they are notifiable, often using information technology management systems for example, MySafety and ASIMS.
Unsafe act	Any act that deviates from a generally recognised safe way of doing a task and increases the likelihood of an accident / incident.
Unsafe condition	Fundamentally associated with the quality of the working environment and may be defined as 'any conditions that may cause or contribute to an accident / incident or occupational illness / disease.'

Note: The definitions used in this JSP 375 chapter have been reviewed and agreed through stakeholder consultation and are the only recognised Defence safety definitions. Defence safety policy is owned by the Director of Defence Safety (DS) and the definitions within this chapter cannot be changed or altered without the explicit authority of the Director DS.

Must and should

Where this chapter says **must**, this means that the action is a compulsory requirement.

Where this chapter says **should**, this means that the action is not a compulsory requirement but is considered good practice.

Scope

The policy contained within this chapter:

a. applies to all those employed by Defence (military and civilian) including those under the age of 18 (for example recruits and apprentices).

b. applies to those working on behalf of, or under the supervision of Defence (for example, contractors or visitors).

c. applies to all Defence activities carried out in any location (UK or overseas).

d. is not written for young persons in the cadet forces[1], Defence-run schools, nurseries and so on; those organisations **must** maintain their own safety policies and governance and **must** provide statutory compliant infrastructure and appropriate safe systems of work. They may use material from this chapter as a reference point, but where appropriate their respective policies **should** be adapted to meet the needs of young persons and to follow any applicable Department for Education guidelines or legislation.

Assurance

The application of the policy contained within this Chapter **must** be assured (that is, its use **must** be guaranteed). As part of their overall assurance activity, the commander, manager, or accountable person **must** make sure that this policy is followed and put into practice effectively. Assurance **must** be carried out in accordance with JSP 815 (Defence Safety Management System Framework), Element 12 - Assurance.

Alternative acceptable means of compliance

This policy is mandatory across Defence and the only acceptable means of compliance (AMC) is attained by following the directive set out in this chapter. However, there may be circumstances where a small number of military units may be permanently unable to comply with (keep to) parts of the policy. In such circumstances the alternative AMC process is set out in the JSP 375 Directive and Guidance.

[1] Guidance for cadet forces is set out in JSP 814 (Policy and Regulations for Ministry of Defence Sponsored Cadet Forces).

Part 1: Directive

Introduction

1. This policy and guidance provides a framework for Defence to deliver its 'duty of care' responsibilities towards personnel and visitors (authorised or not). It also contributes towards demonstrating compliance both with the requirements of the Health and Safety at Work etc Act 1974 and relevant Defence policy and regulations.

2. The term 'occurrence' is used throughout this chapter which is in the context of safety and encompasses the terms accident, incident, near miss, hazard observation, unsafe act, unsafe condition or dangerous occurrence. However, there will still be some references to incidents or accidents where statute, Defence policy and regulations defines them. The terms incident, accident and near miss are defined within the terms and definitions table of this chapter.

3. This chapter sets out the procedural requirements and guidance for notifying, reporting, and investigating all safety occurrences, which apply to any persons for which Defence has a 'duty of care'.

4. The reporting of environmental incidents is not covered in this chapter and is set out in JSP 418 (Management of Environmental Protection in Defence). Safety occurrences and environmental incidents are often linked and can have common causes and consequences. Safety occurrences can have an environmental impact and likewise environmental incidents can have an impact on safety. It is therefore vital that Defence organisations comply with the policy contained within this chapter for safety occurrences and the policy within JSP 418 for environmental incidents.

5. Defence organisations are to promote a culture of learning and a proactive approach to identifying and mitigating potential safety occurrences as set out in JSP 815 Volume 2, Element 10 - Accident / Incident Management and Emergency Response.

Legislation and Defence policy

6. Employers have a general duty under the Health and Safety at Work etc. Act (HSWA) 1974, Section 2 to ensure, so far as is reasonably practicable (SFAIRP), the health, safety and welfare of all of their employees and anyone else who may be affected by a work activity is not compromised. This is commonly referred to as the 'duty of care'. The legislation requires employers to fulfil their 'duty of care' responsibilities by reducing risks as low as is reasonably practicable (ALARP). There is a further duty on employers under the Management of Health and Safety at Work Regulations (MHSWR) 1999 to carry out suitable and sufficient risk assessments, which for Defence requires commanders, managers and accountable persons to assess and mitigate health and safety risks to the personnel under their area of responsibility.

7. In accordance with the Secretary of State for Defence (SofS) policy statement on health, safety and environmental protection, when operating 'overseas, we will comply with the laws of Host States, where they apply to us, and in circumstances where such requirements fall short of UK requirements, we will apply UK standards so far as is reasonably practicable to do so'.

8. The key legislation (herein referred to as 'legislation') that applies to the Safety occurrence reporting and investigation are:

a. Reporting of Injuries Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR 2013),

b. Reporting of Injuries Disease and Dangerous Occurrences Regulations RIDDOR (NI)1997.

c. The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012.

d. Armed Forces Act 2006,

e. Armed Forces (Service Inquiries) Regulations 2008,

Note: Legislation may change, therefore always make sure that the version of the legislation that you are looking for is the current one.

9. The principal statutory regulation for reporting harm to individuals is RIDDOR. RIDDOR requires the reporting of fatalities, and specified injuries, dangerous occurrences and ill health (see Annex A for more detail on injury / illness severity) within Great Britain (GB) to the Health and Safety Executive (HSE) within defined timescales (listed in HSE publication L73 and summarised in the paragraphs below).

10. In accordance with the memorandum of understanding (MOU) between the Ministry of Defence (MOD) and the HSE, paragraph 10, "MOD has undertaken to notify any work-related Death, Major Injury, Disease or Dangerous Occurrence, to HSE as if they were RIDDOR reportable". The Defence organisations procedures **must** detail how they meet this requirement to notify the HSE.

11. The HSE regulates only in mainland Great Britain, not the entire United Kingdom, nor the British Overseas Territories. Defence organisations procedures **must** detail how they meet the requirement to notify any host nation reporting requirements when overseas. In Northern Ireland workplace H&S is regulated by HSE Northern Ireland (HSENI). The primary statutory regulation within Northern Ireland for reporting harm to individuals is set out in RIDDOR (NI)1997.

12. The term 'RIDDOR' will be used as an all-encompassing term (unless otherwise defined) throughout this chapter in the context of referring to both the HSE and HSENI respective legislation.

