

ELEMENT – 4 - HEALTH AND SAFETY MANAGEMENT SYSTEM – CHECKING

- 4.1 Outline the principles, purpose and role of active and reactive monitoring.
- 4.2 Explain the purpose of, and procedures for, investigating incidents (accidents, cases of work-related ill-health and other occurrences).
- 4.3 Describe the legal and organisational requirements for recording and reporting incidents.

4.1 INTRODUCTION

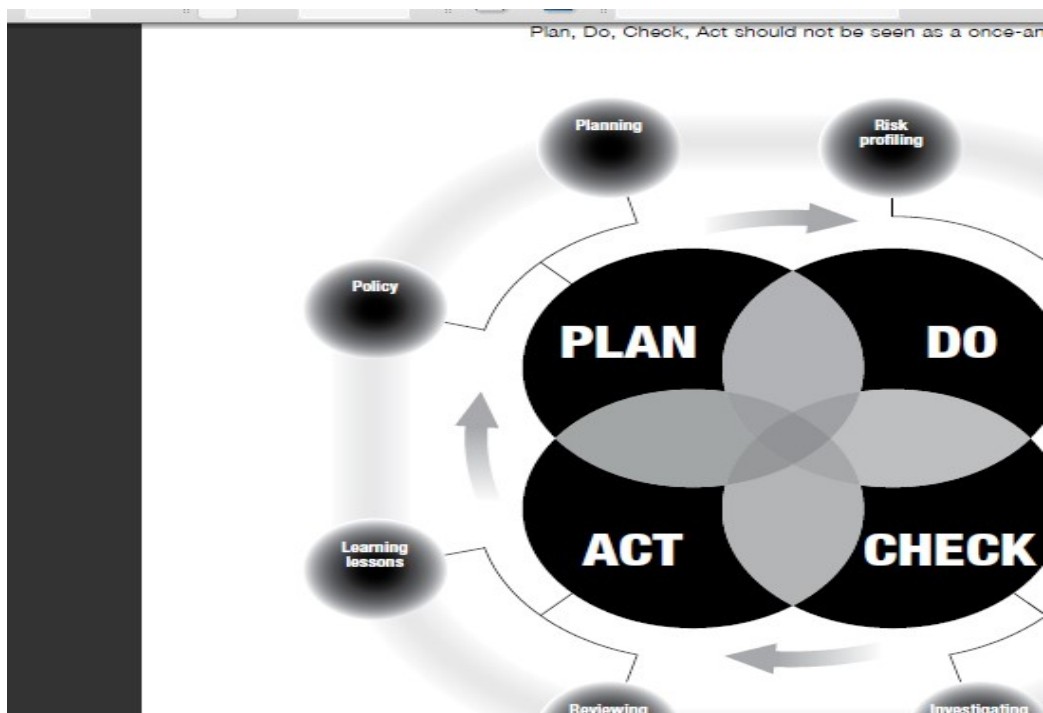
Unless an organisation attempts to measure its safety performance, it will not be able to assess whether the systems and procedures it has in place are working or need to be amended, altered or updated in any way. There are a variety of different activities which can be undertaken to measure health and safety standards. These can be sub-divided into active (proactive) systems which monitor whether standards and objectives are being met, and reactive systems which monitor accidents, ill-health and incidents.

Before looking at different measures to check the effectiveness of a safety management system, it is worth considering how any data will be collected. There are three main ways of collecting data for monitoring purposes:

