Ministry of Defence

JSP 815

Element 10: Accident / Incident Management and Emergency Response

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Amendment record

JSP 815 has been updated as a part of Defence Reform and will be subject to further scheduled reviews and updated as required.

This Element has been reviewed by the Directorate of Defence Safety & Support (DDSS) together with relevant subject matter experts and key Safety stakeholders. Any suggestions for amendments **should** be sent to People-DDS-GroupMailbox@mod.gov.uk.

Version No	Date published	Text Affected	Authority
1.0	Dec 22	BETA version for consultation	Dir HS&EP
1.1	7 Jun 23	Final version	DDS
1.2	10 Sep 24	Annual revision and combined element and assurance framework	DDS
1.3	1 Sep 26	Scheduled revision and Defence Reform update	Dir-DSS

Terms and definitions

The term ‘Defence Area’ refers to one of the four top-level areas of Defence: Department of State (DOS), Armed Forces (MSHQ and Military Commands), National Armaments Director (NAD) Group (and the Defence Nuclear Enterprise (DNE). Within Defence Safety Policy (JSP 815, JSP 375 and JSP 376), reference to a ‘Defence Area’ responsibility applies to the top-level Defence Area however, for the Armed Forces it also applies to their component Military Commands (Army, Air, Navy and CSOC).

General safety terms and definitions are provided in the Master Glossary of Safety Terms and Definitions which can also be accessed on GOV.UK.

Must and should

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

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

Introduction

1. This Element provides the direction that must be followed and the guidance and good practice that should be followed and will assist users to comply with the expectations for Accident / Incident Management and Emergency Response that are set out in this Element.

2. The term 'safety occurrence' is used throughout this Element, which is in the context of safety encompasses the terms unsafe condition / unsafe act / near miss or accident / incident or dangerous occurrence. However, there will still be some references to accidents / incidents where statute, Defence policy and regulations define them.

Purpose and expectations

3. This Element focuses on the frameworks that Defence Areas are to have in place to report, notify, record, and investigate incidents and plan on how to address investigation recommendations. The purpose of this Element is to assist Defence Areas to promote an environment in which there is a culture of learning, where all our people and those external to the organisation feel safe to report safety occurrences. Where lessons are identified and learnt through a process of continual improvement and where there is a proactive approach to identifying and mitigating potential safety occurrences through regular and effective creation and testing of emergency plan.

Reporting, recording and investigating

4. Effective safety management arrangements must include timely reporting (and notification to Defence Accident Investigation Branch (DAIB) if appropriate)), accurate recording and thorough proportional investigation of safety occurrences. Defence Areas must make sure that all safety occurrences within its organisation are reported on MySafety and / or alternative systems where MySafety is not appropriate, these requirements must be clearly reflected in their safety management arrangements. This includes ensuring that statutory duties such as RIDDOR reporting is correctly understood and applied within their Defence Area. These processes ensure Defence meets its legal and Defence policy obligations.

5. RIDDOR 2013 (Regulation 14(5)) and RIDDOR (NI) 1997 (Regulation 10(3)), state 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, the Memorandum of Understanding (MOU) between the Ministry of Defence (MOD) and the Health and Safet Executive (HSE) states; "MOD has undertaken to notify any work-related Death, Major Injury, Disease or Dangerous Occurrence, to HSE as if they were RIDDOR reportable."

6. Safety occurrence reporting and investigation must be carried out in accordance with Chapter 16 – (Safety occurrence reporting and investigation) of JSP 375 Volume 1. In addition to the generic requirements of Chapter 16, the Defence Safety Authority (DSA) Regulations detail each domain-specific reporting requirements.