Note: Paragraphs 6, 7 and 8 only apply to RIDDOR; **all** occurrences **must** be reported wherever they occur in the world in accordance with Defence organisation procedures.

13. Reporting specified injuries, or fatalities to military personnel, **must** be in compliance with Part 16, Section 343 of the Armed Forces Act 2006, which makes provision for the services to hold Service Inquiries (SIs) in prescribed circumstances in relation to matters connected with any of His Majesty's Armed Forces.

14. The Armed Forces Act 2006 also empowers the Secretary of State (SofS) to make regulations in respect of such inquiries, and the policy and guidance provided in JSP 832 (Guide to Service Inquiries) reflects the Armed Forces (Service Inquiries) Regulations 2008, which among other things prescribe the matters about which inquiries **must** (or may) be held, and the membership and functions of a service inquiry panel.

Trade Union safety representative / representative of employee safety

15. Defence organisations have a legal responsibility to consult with the Trade Union (TU) / representative of employee safety (in order to satisfy the Health and Safety at Work etc Act 1974, section 2(6)) following any notifiable occurrence, dangerous occurrence, or work-related disease.

16. TU safety representatives may (at their discretion) exercise their legal right under the Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended) to inspect the workplace following any notifiable occurrence, dangerous occurrence, or work-related disease.

Data Protection Act 2018

17. Defence organisations **must** take active decisions in the processing of personal data, in accordance with the Data Protection Act 2018 (DPA18) implementing the UK General Data Protection Regulations (UK GDPR). In processing personal data, Defence organisations are acting on behalf of the data controller, the Secretary of State for Defence (the Authority).

18. Defence organisations are to put procedures in place to make sure data processing is conducted appropriately, safely and by trained security cleared (SC) Data Processors in accordance with the six data protection principles (set out in article 5(1) of the UK GDPR); which requires that the personal information we hold about a data subject (the person to whom personal data relates), **must** be:

a. processed lawfully, fairly and in a transparent manner;

b. collected for specified, explicit and legitimate purposes;

c. adequate, relevant, and limited to what is necessary;

d. accurate and where necessary kept up to date;

e. in a form which permits identification of data subjects for no longer than is necessary; and

f. processed in a manner that ensures appropriate security of the personal data.

19. The application of DPA 18 principles **must** not prevent an occurrence being reported, however, the security of the data **must** be managed in accordance with JSP 440 (The Defence Manual of Security).

Policy statements

20. Defence has established the following policy statements, which **must** be followed:

a. **Policy statement 1**. A Defence organisation's most senior leader **must** make sure that suitable and sufficient arrangements are in place for the notification, reporting, and management of all work-related safety occurrences within their organisation.

b. **Policy statement 2.** Defence organisation procedures **must** make sure that a work-related fatality, a specified injury, or a dangerous occurrence that occurs within the UK's geographical limits **must** be reported to the HSE as soon as possible in accordance with RIDDOR.

c. **Policy statement 3.** Defence organisation procedures **must** make sure that any serious occurrence (resulting in, for example, a loss of life, a specified injury or any occurrence that is likely to attract public or media interest) is notified as soon as possible to the Defence Accident Investigation Branch (DAIB), the Deputy Chief of Defence Staff Duty Officer (DCDSDO) and, for organisations under OPCOM CJO, the Permanent Joint Headquarters (PJHQ).

d. **Policy statement 4.** All safety occurrences relating to Defence personnel, visitors or contractors that are undertaking Defence activities, using Defence equipment or on the Defence estate **must** be reported on the Defence organisation's reporting system.

e. **Policy statement 5.** All safety occurrences **must** be assessed to determine whether an investigation is required and if so, in what depth. Defence organisations **must** make sure that suitable and sufficient resources and arrangements are in place for the investigation of safety occurrences, and these arrangements **must** be set out in their safety management procedures.

Policy statement 1
A Defence organisation's most senior leader **must** make sure that suitable and sufficient arrangements are in place for the notification, reporting, and management of all work-related safety occurrences within their organisation.

21. A Defence organisation's most senior leader **must** make sure that their organisation has effective procedures and resources in place for the notification, reporting, and management of all work-related safety occurrences.

22. Defence organisations **must** have an information management system in place that is capable of reporting and recording safety occurrences. The system **must** be capable of providing the Defence organisation with access to all safety occurrence data / information to undertake investigation and learning from experience.

23. The information management system **must** be capable of providing Defence Statistics with access to relevant safety occurrence data / information to undertake data analytics and validation on behalf of Defence. Defence Statistics **should** have direct access to the Defence organisation's information management systems to be able to pull information, where it is technically viable to do so.

24. Defence organisation's occurrence information management system **must** have the capability to capture the occurrence information in a format that allows for reporting to statutory authorities where appropriate (for example, the HSE).

25. Defence has developed an information management system (MySafety) to report, record and enable learning from safety (encompassing occupational health), and environmental occurrences across the organisation, which also includes the capability of reporting via mobile devices, known as MySafety Alert. Safety occurrence categories are set out in Annex B and safety occurrence category types are set out in Annex C.

26. MySafety uses an agile development methodology allowing for additional features to be added and for the system to continually evolve with an aim to bring all of Defence onto a single Health Safety & Environment Protection (HS&EP) occurrence reporting and recording system which will enable efficient investigation, exploitation (data mining / analysis / visualisation) and lessons management.

27. Whilst MySafety is being evolved, there will be a staggered approach for acceptance of its use, therefore until fully implemented by all Defence organisation's they **must** continue to use their organisation information management system for the reporting and management of all HS&EP work-related occurrences.

28. The responsibility for implementing and managing the occurrence reporting system may be delegated to a competent person(s). The system **must** have the capability to capture the occurrence information in a format that allows for efficient data analysis and exploitation to enable informed decision making and learning from experience.

29. All reports and data provided to an appropriate statutory authority **must** be in accordance with that Defence organisation's arrangements and any requirements of Defence policy or regulation.

Policy statement 2
Defence organisation procedures **must** make sure that a work-related fatality, a specified injury, or a dangerous occurrence that occurs within the UK's geographical limits **must** be reported to the HSE as soon as possible in accordance with RIDDOR.

30. Where required by the legal requirements of RIDDOR to report fatalities, injuries and dangerous occurrences within the UK's geographical[2] limits, the Defence organisation **must:**

a. notify the HSE of the reportable occurrence by the quickest practicable means without delay; and

b. send a report of that occurrence in an approved manner to the HSE within 10 days of the incident.