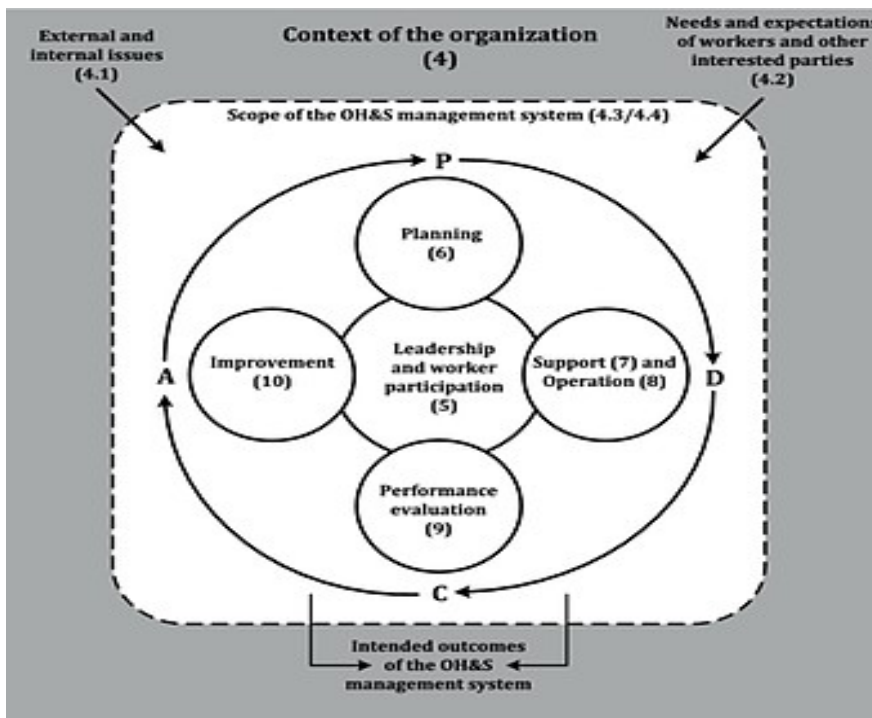
- Observations (including workplace inspections)
- Interviewing and talking to employees
- Reviewing documentation and records

Some techniques only use one data source, others such as audits may use all three methods.

Both reactive and active measuring are required to get a realistic picture of health and safety compliance. One safety management system is highlighted in the document HSG65, with the last two elements (CHECK & ACT) focusing on measuring, reviewing and auditing.



ISO 45001 requires monitoring in the sections on “Performance evaluation” and “Improvement” and the senior management of the organisation should complete a “management review” where they review the results of both internal and external auditing.



Objectives and Targets

Objectives focus the organisation on its goals and set the company's direction and approach to dealing with H&S issues. Targets are the specific detail on what they want to achieve, these will need to be "SMART": Specific, Measureable, Achievable, Realistic and Timely.

For example the objective could be to improve health and safety standards by reducing injury accidents.

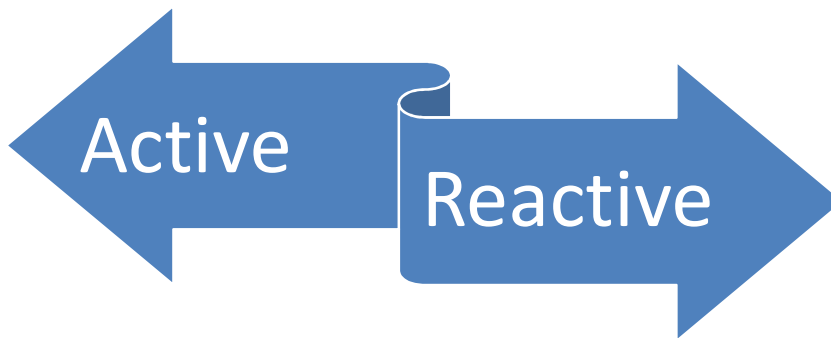
The target could then be "To reduce the number of accidents by the end of the financial year by 5% - based on the base line of 2018."

What factors might need to be considered when setting H&S objectives and targets?

- Responsibilities for action need to be set
- Who will set the objectives and be involved in their development
- Consultation with employees may be completed to ensure they own the targets and objectives set
- Company activities and risk level
- Customer or client need
- The issues highlighted in audits as being managed less effectively
- Resources needed to meet the objectives
- Relevant and realistic timescales
- Who will review the objectives and how often

- Accident history - the company may wish to set an objective on the topic which causes the majority of accidents
- The results of benchmarking or experiences of other organizations
- Consider short and long term issues

Measures



There are two main strategies for monitoring reactive focusing on negative events and outputs of the system. Proactive monitoring focuses on processes and inputs, how an effective safety management system should be working. Whatever health and safety management system is used, active and reactive monitoring should be undertaken.