7. Timely reporting enables Defence Areas to react quickly to unsafe conditions, control consequences and take corrective actions to prevent recurrence to as low as reasonably practicable (ALARP) levels. Accurate recording provides an auditable evidence base demonstrating the nature of the occurrence, the actions taken, and the effectiveness of corrective measures. Defence Areas must retain documented information to demonstrate these outcomes and communicate them in an accessible manner to relevant personnel and stakeholders. This strengthens governance, supports decision-making, and enables Defence to demonstrate compliance with safety legislation, Defence safety policy and regulations.

8. Investigating occurrences establishes causal factors, identifies whether similar hazards and risks exist elsewhere, and prompts a review of existing safety risk assessments to determine if additional control measures are required. Without reporting and investigation, systemic issues remain undetected and the likelihood of repeat incidents increases.

9. Investigating safety occurrences also contributes directly to Defence's continual improvement expectations. Lessons identified through investigations must be shared and used to improve safe systems of work and inform the wider Defence safety community. Defence Areas should adopt relevant learning and good practice from across Defence and external industry (where appropriate) to ensure alignment with up-to-date standards and practices.

10. Reporting and investigating occurrences is also integral to improving emergency preparedness. Occurrences often highlight weaknesses in existing emergency and business continuity arrangements. Defence Areas must maintain and regularly test their plans, reviewing and revising control measures and using lessons learnt from occurrences to strengthen resilience and readiness.

11. Together, these activities ensure Defence protects its people, equipment, capability, and reputation by identifying hazards early, preventing reoccurrence, and driving a strong learning and improvement culture.

12. When a safety occurrence arises the Defence Area 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 reoccurrence to as low as is reasonably practicable (ALARP). This should be done by investigating the safety occurrence to determine the causal factor and consider whether similar safety occurrences have / or could potentially occur.

c. Review existing assessments of safety risks.

d. Determine and implement any additional control measures needed and review their effectiveness.

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

f. Amend the Defence Area's safety management arrangements, if necessary.

13. Corrective actions should be appropriate to the effects or potential effects of the safety occurrences. The Defence Area should retain documented information as evidence of:

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

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

c. The Defence Area should communicate this information to all relevant personnel and stakeholders using accessible communication methods appropriate to the audience.

Culture of reporting

14. An organisation that listens to and learns from its people is one that is constantly improving and understands that mistakes, errors in judgement and the need to adapt are normal.

15. A positive reporting culture underpins effective organisational learning. Defence Areas should promote an environment in which personnel feel listened to and supported to report for example, unsafe acts, near misses and incidents without fear of blame. Listening and learning are key attributes of a mature safety culture, enabling organisations to understand how occurrences happen and how systems can be improved. Consistent reporting enables the identification of trends, emerging risks and learning opportunities essential for continual improvement.

16. When an organisation is listening and learning in relation to safety, the following are true:

a. Leaders support fairness, openness and learning by making personnel feel confident to speak up when things go wrong, rather than fearing blame.

b. Actions and decisions are understood before they are judged, and people are supported to learn from their actions.

c. People are asked for their advice to help with designing the systems that could help change things for the better.

d. Those responsible for managing occurrences draw on human factors (things which influence people's actions and decisions) investigations, skills and expertise to fully understand how an incident happened, the lessons that can be learned and how to adapt in the future.

17. Some Defence Areas have adopted the approach suggested in the Nimrod Review of 2009, such as the Reporting and Learning cultures, as shown in Figure 1, below. The importance of listening and learning is explained more in the safety leadership guide.