31. The Defence organisation's procedures **must** detail how they meet the statutory requirement to report occurrences involving civilians to the HSE. They **must** report occurrences meeting the requirements of RIDDOR 2013 in GB to the HSE using the HSE online report form, and for reporting fatal and specified injuries, by telephone on 0845 300 9923 (Monday to Friday 8.30 am to 5 pm) and for Northern Ireland using the direction set out in (RIDDOR (NI) 1997).

[2] Twelve nautical miles (the territorial waters under the Territorial Sea Act 1987).

32. This does not preclude the requirement for contractors and sub-contractors to report and investigate occurrences to their own respective employers, who are responsible for reporting to the HSE any RIDDOR reportable occurrences that meet the criteria.

33. Where a person (for example a visitor or a member of the public), as a result of a Defence activity or whilst on the Defence estate, suffers an injury and that person is taken from the site to a hospital for treatment in respect of that injury, it is the responsibility of the Defence organisation (once they have been informed of the occurrence) to notify the HSE of any RIDDOR reportable occurrences that meet the criteria.

34. In accordance with RIDDOR 2013 (Regulation 14(5)) and RIDDOR (NI) 1997 (Regulation 10(3)), there is no requirement to report to the HSE the injury, death or diagnosis of a member of the armed forces of the Crown or of a visiting force, on-duty at the time. However, in accordance with the memorandum of understanding (MOU) between the Ministry of Defence (MOD) and the HSE, “MOD has undertaken to notify any work-related Death, Major Injury, Disease or Dangerous Occurrence, to HSE as if they were RIDDOR reportable”.

35. To meet the requirements of the MOU for occurrences to service personnel within the UK, Defence organisations procedures **must** detail how they meet the requirement to report occurrences and **must** notify the HSE of:

a. work-related death(s);

b. specified (major) injuries (these in the main are reported to the HSE on behalf of the Defence organisations by Defence Statistics via a monthly spreadsheet based on information directly exported from the Defence organisation’s reporting system where technically able to do so. Defence organisations who do not provide data to Defence Statistics **must** report directly to the HSE (for example the Defence Infrastructure Organisation (DIO));

c. disease(s); and

d. dangerous occurrence(s).

36. In addition, in line with RIDDOR where a civilian at work is incapacitated for routine work for more than seven consecutive days (excluding the day of the accident) because of an injury resulting from an accident or in connection with that work, a report **must** be sent to the relevant enforcing authority [HSE] in an approved manner as soon as practicable and in any event within 15 days [10 days iaw RIDDOR NI] of the accident.

What is meant by ‘work-related?

37. From HSE key definitions. "RIDDOR only requires you to report accidents to the HSE if they happen “out of or in connection with work”. The fact that 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 carried out;
- any machinery, plant, substances or equipment used for the work; or
- the condition of the site or premises where the accident happened”.

38. In relation to the term ‘work-related’, there is the additional consideration of an individual’s ‘on or off-duty’ status as to whether or not they were working at the time of the occurrence. For example, generally, commuting to and from a normal duty station is unlikely to be classed as being on-duty. However, the distinction between on and off-duty may not always be clear, particularly in the military environment, therefore, it is for the chain of command to determine the ‘on or off-duty’ status of their personnel at any given time.

39. Factors that may mean an injury was more likely to be caused by service include, but are not confined to: acting on orders, responding to a service-related emergency, being on operations or exercise, performing an activity specified in the individual’s job description. Other factors may be as a result of taking part in service-approved sport and adventurous training (AT), as set out in JSP 419 (Adventurous Training in the UK Armed Forces).

40. Sporting activities are categorised into two principal areas;

a. Official sport activity, as set out in JSP 660 (Sport in the UK Armed Forces).

b. Recreational sport (sporting activities in an unofficial capacity, for example in own time).

41. Official sport activity and AT injuries **must** be treated the same as all work-related injuries detailed in this Chapter regarding reporting on the Defence organisations reporting system, notifying the Defence Accident Investigation Branch (DAIB) and the HSE (if they occurred within GB and result in a RIDDOR reportable injury that was due to defective equipment or safety failings in the organisation or management of the event).

Policy statement 3
Defence organisation procedures **must** make sure that any serious occurrence (resulting in, for example, a loss of life, a specified injury or any occurrence that is likely to attract public or media interest) is notified as soon as possible to the Defence Accident Investigation Branch (DAIB), the Deputy Chief of Defence Staff Duty Officer (DCDSDO) and, for organisations under OPCOM CJO, the Permanent Joint Headquarters (PJHQ).

42. Notifying the DAIB, DCDSDO and PJHQ (as applicable), (see paragraph below for contact details) of a serious (in this context of DAIB notification and not to be confused with the RIDDOR category of serious) occurrence **must** be a priority activity. The Defence organisations safety occurrence reporting procedures **must** detail how this notification is to be actioned, this may be in addition to the Defence organisation's usual reporting methods (for example, raising through the chain of command and on their reporting system).

43. Serious safety occurrences where it is related to Defence employment, activity or estate, and / or any significant loss of operational capability are notified to the DAIB in order to rapidly inform the decision to deploy a team of investigators to ensure preservation of evidence, and to the DCDSDO in order for them to inform and initiate action in accordance with the CDSDO standard operating procedures (SOPs).

44. Serious safety occurrences in this context are defined as:

a. one or more death;

b. one or more specified injuries to a person (as listed in Annex A);

c. a total loss of a platform or force element that forms a significant part of an operational capability;

d. an emergency response by civil or military emergency services is required, for example to tackle a major fire, rescue a person(s) for a safety related issue or rescue a platform, or an ambulance is called (only where there is a work-related loss of life or a specified injury);

e. any other safety occurrence of significance that may attract media interest or otherwise have potential impact on Departmental reputation;

f. any injury to a member of the public who is taken from the site to a hospital and then requires admission to hospital for treatment in respect to that injury being due to a Defence safety related issue; and

g. a dangerous occurrence (as listed in Annex C).

45. The DAIB Duty Coordinator is contactable as per DSA 01.4 on 01980 348622. The DAIB number is monitored 24/7 by duty staff who will take the details of the occurrence and make an initial assessment of whether DAIB **should** deploy. If units are unsure of whether an occurrence warrants DAIB involvement they **should** seek advice from the DAIB duty staff.