4.2 ACTIVE MONITORING

(Pro) - active monitoring is part of “Measuring” it is a way of checking that control measures and safety procedures are actually working, this involves measuring positive issues rather than reactive monitoring which focuses on accidents and incidents. It measures inputs and processes rather than negative outputs.

Typical proactive measures:

- Number of risk assessments completed
- Number of actions taken as a result of risk assessments
- Number of risk assessments reviewed
- Number of staff attending H&S inductions
- Number of inspections completed
- Health surveillance results
- Sampling results

4.2.1 INSPECTIONS

The completion of workplace inspections is a way of monitoring whether local health and safety standards are being adhered to. The inspection can focus either on just one aspect

of safety, such as fire, workplace or work equipment hazards, those hazards associated with the actual activities being undertaken or a mixture of all these issues.

What is a workplace inspection?

The identification of hazards and recommendations to reduce the risk of injury.

The aim of the inspection should be to identify any hazards and to highlight remedial action required to prevent the hazard from causing an accident or risk.

Why might workplace inspections be undertaken?

- To measure/improve H&S performance
- To spot behaviour trends
- To spot unsafe conditions/hazards
- To collect information on trends (is the number of hazards increasing or decreasing?)
- To display a commitment to health and safety
- To check the results of H&S policies and procedures
- To check legal standards

A variety of people may be involved in the inspection process including:-

- H&S Adviser
- Supervisor / Line Manager
- Union Safety Representative
- EHO / HSE Inspector
- Insurance Company

The use of a safety checklist is an effective way of completing an inspection. Here a list of standards which should be met are written, either as standards “ fire exits clear and unobstructed” or as a question “are all fire exits clear and unobstructed?”. These checklists support the inspection and are ideal for those who have little H&S knowledge, as just by answering the question they are able to assess whether their area is meeting the required standards of not.

Example Checklist

Item	Check for	Remedial Action
Floors	Are surfaces even? Are surfaces slippery? Is there any spillage? Is the floor clean? Are there any damaged tiles or carpet? Are bins and receptacles available to keep items contained?	
Stairs	Are they worn, slippery or chipped? Are handrails secure? Is lighting adequate? Are stairs free from litter and obstructions?	
Exits and Doors	Are door mechanisms stiff or defective? Do doors have sight panels which are obstructed? Do any doors have sharp edges? Are passages or doorways obstructed?	

List the advantages and disadvantages of relying on a checklist to complete workplace inspections.

Advantages	Disadvantages
Give the inspection a clear and repeatable structure	May end up being a tick box exercise

4.2.2 TEMPLATE NEBOSH INSPECTION FORM

<i>Observations</i>	<i>Actions</i>	<i>Priority/timescale</i>
Location Hazard Adverse effect	Consider short and long term actions aimed to correct the issue and assist in preventing it from re-occurring.	Immediate (I) Or timescale
Kitchen Variety of unmarked chemicals stored in food cupboard. Causing food contamination & mis-use	Separate out Provide separate store cupboard Provide info to staff on safe storage	Immediate 1 week 1 month

4.2.3 WHAT FACTORS MIGHT AFFECT THE FREQUENCY OF WORKPLACE INSPECTIONS UNDERTAKEN?

- The complexity of the work being undertaken
- The hazards and risks involved – the higher the risks the more frequent inspections may be needed
- Legal requirements – there are a number of specific legal requirements which require statutory examinations and inspections to be completed. This includes the requirement within COSHH to thoroughly examine equipment such as local exhaust ventilation at least every 14 months. Other requirements are in place for inspection work equipment such as power presses and lifting equipment.
- Accident history – if there have been specific accidents in one particular area or involving a certain piece of equipment this may need to be inspected more frequently.
- The type of people at risk – where there are vulnerable people in the workplace it may be even more important to ensure that regular workplace inspections are undertaken.
- The advice of the enforcer or as a result of enforcement action
- Insurance requirements
- Customer or client specification.
- Requirements as stated in the company health and safety policy or safety management system.

4.2.4 INSPECTION REPORT WRITING GUIDANCE

Many workplace inspections fail to achieve their aim due to the way that they are presented to managers, on many occasions they fail to gain the commitment of those in authority to actually support the improvements required. Once an inspection is completed

the key findings may need to be summarised in the form of a management report rather than just presenting the inspection form to the relevant manager.