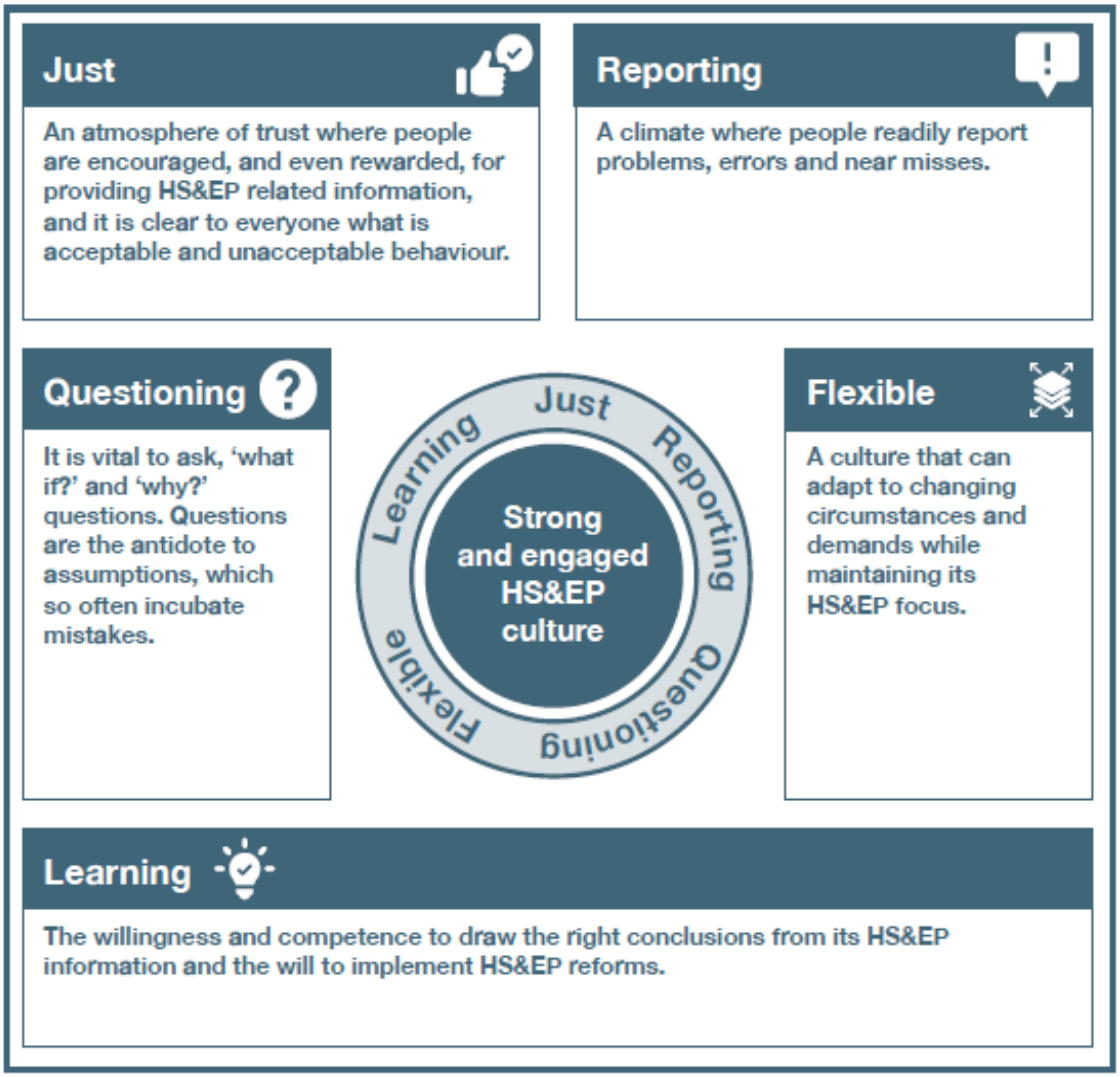

Figure 1 - Nimrod review culture diagram

Continual improvement

18. A lesson is something learnt by study or experience. The benefits from learning from experience (LfE) are to anticipate and prevent, similar or other potentially more serious outcomes. Lesson(s) learnt from safety occurrence investigations and formal inquiries should be shared with stakeholders where relevant within the Defence Area and across the wider Defence safety community where appropriate.

19. Defence Areas should identify lessons from safety occurrences to better predict and prevent future safety occurrences and adopt good practice(s) in order to develop and drive continual improvement of their own safe systems of work (SSW) and those across Defence. This demonstrates a good learning culture within the Defence Area.