46. In addition to the DAIB notification:

a. The DCDSDO is contactable 24/7 via Civ: 020 7218 8938 and Mil: 9621 88938 or Civ: 020 7218 8850 and Mil: 9621 88850.

b. For organisations under OPCOM CJO, the PJHQ Duty Ops Controller is contactable via Civ: 01923 955311 or Mil: 9360 55310.

c. Notification of a Casualty (NOTICAS) is set out in JSP 751 (Joint Casualty and Compassionate Policy and Procedures).

Policy statement 4
All safety occurrences relating to Defence personnel, visitors or contractors that are undertaking Defence activities, using Defence equipment or on the Defence estate **must** be reported on the Defence organisation's reporting system.

47. Defence personnel have a statutory duty to report any work situation which presents a risk to the safety of themselves or others. They **must** report all occurrences in accordance with their Defence organisation's occurrence notification and reporting procedures and co-operate fully with any resulting investigation or formal inquiry.

48. All work-related occurrences involving contractors and sub-contractors, whether they are permanent or visiting a Defence unit or estate (site), conducting Defence activities, **must** be reported in accordance with the Defence organisation's notification and reporting procedures.

49. With the exception of United States Visiting Forces (USVF) personnel on USVF bases and Atomic Weapon Establishment (AWE) personnel on AWE sites, all accidents / incidents relating to Defence personnel, visitors, premises, estate or equipment, of which Defence exercises an element of control or for which Defence may be otherwise culpable **must** be recorded, reported and investigated.

50. The RIDDOR reporting requirements to the HSE are covered in policy statement 2, however a 'minor injury' is not reportable and falls outside the requirements, nevertheless, it is a legal requirement to keep a record of any work-related injury resulting in three to seven consecutive days' incapacitation, after which (beyond seven consecutive days) it becomes reportable to the HSE in accordance with RIDDOR. Equivalent local reporting procedures **must** be followed when working in Northern Ireland and oversees. This record **must** be kept in accordance with the Defence organisation's notification and reporting procedures.

51. The reporting of an injury is in addition to any medical attention and records kept by the medical department, as they will likely be classed as medical in confidence and therefore, any lessons to be identified would otherwise be lost by the organisation.

52. The Defence organisation's procedures **must** include the reporting of occurrences to:

a. the Defence organisation's Incident Notification Cell (INC) (or equivalent);

b. the Defence organisation's Safety Centre / Chief Environment and Safety Officer (CESO) (or equivalent);

and also, in the case of serious occurrences, notification to:

c. the DCDSDO, DAIB and where applicable PJHQ;

d. the Director DS; and

e. the local TU or Representative of Employee Safety.

53. The information for the initial reporting of an occurrence **must** include as a minimum:

a. Casualty(s) name and details of injury(s) (if appropriate);

b. type of platform, equipment and / or activity involved;

c. description of occurrence;

d. location, date and time;

e. status and numbers of any known casualties;

f. parent unit of casualty(s) if known;

g. contact details of person / organisation reporting the occurrence;

h. emergency services attending the scene;

i. which police forces or rescue services notified (military or civilian) and which medical facilities (military or civilian) were involved (if any); and

j. where an occurrence happened outside the UK, the details of any host nation support offered or received. Notice **should** be given to the command chain, British Embassy and so on, where details are known.

54. The commander, manager or accountable person[3] (AP) may appoint a designated officer for the reporting of estate related occurrences (for example, RIDDOR specified injuries, dangerous occurrences, and so on) in accordance with Defence organisation's reporting requirements; and make sure that commanders, managers or APs understand the procedures for the reporting of all other occurrences.

[3] The person whose terms of reference state that they are responsible for making sure there are suitable and sufficient systems in place to control health and safety risks in their unit, estate (site) or platform. This term is used in place of CO, HoE, OC, Station Commander and so on, or as decreed by the Defence organisations.

55. The processing of personal data is to be held as 'Official-sensitive personal' information and **must** be in full compliance with DPA 18 and where appropriate the specific requirements of the special forces.

56. Notwithstanding any Defence organisation-specific reporting requirements, the commander, manager, or AP **must** make sure that any outbreak of fire on the Defence estate, under their control is reported to the Defence Fire and Rescue (DFR) in accordance with JSP 426 (Defence Fire Safety & Risk Management Policy) Leaflet 10, Paragraphs 5 – 8. DFR hold responsibility for informing the Defence Fire Safety Regulator (DFSR) who may conduct a post fire investigation (FI) (dependent on severity) to ascertain if there were breaches of legislation. In accordance with JSP 426 Leaflet 11, Paragraph 5 "Capita Fire and Rescue (CFR) are responsible for undertaking FIs for all outbreaks of fire on the Defence estate following the notification of a fire".

57. Where domain-specific reporting is required, and proportionate investigations and analytics have been conducted, the conclusions of these **must** be made available to the appropriate AP within the Defence organisations so that opportunities to enhance reporting and understanding are optimised.

58. In addition to the generic requirements of this chapter, Defence Safety Authority (DSA) Regulations (see gov.uk website) detail each domain reporting requirements:

a. **Aviation.** The Military Aviation Authority (MAA) defines aviation domain reporting requirements in: Regulatory Article 1410 - Occurrence Reporting and Management.

b. **Maritime**. The Defence Maritime Regulator (DMR) defines maritime reporting requirements in DSA 02 - DMR- Defence Maritime Regulations for Health, Safety and Environmental Protection.

c. **Nuclear**. The Defence Nuclear Safety Regulator (DNSR) identifies the nuclear reporting requirements as follows:

(1) DSA 02 - DNSR and DSA 03 DNSR (Defence Nuclear Safety Regulations of the Defence Nuclear Enterprise and Guidance) with reference to:

a. JSP 471 (Defence Nuclear Emergency Response).

b. JSP 392 (Management of Radiation Protection in Defence).

d. **Land**. The Defence Land Safety Regulator (DLSR) defines occurrence reporting requirements in DSA 02 - DLSR (Policy and Regulations for Health, Safety and Environmental protection).

e. **Ordnance, Munitions and Explosives (OME)**. The Defence Ordnance, Munitions and Explosives Safety Regulator (DOSR) requirements for reporting ordnance, munitions and explosives safety occurrences are found in DSA 03 - OME Part 2 (In-Service and Operational Safety Management of OME).

f. **Fire.** The Defence Fire and Rescue (DFR) occurrence reporting requirements for reporting fires and alarms are found in JSP 426 Leaflet 10.

g. **Medical**. The Defence Medical Services Regulator (DMSR) occurrence reporting requirements that involve severe harm or death of a service person are found in DSA 02 - DMSR (Healthcare Regulations).