The aim of this report is to highlight the key finding from the inspection and justify why action needs to be taken. A well presented management report will outline:-

- The work environment where the inspection was undertaken
- The date and time of the inspection
- Those involved in the inspection
- A few of the positive issues identified
- A summary of the main findings in priority order – the key issues, not all the trivial issues identified. The hazards and adverse effects should be detailed
- Any issues needing immediate action
- The recommendations needed to eliminate or reduce the risks with their costs and timescales
- Any breaches of legislation
- Justification for action : consider legal, moral and financial and the consequences of not taking action
- Ensure all hazards are clearly described, do not just state electrical hazard, if it was a damaged cable detail where it was, what was it connected to and what harm could it do in this situation?
- Space out and use headings to bring out the key issues

4.2.5 OTHER TYPES OF INSPECTION

Survey

Employees may be asked or targeted with a questionnaire to rate their knowledge or attitude towards health and safety. This allows the measurement of the health and safety culture of the organisation.

Safety Tours

This involves walking around the workplace on a set route and counting the number of hazards present on a regular basis. This allows you to acquire a picture on how that area/local manager is dealing with the H&S issues. If the number of hazards is constantly rising then issues, once identified, are obviously not being dealt with.

No of hazards	Jan	Feb	March
Chemicals	1	1	0
Electrical	2	3	6
Fire	2	1	1
Housekeeping	3	5	4
Guarding	0	0	0

Safety Samples

These are identical to safety tours but only identify one specific type of hazard e.g. electrical/chemical etc.

Example format - Electrical issues which could be identified during a safety sample:-

Hazard	Jan	Feb	March	April
Trailing cables	2	2	2	
Broken sockets	0	2	2	
Broken switches	1	1	3	
Over-loaded sockets	0	0	1	
Damaged equipment	3	2	0	
Damaged cables	1	1	1	
Multiple extension leads	5	3	3	
Broken light fittings				

Behavioural observation – an inspection is completed with the focus on unsafe actions rather than hazards associated with plant and premises.

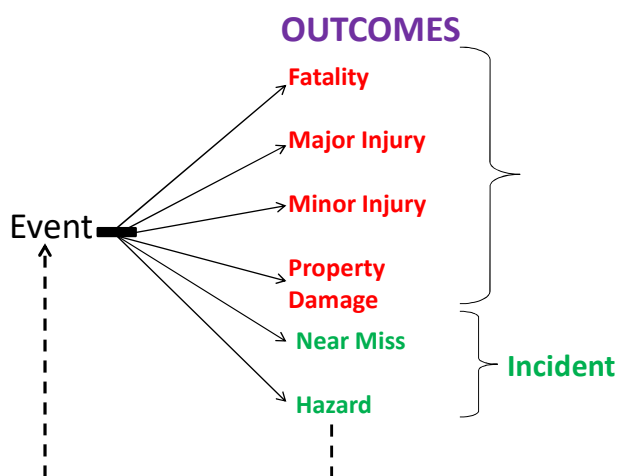
4.3 ACCIDENT CAUSATION

People not things cause accidents. All have a complicated sequence of causes and contributory factors.

The term accident is defined as “**a random, unplanned, unexpected event which may result in loss, damage or injury**”.

This definition includes accidents which result in an injury as well as those which do not. However there is no legal definition of “accident” which is why some employers may prefer to use the term accident for those events which lead to injury and near miss or incident for those which do not involve any personal injury.

Events & Outcomes



4.3.1. RELATIONSHIP BETWEEN NEAR MISSES AND INJURY ACCIDENTS

The relationship between the number of near misses and accidents which have resulted in serious injuries or deaths has been widely researched. Although the individual figures from each study have been different the principle has remained the same e.g. the number of near misses by far exceeds the number of injury accidents. Many organisations only investigate the one or two serious incidents and may not even know what types of near misses are occurring. They could be hidden below the “waterline”.



(HSE - The Cost of Accidents At Work HSG 96 published in 1997)

There are normally far more near misses than serious accidents resulting in injury. If these are not reported they have the potential to develop into accidents involving injuries of worse. Employees should be encouraged to report near misses to ensure that action can be taken to prevent the event occurring again and possibly causing an injury.