20. Defence Areas may also learn lessons and adopt good practice from other Defence Areas and / or from organisations that are outside of Defence. These lessons and / or good practices should be adopted appropriately by Defence Areas to enable them to identify new methods and maintain currency with the most up to date industry safety standards and practices.

Business Continuity Management and emergency planning

Business Continuity Management (BCM)

21. In simple terms, BCM identifies what needs to be done before an incident occurs to protect people, premises, technology, information, supply chains, stakeholders, and reputation. It focuses on the development of strategies and contingency plans to manage the consequences of disruption, mitigate the impact on critical activities or outputs, and recover business back to normal levels of operation as soon as possible after an incident.

22. The Defence BCM model is based on the British Standard's BCM lifecycle and has six components. The specific scope, structure and effort expended within a BCM programme is likely to vary between Defence Areas. However, the six components of the model should be considered at each level of the Defence Area.

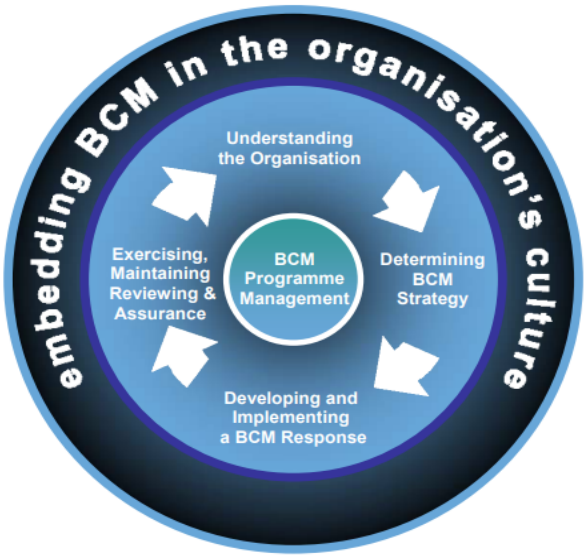

Figure 2 - Defence BCM Model diagram

a. **BCM programme management**:
The organisational approach to BCM and how it is maintained, taking into account the size and complexity of the Defence Area.

b. **Understanding the organisation**:
This identifies the Defence Area's key outputs and the critical activities and resources (including personnel) which support them. This phase involves undertaking a Business Impact Analysis and a risk assessment and identifying key stakeholders and dependencies.

c. **Determining business continuity management strategy**:
Appropriate BCM strategies are developed, using the output of phase 2, so that key Defence outputs continue their delivery during and following an incident.

d. **Developing and implementing a BCM response**:
Business continuity plans, site recovery plans and incident management plans should be developed and implemented. Plans should consider the needs of personnel who may require additional support, adjustments or accessible communications during incidents and recovery activities. These detail the steps to be taken during and after an incident to maintain or recover the delivery of Defence critical activities.

e. **Exercising, maintaining, reviewing and assurance**:
Plans must be updated at least annually to reflect organisational changes, and tested regularly to assess if they are fit for purpose. Properly planned and conducted exercises will reveal weaknesses in arrangements which can then be addressed. Best practice corporate governance requirements expect that formal assurance reviews occur each year, generating any issues to then be addressed, resulting in improvements to the BCM arrangements.

f. **Embedding BCM culture**:
It is crucial that there is widespread and sufficient understanding of business continuity aspects. Defence organisations should raise and maintain awareness of BCM so that personnel recognise why it is important and understand their role.

23. For further guidance on business continuity management and implementing the BCM model across Defence organisations, refer to JSP 503 – Defence Resilience.

Emergency and disaster planning

24. The Management of Health and Safety at Work Regulations 1999 requires Defence to risk assess its activities and to establish appropriate (emergency) procedures that should be accessible, clearly understood and capable of supporting the needs of all personnel, including those requiring reasonable adjustments, to be followed in the event of serious and imminent danger to Defence personnel and visitors, and the necessary contact required with external services (Ambulance, Fire, and so on).