Policy statement 5
All safety occurrences **must** be assessed to determine whether an investigation is required and if so, in what depth. Defence organisations **must** make sure that suitable and sufficient resources and arrangements are in place for the investigation of safety occurrences, and these arrangements **must** be set out in their safety management procedures.

59. All safety occurrences **must** be assessed to determine whether an investigation is required and if so, to what depth. The investigation **should** be proportional to the severity / potential severity of the occurrence outcome (unless specific legislation or Defence policy dictates a more stringent approach). It is the potential consequences and the likelihood of the occurrence happening again, which **should** determine the level of investigation, not simply the injury or ill health suffered on that occasion.

60. The Defence organisation's safety management procedures **must** detail how all occurrences will be investigated. This **must** include the composition of any panel necessary to conduct the inquiry. Panel members do not have to be experts in any discipline although it will often be helpful if they have professional knowledge or experience of the environment involved. However, members **should** not have been involved or been witness to the matter under investigation.

61. Where any lessons are identified, appropriate correction (addressing the specific issue) **must** be taken. Defence organisations **must** make sure that there are sufficient resources for the investigation of occurrences and they **must** make sure that support is given to any formal inquiry required by DAIB or relevant Defence organisation as appropriate for any specified injury, occurrence and dangerous occurrence.

62. Defence organisations **must** make sure that suitable arrangements are in place and there are sufficient resources for the investigation of occurrences, any subsequent formal inquiry and the co-operation with:

a. Police investigations;

b. Defence formal inquiries; and

c. Independent investigations by external organisations (for example the HSE and / or a TU).

63. It is likely that the Police (Civilian or Military) will usually be the first authority at the scene of any occurrence involving a death or serious injury. The Police will investigate potential criminal offence(s), the focus of their investigation being the gathering of evidence regarding the possible commission of a crime which either indicates or helps to explain the circumstances that contribute to or cause a death, with a view to assessing whether there should be a criminal prosecution.

64. Formal Defence inquiries[4] may take the form of a statutory SI or a Non-Statutory Inquiry (NSI) as detailed within a Defence organisation's procedures. Where an occurrence results in the death or serious injury of a service person or a civilian, it is mandated by statute that an SI **must** be convened in accordance with JSP 832 (Guide to Service Inquiries) and in compliance with the Armed Forces (Service Inquiries) Regulations 2008; this may involve service and civilian personnel.

[4] DG-DSA is the primary convening authority for all safety related service inquiries – DSA Charter

65. The purpose of a Service Inquiry (SI) is not to attribute blame, but to establish the facts and make recommendations in order to prevent it happening again.

66. The conduct of a Police investigation has primacy but **should** not prevent a Service Inquiry, which may run in parallel as long as the president (and the Single Service Inquiry Co-ordinator (SSIC) if required) and Police liaise closely to avoid any risk of prejudicing or otherwise interfering with the Police investigation.

67. Investigations may range from short interviews with the individuals concerned to formal inquiries. If further occurrences are to be avoided, it is essential that the investigation identifies the root causes as well as the direct causes (see Part 2 for further detail on conducting investigations).

68. The lead investigator may call upon the assistance of a competent person(s), for example: the DAIB, site safety adviser or Safety Centre / CESO (or equivalent) as appropriate.

69. Defence organisations **must** wherever possible accommodate any request by a TU or representative of employee safety to inspect the workplace after an occurrence and to participate in joint investigations (subject to security and data protection controls).

70. The inquiries **should** identify safety lessons that when published will contribute to the development of a safer operation across their organisation(s) and therefore, across Defence. In this context a lesson is defined as:

a. an experience, example or observation that imparts beneficial new knowledge or wisdom; and / or

b. it is something that can be analysed to produce recommendations and / or actions.

71. Lessons identified and subsequently learnt from SIs or a Defence organisation NSI **must** be notified to the Defence organisation's Safety Centre / CESO (or equivalent) and where appropriate to the relevant Defence safety organisation(s) for recording on their occurrence reporting system to enable and benefit from the lessons learnt.

72. Where lessons highlight corrective recommendations, the appropriate recommendation owner **must** make sure that appropriate corrective action is taken, risk assessments updated and the relevant information shared across the organisation. They **should** also monitor the effectiveness of new or revised control measures and make sure that all stakeholders are made aware of changes to existing management systems or risk assessment processes, as set out in JSP 375 Volume 1 Chapter 8 (Safety Risk Assessment and Safe Systems of Work).

73. Where lessons are learnt, the recommendation owner **must** report these findings to the relevant Defence organisation's Safety Centre / CESO (or equivalent) and make sure that the appropriate corrective action (to address wider and underlying factors) is taken, and the effectiveness of new / revised control measures are monitored.

Part 2: Guidance.

This part provides the guidance and good practice that **should** be followed to help you comply with this policy.

Reasons for notification and reporting

1. Following the initial immediate notification, the reporting of occurrences provides a record that can be used to inform the planning of actions to be taken to prevent recurrence, or more importantly to learn from experience (LfE) to anticipate and prevent other potentially more serious outcomes, both locally and across Defence, thereby reducing risk to life (RtL).

2. Reporting of occurrences can also identify where good practice has resulted in a better outcome than would otherwise have been expected, and may identify opportunities to share good practice wider, in order to improve organisational performance.

3. The Defence Safety Committee (DSC) require information regarding occurrences across Defence to support the analysis and identification of trends. The necessary 'data set' to support this requirement and comply with safety law, Government policy, Defence policy and regulation, is to be detailed within the Defence organisations notification, reporting system procedures.

4. The consequences of occurrences can be injury or illness, ranging from mild to long-term, severe, or even a fatal injury. It is therefore important to make sure all the relevant details of an occurrence are recorded, this includes but is not limited to: any work instructions, risk assessments, or JSP 375 chapters being used at the time. This information will provide evidence, should a compensation claim be made against Defence.

5. In a case of injury or death in the workplace or Defence estate, a claimant may bring a claim for damages against Defence on the basis of alleged negligent breach of a duty of care. Furthermore, in cases of death involving an alleged gross breach of a duty of care, Defence may also face prosecution for corporate manslaughter. It is therefore important that accurate comprehensive records are made and kept (in accordance with UK GDPR principles) to make sure that any legal proceedings are fair and that the correct outcome is reached.