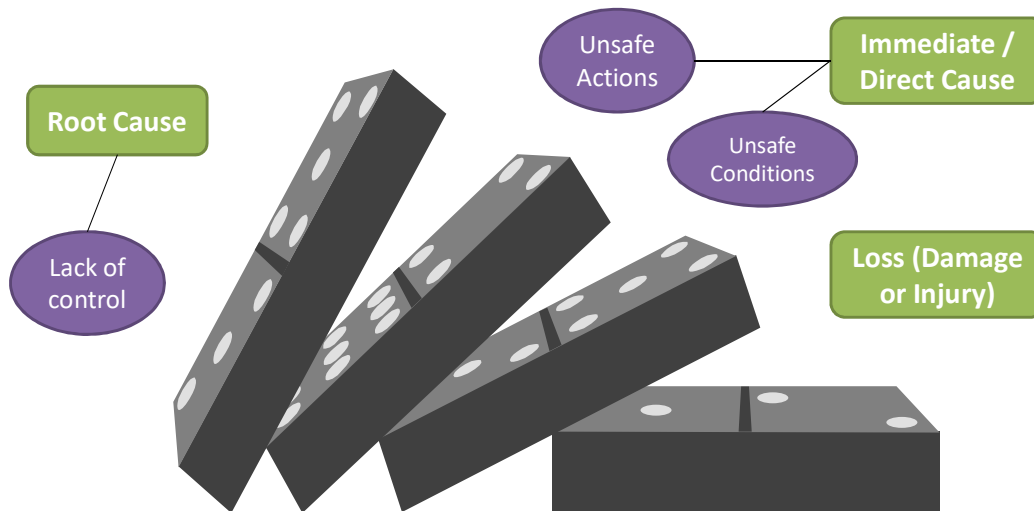
4.3.2 ACCIDENT CAUSATION

Most causes are either:-

- by unsafe acts (*85%), or,
- by unsafe conditions (*10%).

Unsafe conditions are caused by people, for example, a trolley left in front of a fire exit is an unsafe condition, but it must be the result of the unsafe action of a person, in this case the individual who left it there.

(* HSE Research suggested that only 5% of accidents were true accidents i.e. those not foreseeable or preventable.)



Employees need to be trained and informed of the need to report accidents. Those that have resulted in any type of injury must legally be reported under the Social Security Regs. Staff must know what type of events need to be reported, where the record forms are and who needs to be passed details of any work-related sickness absence. The reporting procedure may involve a hand written form or the logging of an accident on a computer database. Timescales for reporting must be known plus what occurs if the person is unable to report the accident themselves. There may be a need for immediate reporting under RIDDOR as well.

i) The Accident Causation Sequence

Accidents do not just happen, there is a sequence of events which occurs. This is often compared to a line of dominoes - once the first one falls, the second will follow as a knock on effect.

The principle behind the domino theory states that if one of the dominoes to the left of the “Loss” domino falls, it will knock over those to the right, with a loss occurring at some stage if not with every occurrence.

For example:

- A lack of supervision (management control) results in a situation where oil can be spilt and is not cleared up.
- An unsafe act then occurs e.g. spilling oil and not clearing it up.
- An unsafe condition results e.g. a pool of oil on the floor.
- A loss occurs e.g. someone slips on the oil, falls and breaks an arm.

When we investigate an incident, we should identify unsafe conditions, unsafe acts, any lack of management controls and establish causes for these, as well as causes for the loss, if there has been one.

For example;

- Possible causes of a person slipping on a patch of oil might be that they were not looking where they were going or were not wearing appropriate footwear.
- Possible causes of not clearing up spilt oil might be lack of time, or not seeing cleaning up as part of the job.
- Possible causes of spilling oil might be working in a hurry, inappropriate implements being used or a poor method of work.
- Possible causes of poor management and a lack of control might be excessive pressure for production (resulting in hurrying), lack of funding for proper improvements or insufficient attention to designing appropriate systems of work.

The further to the left you go with the dominoes, the greater the implications of the causes identified. For example, lack of appropriate systems of work may apply to a large number of operations, not just to those which can result in oil spillages. It follows that if we can identify and remedy failures in management controls, there is the potential to eliminate large numbers of losses. Thus the usefulness of the investigation can extend beyond simply preventing a single accident happening again.