25. When the emergency services are required then the principles for joint working should be used during all phases of an incident and the Joint Emergency Services Interoperability Principles (JESIP) set the standards that Defence Areas should follow. The JESIP is a UK-based organisational framework that has been designed to enhance collaboration and coordination among emergency services (fire, ambulance, police, and disaster recovery).

26. The JESIP website provides some useful guidance on interaction with the emergency services, completing a M/ETHANE report, using the 'What 3 Words app and so on. For further guidance on emergency and disaster planning, refer to Chapter 1 - (Emergency and Disaster Planning) of JSP 375 Volume 1.

Element assurance framework

27. The focus of this Element requires that the Defence Area has frameworks in place to report, notify, record, investigate accidents, incidents and near misses and plan on how to address investigation recommendations. The Defence Area should promote an environment in which there is a culture of learning, where all our people and those external to the organisation feel safe to report accidents, incidents and near misses. Lessons are identified and learnt through a process of continual improvement. There needs to be a proactive approach to identifying and mitigating potential incidents through regular and effective creation and testing of emergency plans.

28. The expectations and performance statements for this Element are set out in the following pages.

Element 10: Accident / Incident Management and Emergency Response

The Expectations in this Element are:

E10.1 The Defence Area promotes a culture of open reporting of accidents, incidents and near misses that occur.

E10.2 The Defence Area has a system in place which is consistent with the Defence policy to report and record accidents, incidents and near misses from initial submission to close-out, allowing for effective investigation and resolution.

E10.3 The Defence Area has resources in place to investigate accidents, incidents and near misses.

E10.4 The Defence Area has systems in place to implement the corrective actions and learning from accidents, incidents and near misses to manage and drive continual improvement.

E10.5 Emergency and business continuity plans are in place, tested regularly and consider safety matters.

Documents often associated with this Element:

- 1LOD assurance reports
- Actions to strengthen Management Information based on this learning
- Analysis and lesson learned
- Business continuity plans
- Strategic plan
- Continual Improvement (CI) Logs
- Defence Area business plans,
- Defence Area Operating Model
- Defence Area safety management arrangements
- Effective interface with TUs and statutory regulators including reporting (e.g., Reporting of Injuries, Diseases and Dangerous Occurrences Regulation (RIDDOR)) 2013
- Information collection process for safety performance analysis and lessons learned
- Major Accident Control Regulations (MACR) plan
- Samples of emergency response exercise planning
- Whistle blower / anonymous escalation route / reporting

Expectation 10.1 The Defence Area promotes a culture of open reporting of accidents, incidents and near misses that occur.

Unsatisfactory	Limited	Moderate	Substantial
• There is little or no evidence to demonstrate that the Defence Area promote a culture that allows for people to openly report accidents, incidents, and near misses that occur.	• There is some, but not enough evidence that the Defence Area promotes a culture that allows for people to openly report accidents, incidents, and near misses that occur. There is not enough evidence of reports being reviewed or acted upon.	• There is some but could be improved that the Defence Area promotes a culture that allows for people to report accidents, incidents, and near misses that occur. Reports are reviewed and acted upon by the organisation and its leadership in a timely manner. • Investigations into root cause analysis are conducted, but improvements identified are not implemented in a timely manner.	• There is robust evidence that the Defence Area promotes a culture that allows for people to report accidents, incidents, and near misses that occur. The organisation positively re-enforces this culture. • Reports are reviewed and acted upon by the organisation and its leadership in a timely manner. • Leadership use reports to develop methods to prevent reoccurrence and drive continual improvement. • The focus of investigations is on the root cause and systematic improvements, with actions being taken in response, in a timely manner.