6. As stated in the introduction of this Chapter, the term **'Occurrence'** encompasses the categories; accident, incident, near miss or hazard observation and the occurrence category types; unsafe condition, unsafe act and dangerous occurrence.

Note: Some domains may follow other civilian equivalent industry terminology.

7. To assist with providing some context to these terms and considering if a report **should** be raised, it may be prudent to consider the cartoon below at Figure 1, as this provides an illustrative example of each definition:

   a. the first picture shows an 'eyebolt' that the chains are connected to in order to lift the large load. It is no longer secure and has a potential to fail, creating an '**unsafe condition**';

b. the second picture shows two people walking directly underneath the ‘underslung’ load, this is an ‘**unsafe act**’ as the load may fall onto them if the lifting points were to fail;

c. the third picture shows the eyebolt failing and the large load falling and narrowly missing the two people, this is a ‘**near miss**’ as no actual harm to the people occurred;

d. the fourth picture shows the eyebolt failing and the large load falling, although no people were harmed, this is an **‘incident**’ as damage to the load did occur; and

e. the last picture shows the eyebolt failing and the large load falling and the two people getting crushed by the load, this is an ‘**accident**’ as harm to the people did occur.

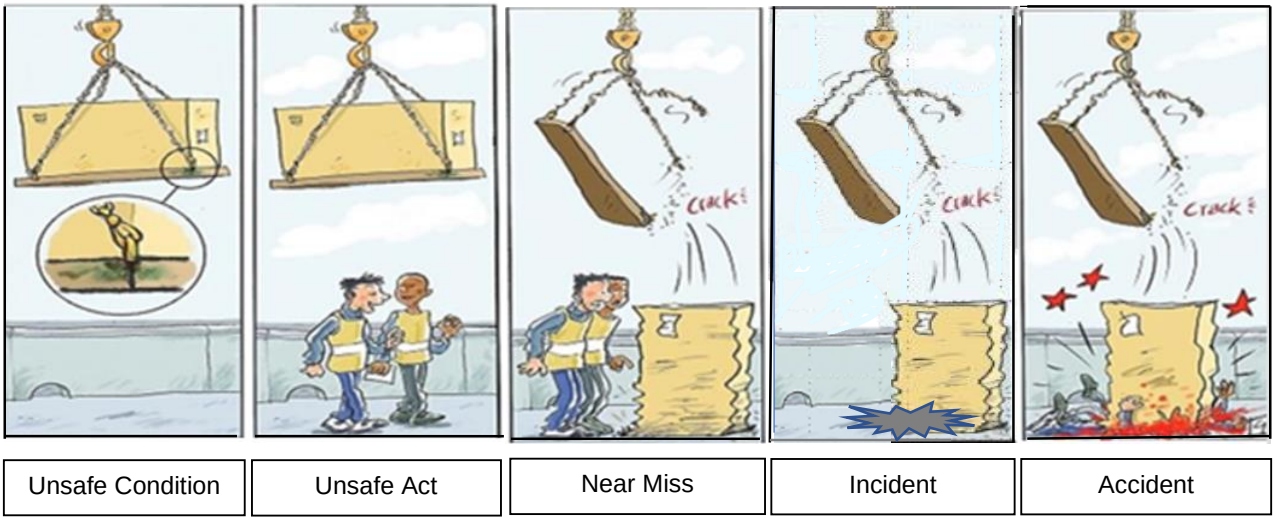

Figure 1 - Illustrative example of each definition

8. Additional procedures to those covered by this chapter include appropriate reporting to:

a. the commander, manager or accountable person responsible for the activity / facility;

b. all appropriate safety leads in the command chain, their Defence organisation’s local TU safety representative; and

c. the specialist reporting cell when a function is not covered by the Defence organisation’s incident notification cell (INC) or equivalent.

Responsibilities

Head of the organisation

9. The head of the organisation or the AP **should** be able to demonstrate that:

a. suitable procedures are in place for the notification, reporting of occurrences and any enforcement action (for example by the HSE or Defence regulators) and that these are embedded at a local level for their area of responsibility;

b. the procedures that have been put in place comply with Defence policy requirements for notifying, reporting of occurrences and dangerous occurrences.

10. Notwithstanding any Defence organisation specific reporting requirements, the AP **should** make themselves aware of Defence regulations requiring:

a. the notification of DAIB, DCDSDO and PJHQ (as applicable);

b. outbreaks of fire on the Defence estate (where under their control) are reported to the Defence Fire Safety Regulator who will lead any subsequent investigations by Defence;

c. specific reporting of specialist incidents (OME, nuclear, maritime, aviation, land systems, fire or medical) to be completed; and

d. that they have informed the appropriate DSA regulator of when a statutory notice has been issued.

Commanders, managers or AP

11. Commanders, managers or AP **should** be able to demonstrate that:

a. Occurrences (as set out in policy statements 2, 3 and 4 in this chapter) are brought to the attention of the local site safety adviser or equivalent / AP as indicated by local instructions (where this is not possible, this responsibility passes up the chain of command);

b. reporting up the chain of command for all work-related (non-combat) fatalities meeting the following criteria:

(1) where the fatality is a person employed by Defence (military or civilian);

(2) any person (for example, contractors, visitors, and members of the public) where the fatality was on the Defence estate, on a Defence platform or using Defence equipment; or

(3) any person where a fatality was caused by Defence activities (these **must** be notified to the DAIB and to the Defence organisation's safety lead as soon as possible so that notification to the statutory regulator is carried out).

c. unless local procedures dictate otherwise, the commander, manager or accountable person responsible for the activity or facility **should** make sure occurrences are reported;

d. where appropriate, unless already under the control of the civilian Police, Ministry of Defence Police (MDP), HSE, Local Authority Fire Service or DFSR, the commander, manager or accountable person responsible for the activity / facility is responsible for post occurrence management. They **should** make sure that the scene of an occurrence is made safe and that all reasonable steps are taken to secure / quarantine the area and any equipment or vehicles and so on, to preserve evidence as part of pre-investigation activity;

e. occurrences involving contractors, sub-contractors and those (non-Defence) visiting a Defence unit (site) / establishment are reported by their Defence host to the host's INC (or equivalent). Contractors may additionally report any occurrences to their employers;

f. where they are responsible for the activity / facility, they took reasonable steps to notify representatives above of any occurrence reported and ensured any legal right to inspect a workplace occurred; and

g. following any notifiable occurrence, dangerous occurrence, or report of occupational disease, work-related illness or injury, any request by a TU / employee safety representative was accommodated and included in any subsequent Unit investigation into that occurrence.