Note that you do not have to wait for a loss to occur before conducting an investigation. You could investigate, for example, why a pool of oil has been left on the floor even if this has not resulted in an injury.

ii) The Dominoes

1. Lack of Control (Root causes) – This is about the lack of control an organisation exerts on its health and safety practice. Failure to maintain compliance with adequate standards e.g. Leadership, Planned Inspections, Accident Investigations, Emergency Procedures, Employee Training, PPE, Communications. If these are not controlled or managed by the organisation, accidents will result.

2. Unsafe Acts – running, misusing equipment, not disposing of waste correctly, removing guards etc.

3. Unsafe Conditions – unsuitable equipment, wet floors, unguarded scaffolding etc.

Unsafe conditions and unsafe actions are normally the immediate or direct cause of an accident or injury but just dealing with them will not prevent all future accidents. The root causes need to be dealt with as well.

4. Loss. This could be an incident, near miss or an accident which results in injury.

4.4 ACCIDENT REPORTING AND INVESTIGATION

Why report accidents?

- Legal requirement
- Social Security (Claims & Payments) 1979 - BS510
- RIDDOR (Reporting of injuries, diseases and dangerous occurrences regulations)
- Take action to prevent other accidents
- Make the workplace safer
- Demonstrate concern to employees

Accident Investigation

This is a:

"systematic observation, analysis and evaluation of events that have occurred which have caused damage to people, damage to property or had the potential to do so"

The investigation should highlight the deficiencies in the interaction between:

- Environment (e.g. floor surface, lighting, temperature)
- Management systems (SSOW, supervision & permits)
- Equipment being used (e.g. suitable, adequately guarded?)
- Personal factors (e.g. is the individual trained, competent?)
- Job or Task (e.g. was it being performed in the correct way?)

Why investigate accidents?

- Prevention - Develop control measures and take action to prevent re-occurrence
- Identify causes (immediate & root)
- Identify additional risks
- Reduce the probability of illness and injury
- Creation of a safe working environment
- Moral duty to employees
- Legal requirement - RIDDOR only
- Gather information for insurance/civil claims
- Investigate trends

Immediate action after an accident

- Make sure the area is safe to enter
- First aid/emergency services
- Secure area
- Isolate damaged equipment
- Report Incident - internally and externally (RIDDOR)
- Communicate –senior mgr /health and safety representatives
- Inform next of kin
- Gather investigation team

Accident Investigation Steps

- Prompt action must be taken
- Take control of scene and ensure the area is safe to enter
- Ensure the well-being of injured person
- Secure the scene – keep others away
- Gather information
- Analyse information
- Draw conclusions
- Make recommendations
- Compile report
- Take appropriate follow-up action

Gathering Information

- Be positive - ensure there is no blame culture
- Be objective - never assume
- Time and date
- Exact Location of accident
- Details of Injured person: Name, age, job title
- Injury details
- Was first aid given?
- Photographs / draw sketches / take measurements
- Machinery or Equipment being used
- Activity being performed
- Any PPE being used
- Record in accident book or on accident form.

Taking Witness Statements

- Put witness at ease
- Explain the purpose of the interview – to establish the facts not apportion blame
- Interview separately
- The aim is to obtain the facts, what they saw or what they didn't see, not their opinions!
- Quiet location – in private
- Make sure there are no interruptions
- Consider appropriate interview location
- Ask direct questions – “You saw that didn't you..”
- Ask one question at a time – no multiple questioning.
- Check your understanding of the points provided by the witness
- Endeavour to have facts corroborated
- Make notes of key points
- Where possible ask the witness to sign and date statements given

Outcomes from the Investigation

- New safe system of work
- Identification of training needs
- Alterations to the workplace (e.g. repair to floor, improvement in lighting)
- Replace equipment or fit additional guarding
- Monitor the situation
- Improve safety communication
- Remind supervisors of their responsibilities and the need to supervise.