Expectation 10.2 The Defence Area has a system in place which is consistent with the Defence safety policy to report and record accidents, incidents and near misses from initial submission to close-out, allowing for effective investigation and resolution.

Unsatisfactory	Limited	Moderate	Substantial
• There is little or no evidence to demonstrate that the Defence Area has a system in place to record and report accidents, incidents and near misses for all stakeholders. • Within the Defence Area there is no, or little understanding, of the importance of leadership review of accidents, incidents and near misses so that recurrence is prevented.	• The Defence Area has a system in place to record accidents, incidents and near misses. There is some, but not enough evidence that this is consistent with Defence policy and includes all stakeholders. • The Defence Area conducts investigations into accidents, incidents and near misses. There is some, but not enough evidence that this is inconsistent with Defence policy.	• The Defence Area has a system in place which is consistent with Defence policy to record accidents, incidents and near misses. There is some but could be improved evidence that it includes all stakeholders. • The Defence Area conducts investigations into accidents, incidents and near misses, and manages close out in line with Defence policy in a timely manner.	• The Defence Area has a system in place which is consistent with Defence policy to record accidents, incidents and near misses and includes all stakeholders. • There is robust evidence that the Defence Area uses root cause analysis or similar methods to avoid future event recurrence and drive continual improvement in a timely manner.

Expectation 10.3 The Defence Area has resources in place to investigate accidents, incidents and near misses.

Unsatisfactory	Limited	Moderate	Substantial
• There is little or no evidence to demonstrate that the Defence Area has resources in place to investigate accidents, incidents and near misses.	• There is some, but not enough evidence that the Defence Area have sufficient resources to fulfil its investigatory responsibilities which results in investigations meeting Defence policy expectations.	• There is some but could be improved evidence that the Defence Area has sufficient resources to fulfil its investigatory responsibilities. • The Defence Area performs investigations which produce recommendations that can be applied both within the organisation and across Defence.	• There is robust evidence that the Defence Area proactively assesses its investigatory resources to ensure both current and future requirements can be met.

Expectation 10.4 The Defence Area has systems in place to implement the corrective actions and learning from accidents, incidents and near misses to manage and drive continual improvement.

Unsatisfactory	Limited	Moderate	Substantial
• There is little or no evidence to demonstrate that the Defence Area has systems in place to implement corrective actions and learning from accidents, incidents and near misses.	• There is some, but not enough evidence that the Defence Area has systems in place to implement corrective actions and learning from accidents, incidents and near misses and consistently implement the actions and learning.	• There is some but could be improved evidence that the Defence Area has systems in place to implement corrective actions and learning from accidents, incidents and near misses. These are used to manage and drive continual improvement. • The Defence Area shares corrective actions and learning internally and there is some evidence that it shares these across wider Defence but this could be improved.	• There is robust evidence that the Defence Area uses its learning to better predict future accidents, incidents and near misses and takes steps to mitigate them ahead of realisation. • The Defence Area shares corrective actions and learning both internally and across wider Defence. • The Defence Area adopts good practice from outside organisational boundary to drive continual improvement.

Expectation 10.5 Emergency and business continuity plans are in place, tested regularly and consider safety matters.

Unsatisfactory	Limited	Moderate	Substantial
• The Defence Area does not have an emergency and business continuity plan in place.	• The Defence Area has an emergency and business continuity plan in place that considers events that could arise, but controls are not tested regularly, not all responsibilities are assigned or there are gaps in competency.	• The Defence Area has an emergency and business continuity plan in place that considers events that could arise, and controls are tested regularly. • Relevant controls are reviewed and revised on a regular basis.	• The Defence Area proactively looks forward when planning emergency responses to identify potential scenarios and uses good practice to deliver continual improvement in their planning. • Emergency and business continuity plans include defined equipment and infrastructure requirements and are tested regularly. • The Defence Area liaises with relevant external stakeholders (such as their Fire & Rescue) to better prepare its emergency arrangements.