All personnel

12. All personnel **should** be able to demonstrate that they are aware of:

a. the need to report all occurrences to their commander or manager and to any other persons as directed by their Defence organisation's local procedures;

b. the need to co-operate with any investigation or formal inquiry; and

c. their role in reporting any work situation which represents a risk of serious or imminent danger to safety without delay, including shortcomings in the protection arrangements through their chain of command / reporting chain and including their local safety advisor.

13. All personnel **must** notify and report occurrences in accordance with the Defence organisation's notification, reporting procedures. The report **should** be raised by the individual where able to do so or by their commander, manager or accountable person where this is not possible.

Investigation

14. The following guidance is for all Defence organisations to use, as the approach to investigations **should** be consistent across Defence. Any deviation from this approach **should** be documented with a clear rationale and explanation given.

15. Investigations **should** be proportional to the severity / potential severity of the occurrence and be determined by an assessment of the risks involved, not just the specific outcome. Investigations may range from short interviews with the individuals concerned to formal inquiries.

16. When deciding whether an occurrence crosses the threshold for an investigation, the following aspects **should** be considered (this list is non-exhaustive):

a. the selection of investigation team, for example experience and training;

b. the extent and level of any injuries sustained;

c. any impact on or loss of operational capability;

d. the potential impact on Departmental reputation;

e. any assessment of whether significant lessons might be learnt; and

f. any specific medical incident which involves severe harm or death of a service person is to be reported as detailed in Part 1 of this chapter.

17. Occurrence investigations other than a Service Inquiry (SI) or Defence organisation non-statutory inquiry (NSI) **should** be detailed within the Defence organisation's procedures. The HSE provide guidance as set out in HSE HSG 245 - Investigating Accidents and Incidents which if used, can assist personnel to conduct investigations. Personnel should also seek assistance from subject matter experts as appropriate.

18. In some instances, it will be appropriate for additional detailed technical occurrence investigations to be conducted. These may be independent of the formal inquiry, the operators and the regulators. The reporting requirements for additional investigations **should** be clearly defined within the Defence organisation's procedures.

19. When making the decision to investigate an occurrence, consideration **must** be given to the potential for learning lessons. This is a critical requirement of an effective learning organisation and will form part of the feedback to the individual and / or establishment / unit and where appropriate the wider Defence community. For example, a minor occurrence may not require an in-depth investigation; however, a series of similar occurrences may be subject to a more detailed and thorough investigation. The analysis may identify a chain of failures and errors that inevitably lead to the occurrence happening again.

20. The focus of any investigation is to establish the facts of a particular occurrence and to make recommendations in order to prevent it happening again. :

a. **Cause -** The 'immediate' cause is a factor which leads directly to an outcome. Typically, the last barrier to fail; the final link that directly caused / led to the occurrence.

b. **Causal factors -** This describes the real world as a set of 'underlying' pre-conditions and are further categorised as below:

(1). **Contributing factors -** Those factors that did not directly cause, but did contribute, to the occurrence. The presence of these factors increased the probability of the occurrence.

(2). **Aggravating factors -** Those factors that did not directly cause the occurrence but made the outcome worse / more severe.

(3). **Other factors -** Any other factors associated with the occurrence - i.e., relevant to this occurrence but not affecting the likelihood or severity of the outcome.

c. **Root cause -** The failure from which all other failings grow, often remote in time and space from the adverse event (for example failure to identify training needs and assess competence, low priority given to risk assessment and so on).

21. Based upon the findings of the investigation, which **should** be contained in the Defence organisations notification, reporting system, Defence organisations are able to make informed decisions to establish improvements to prevent further occurrences.

Post occurrence actions

22. When an occurrence arises, the Defence organisation **should**:

a. React in a timely manner, take action to control and correct it, and deal with the consequences.

b. Evaluate the need for corrective action to eliminate or reduce the likelihood of recurrence to as low as is reasonably practicable (ALARP). This **should** be done by investigating the occurrence, including consideration of previous similar occurrences.

c. Review existing assessments of safety risks.

d. Determine and implement any actions needed and review their effectiveness.

e. Assess safety risks which relate to new or changed hazards, prior to acting.

f. Amend the Defence organisation's safety management system (SMS), if necessary.

23. Corrective actions **should** be appropriate to the effects or potential effects of the occurrences or nonconformities encountered. The Defence organisation **should** retain documented information as evidence of:

a. The nature of the occurrences or nonconformities and any subsequent actions taken.

b. The results of any action and corrective action, including their effectiveness.

c. The Defence organisation **should** communicate this information to all relevant personnel and stakeholders.

Retention of records

24. All records including the unit / establishment register, risk assessments, and so on, **must** be kept in accordance with JSP 375 Volume 1 Chapter 39 (Retention of Records).

Related documents

25. The following documents are related to this chapter:

a. Other MOD Publications;

(1). JSP 815 - Defence Safety Management System;

(2). JSP 832 - Guide to Service Inquiries

(3). JSP 751 - Joint Casualty and Compassionate Policy and Procedures

(4). JSP 317 - Safety Regulations for the Storage and Handling of Fuels and Lubricants;

(5). JSP 862 - MOD Maritime Explosive Regulations;

(6). JSP 950 - Medical Policy;

(7). DSA02-MRP-2000 Series - Flying Regulations; and

(8). DSA02-DLSR - Defence Movements and Transport Regulations and JSP 800 Guidance.

b. Legislation and further guidance;

(1). Legislation - Gov.uk - Health and Safety at Work etc Act;

(2). Gov.uk - MGN 564 - marine casualty and marine incident reporting;

(3). HSE INDG 232 - A Guide to the Safety Representatives and Safety Committees Regulations and The Health and Safety (Consultation with Employees) Regulations;

(4). HSE INDG 453 (rev 1) - A guide to Reporting of Accidents and Incidents at Work; and

(5). HSE HSG 48 - Reducing Error and Influencing Behaviour.