- Review risk assessments

4.5 HSE ACCIDENT GUIDANCE HSG245

This is a work book designed for managers, supervisors and safety representatives outline the key stages in the investigation and prevention of accidents. It includes:

- Gather information
 - Who/what/when/where
 - witnesses
- Analyse info
 - Immediate & root causes
- Risk control measures
 - Long & short term action
 - Weigh up options
 - Trends & costs
- Take action
 - SMART / Communicate
 - Check action taken

4.6 THE REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS 2013 (RIDDOR)

These regulations require employers to report certain accidents and injuries to the Incident Contact Centre (ICC). The ICC must be contacted by telephone if there is a workplace fatality or major injury, but all other incidents must be reported by the online reporting system via www.hse.gov.uk/riddor. Every company must appoint a “responsible person” who will report any reportable injuries, a deputy will be appointed when they are unavailable. When deciding if the accident that led to the death or injury is work-related, the key issues to consider are whether the accident was related to:

- the way in which the work was carried out;
- any machinery, plant, substances or equipment used for work; and
- the condition of the site or premises where the accident happened.

If any of the above factors were related to the cause of the accident, then it is likely that a reportable injury will need to be reported to the enforcing authority. If none of the above factors are satisfied, it is likely that you will not be required to report.

RIDDOR Requirements

The main requirements of reporting include:

1. Fatalities
2. Specified Injuries
3. Workplace accidents which involve over seven days off work (or away from normal activities)
4. Dangerous Occurrences (certain specified high-risk, near misses)
5. Diagnosed Industrial Diseases
6. Accident Related Deaths – within a year of an accident

Fatalities -

All deaths to workers and non-workers, with the exception of suicides, must be reported if they arise from a work-related accident, including an act of physical violence to a worker.

- The nominated person must report this **immediately by the quickest practicable means** (telephone, or online) to the Incident Contact Centre 0845 300 9923. www.hse.gov.uk/riddor.

Specified Injuries

- There are a small number of named serious injuries which if they involve an employee or worker on your site are reportable to the Incident Contact Centre.
- These must be reported immediately by the quickest practicable means (telephone, or online) to the Incident Contact Centre 0845 300 9923. www.hse.gov.uk/riddor.

Example specified injuries

- a fracture, other than to fingers, thumbs and toes;
- amputation of an arm, hand, finger, thumb, leg, foot or toe;
- permanent loss of sight or reduction of sight;
- crush injuries leading to internal organ damage;
- serious burns (covering more than 10% of the body, or damaging the eyes, respiratory system or other vital organs);
- scalpings (separation of skin from the head) which require hospital treatment
- unconsciousness caused by head injury or asphyxia;

- any other injury arising from working in an enclosed space, which leads to hypothermia, heat-induced illness or requires resuscitation or admittance to hospital for more than 24 hours.

Workplace accidents which involve over seven days off work

These involve any accident involving a member of staff or a contractor which results in absence from work or inability to perform normal duties for seven days or more. If an individual continues to work following the accident but is subsequently absent for seven days or more due to the accident, it is still classified as an over seven day injury. The seven days excludes the day of the accident, so if an accident occurs on a Wednesday, it would become reportable if the injured party was not fit for work on the Thursday of the following week.

If a person is incapacitated for work for more than seven days, or not able to carry out their full normal duties for over seven days, this must be reported via the F2508 form online via www.hse.gov.uk/riddor within 15 days of the accident occurring.

Dangerous Occurrences

Dangerous occurrences are high risk near misses. Not all such events require reporting to the HSE but they must be reported if they appear on the RIDDOR dangerous occurrences list. Reporting is via the online reporting system and must be completed as soon as practicable.

There are 27 categories of dangerous occurrences that are relevant to most workplaces. For example:

- the collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
- plant or equipment coming into contact with overhead power lines;
- the accidental release of any substance which could cause injury to any person

Diagnosed Industrial Diseases

Certain industrial related diseases must be reported but only if they are associated or linked to the work that the employee completes. After notification via a doctor's medical certificate, the company has to report these issues forthwith (ASAP) via the online form F2508A. This online form will normally be completed by the responsible person via www.hse.gov.uk/riddor.

Example industrial reportable diseases

- carpal 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

If an employee dies within one year as a result of an accident which has been reported under RIDDOR, the employer must notify the enforcing authority via the online system as the death comes to his knowledge.

Incident Contact Centre Contact Details

The Manager, Incident Contact Centre, Caerphilly Business Park, Caerphilly, CF83 3GG

www.hse.gov.uk/riddor

Major injuries/ fatalities only 0845 300 9923 8.30 am to 5 pm only

Emergency on call out-of- hours inspector for major accidents or disruption only 0151 922 9235

Reporting by the quickest practicable means can be via telephone, for fatalities or major injuries, or online for all other reportable incidents.

Exemptions to RIDDOR reporting requirements

In general, reports are not required (regulation 14) for deaths and injuries that result from:

- medical or dental treatment, or an examination carried out by, or under the supervision of, a doctor or registered dentist;
- the duties carried out by a member of the armed forces while on duty; or
- road traffic accidents, unless the accident involved:
- the loading or unloading of a vehicle; work alongside the road, e.g. construction or maintenance work; the escape of a substance being conveyed by the vehicle; or a train.

Record keeping

- Records of any reportable injuries, diseases or dangerous occurrences will be kept, in a safe and secure place, for three years. The records must include:
 - The date and method by which the incident was reported
 - The date, time and place of the incident
 - The personal details of those who were involved
 - A short description of the nature of the event or disease.
 - A note of any injuries not reportable but where over three days absence has been recorded must also be maintained by the employer.

4.7 REACTIVE MONITORING

Reactive monitoring is another form of “Measuring” it is a way of helping to reduce the reoccurrence of accidents and making the workplace safer for both employees and others. It deals with the reporting, recording and analysis of loss data including injuries and ill-health.

It serves two main functions.

1. Using trend analysis, it monitors whether performance with respect to losses such as accidents is improving or deteriorating.
2. Using investigations of individual incidents to identify what has gone wrong in the past.

Reactive safety monitoring relies on taking action after incidents have been reported to prevent the re-occurrence of similar events.

It relies on a range of management activities including:-

- Effective accident and incident reporting
- Ensuring employees know what to report and who to report accidents to
- Analysing accident data for trends and patterns.
- Completing accident investigations
- Taking remedial action after accidents / incidents

Accident Trends and Ill-health Data

A variety of safety related statistics can be used to assist in the monitoring and measuring of safety standards. Some measures may be used in-house such as the number of accidents causing injury, near misses, incidents or RIDDOR accidents. These may be broken down further to give details of the type of accidents, their cause, the type of injury involved, the time of day or the grade / job of the person involved. This can be part of the organisation’s monitoring arrangements for safety.

A number of external benchmarks and standards are used, the most common is the incident rate per 100,000 employees, which is published annually by the HSE.

Key Statistical Terms

Frequency rate

$$\frac{\text{Total number of accidents}}{\text{Total number of person hours worked}} \times 100,000$$

= Total number of accidents for every 100,000 hours worked.

Incidence Rate

$$\frac{\text{Total number of accidents}}{\text{Number of people employed}} \times 1,000$$

= Total number of accidents per 1,000 employees

This is a relatively simple calculation but does not take into account the varying proportions of part time staff or the severity of accidents.

Severity rate

$$\frac{\text{Total number of days lost}}{\text{Total number of working hours worked}} \times 100,000$$

= average number of days lost per 100,000 hours

This can help show how severe accidents are.

Internal Reactive Measures

- Number of accidents
- Number of near misses
- Accident frequency rate
- Accident incidence rate
- Days lost due to accidents and occupational ill-health
- Number of complaints (internal or external)
- Number of civil claims
- Number of enforcement notices
- Amount of compensation paid out
- Cost of accidents

Why collect near miss data?

- identify root causes
- identify trends
- identify weaknesses in RA
- to prevent injuries/loss
- improve employee morale
- company reputation
- Legal requirement RIDDOR (Dangerous Occurrences)

National Sources of Accident & Ill-health Data

Annually the HSE in conjunction with the Office for National Statistics (ONS), prepare a comprehensive publication which provides a wealth of accident, ill-health and RIDDOR related data. This data is presented in a variety of ways including tables, pie charts and histograms. It shows trends over time as well as breakdowns of injury types, severity and the types of industries they occur in. Many of the categories are broken down into fatal injuries, non fatal major injuries and three day plus incidents.