Annex A - Injury / illness severities

Injury / illness severity		RIDDOR reportable	Defence organisation reportable	DAIB notifiable
Fatality	Single / multiple (numbers) whilst at work or in relation to the work being undertaken.	✓	✓	✓
Specified Injury (Major)	Where any person at work, as a result of a work-related accident, suffers – a. a life-threatening or life-changing injury, such as paralysis. b. any bone fracture diagnosed by a registered medical practitioner, other than to a finger, thumb or toe; c. amputation of an arm, hand, finger, thumb, leg, foot or toe; d. any injury diagnosed by a registered medical practitioner as being likely to cause permanent blinding or reduction in sight in one or both eyes; e. any crush injury to the head or torso causing damage to the brain or internal organs in the chest or abdomen; f. any burn injury (including scalding) which - (i) covers more than 10% of the whole body's total surface area; or (ii) causes significant damage to the eyes, respiratory system or other vital organs; g. any degree of scalping requiring hospital treatment; h. loss of consciousness caused by head injury or asphyxia; or i. any other injury arising which - (i) requires resuscitation or admittance to hospital for more than 24 hours or (ii) leads to hypothermia or heat-induced illness requiring admittance and emergency treatment in hospital for more than 24 hours.	✓	✓	✓

Injury / illness severity		RIDDOR reportable	Defence organisation reportable	DAIB notifiable
Serious (Moderate)	Any injury, which results in: a. any person at work incapacitated (unable to perform full range of duties) for routine work for more than seven consecutive days (excluding the day of the accident) because of an injury resulting from an accident arising out of or in connection with that work requiring medical treatment but not admission to hospital for more than 24 hours; b. a formal report to the HSE under RIDDOR not a specified injury, accident / incident or dangerous occurrence; c. heat illness requiring admittance to hospital for more than 24 hours; or d. cold injury requiring admittance to hospital for more than 24 hours.	✓	✓	✓
Minor (Slight)	An injury, which results in: a. pain, for example a sprain or strain that does not require medical assistance or restrict ability to conduct normal duties. b. any injury that requires professional medical assistance (including that of a registered first aider) or results in time lost and / or restricted ability to conduct normal duties. c. up to seven consecutive days lost time and is not reportable under RIDDOR or causes minor damage to Defence, or other party, property or materials. Minor injury. d. heat illness not requiring admission to hospital; or e. cold injury not requiring admission to hospital.		✓	

Annex B - Safety occurrence categories

Safety occurrence category (unique event, situation or set of circumstance)		RIDDOR reportable	Defence organisation reportable	DAIB notifiable
Accident	An event that results in injury, ill health or death to a person(s). **Note:** Where an accident is categorised as a Dangerous Occurrence (occupational health, and diseases) it **must** be reported as such to the HSE in accordance with RIDDOR. Please see Annex C below for further details.	✓ Depending on severity (See Annex A)	✓	✓ Depending on severity (See Annex A)
Incident	An event which causes loss or damage to property, plant or equipment. **Note:** Where an incident is categorised as a Dangerous Occurrence it **must** be reported as such to the HSE in accordance with RIDDOR. Please see Annex C below for further details.		✓	✓ Depending on DAIB severity criteria (See Part 1)
Near miss	An event that had the potential to cause injury, ill health or death to a person(s) but no actual harm occurred. **Note:** Where a near miss is categorised as a Dangerous Occurrence it **must** be reported as such to the HSE in accordance with RIDDOR. Please see Annex C below for further details.		✓	✓ Depending on DAIB severity criteria (See Part 1)
Hazard observation	A specific situation or set of circumstances which did not actually result in a safety occurrence but where the potential for a safety occurrence to occur in the future was identified. **Note:** A hazard observed which is not already identified as part of a standard working environment or activity risk assessment, for example; DSE, Manual handling, COSHH.		✓	

Annex C - Safety occurrence category types

Safety occurrence category type (any / all could apply in addition to a safety occurrence category)		RIDDOR reportable	Defence organisation reportable	DAIB
Unsafe condition	Any conditions that may cause or contribute to an accident / incident or occupational illness / disease.		✓	
Unsafe act	Any act that deviates from a generally recognised safe way of doing a task and increases the likelihood of an accident / incident.		✓	
Dangerous Occurrence (*Developed from specific RIDDOR 2013 categories for reportable Dangerous Occurrences from Schedule 2 Parts 1 & 2 available at this link*)	Reportable Dangerous Occurrences are certain, specified near-miss events. Not all such events require reporting. There are 27 categories of dangerous occurrences that are relevant to most workplaces. Any occurrence that results in: 1. The collapse, overturning or failure of any load-bearing part of any lifting equipment, other than an accessory for lifting. 2. The failure or any closed vessel or of any associated pipework (other than a pipeline) forming part of a pressure system. 3. Any explosion or fire caused by an electrical short circuit or overload. 4. Any accident / incident which resulted or could have resulted in the release or escape of a biological agent likely to cause severe human infection or illness. 5. Any unintentional explosion or ignition of explosives (unless caused by the unintentional discharge of a weapon, where, apart from that unintentional discharge, the weapon and explosives functioned as they were designed to), except where a fail-safe device or safe system of work prevented any person being endangered as a result of the fire, explosion or ignition. 6. The malfunction of breathing apparatus: a. where the malfunction causes a significant risk of injury to the user; or b. during testing immediately prior to use, where the malfunction would have caused a significant risk to the health and safety of the user had it occurred during use.	✓	✓	✓

Safety occurrence category type (any / all could apply in addition to a safety occurrence category)		RIDDOR reportable	Defence organisation reportable	DAIB
Dangerous Occurrence (Diving)	7. Diving operations, where the failure, damaging or endangering of: a. any life support equipment, including control panels, hoses and breathing apparatus; or b. the dive platform, or any failure of the dive platform to remain on station, which causes a significant risk of personal injury to a diver. **THIS IS NOT A DEFINITIVE LIST** - For a full, detailed list, refer to the online guidance at: www.hse.gov.uk/riddor.	✓	✓	✓
Dangerous Occurrence (Occupational health)	Occupational Illness other than Medical in Confidence, issues are to be reported, for example noise induced hearing loss, work-related upper limb disorder, contact dermatitis, continued exposure to vibration and so on.	✓	✓	
Dangerous Occurrence (Diseases)	Diseases reportable to the HSE under RIDDOR include: • Carpel tunnel syndrome • Severe cramp of the hand or forearm • Occupational dermatitis • Hand-arm vibration syndrome • Occupational asthma • Tendonitis or tenosynovitis of the hand or forearm • Any occupational cancer • Any disease attributed to an occupational exposure to a biological agent • Other **Note:** Employees **must** report diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work.	✓	✓	