Review of the Reporting of Accidents and Incidents Involving Learners

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Executive Summary

In 2004 the LSC awarded a contract to the Institute for Employment Studies to conduct a review of the current procedures and processes for reporting accidents and incidents involving learners. The aim was to identify factors that may contribute to under-reporting.

While learners are defined as all those on learning programmes funded by the LSC, the main focus of the project was to be mainly those on work-based learning, primarily apprentices and those on entry to employment (E2E) programmes. The programme of work agreed between the Institute and the LSC was to consist of six parts:

- A literature review
- Interviews with LSC regional health and safety managers
- A review of the data on accident reports
- Focus groups with learners
- A survey of learning providers
- A survey of employers.

The literature review is presented in chapter 2. The review looked at previous research into the reasons for under-reporting of accidents and incidents. There is only limited research literature on this topic and largely it is focused on employees rather than learners or trainees.

The literature reveals that there is evidence that accidents are under-reported not just in the UK but in other countries too. There are large differences in the reporting rates of different sectors. It is generally the less serious injury that tends to go unreported, but there is evidence that major injuries may fail to be reported too.

A range of factors contribute to failure to report. Organisational culture and individual attitudes are two major factors. Other reasons for non-reporting include administration and communication problems, including differences in the ways managers in the same organisation interpret requirements, lack of communication between different departments, an absence of follow-up procedures or systems and inadequate recording.

Perversely, there is evidence that incentives to reduce accidents and injuries may serve to reduce the numbers of incidents reported, rather than reduce the number of incidents. Incentives may take the form of reduced insurance premiums and the likelihood that those organisations with a lower number of recorded incidents receiving fewer inspections from enforcement bodies.

Chapter 3 reports the outcomes of interviews with LSC regional health and safety managers. The interviews with regional managers covered LSC policy and practice and also provider and employer practice. Many of the accounts given by regional managers supported the findings of the literature review regarding the influence of organisational culture and the impact of safety incentives. A particular concern was whether providers asked young learners appropriate questions that would ensure they found out about all incidents that had happened since they last saw the young person.

A series of recommendations were made to the LSC based on the findings of the interviews. These recommendations were aimed at building on good practice and developing a more consistent approach across the regions.

Chapter 4 presents the outcomes of analyses of the Labour Force Survey, the Learner Incident Report and the Individual Learner Record. Analysis of the LFS revealed that those who are still in training have a slightly increased likelihood of having an accident at work, relative to those who have completed their apprentice-ship. When age composition and general accident rates within sectors are taken into account, apprentices are seen to have a slightly reduced likelihood of having an accident compared to other workers with that profile. However, the analyses also show that, compared to all workers across all sectors, those who were classified as 'modern apprentices' at the time of the research have a significantly increased probability of having an accident at work. However, these data must be treated with some caution as the number of modern apprentices sampled by the LFS is relatively small and distortions can be caused by the weighting process used in scaling up the LFS data.

Analysis of the Learner Incident Record reveals that there are large differences in the numbers of incidents reported by further education and work-based learning providers. While FE reports more incidents than the work-based learning sector, when the relative numbers of learners in each sector is taken into account the rate of reporting in FE is much lower than in work-based learning.

The Individual Learner Record requires providers to report on learner deaths but not cause of death. Analysis revealed high numbers of deaths amongst learners in two sectors in particular,

motor industry and engineering manufacture. Although there were higher numbers of deaths in the age group 16 to 18 than 19 to 20 and 21 to 24, when rates were calculated based on numbers of learners in those age groups in those sectors there was no difference in death rates for the age groups.

Two surveys were conducted as part of the research. The survey of providers is reported in chapter 5 and the survey of employers in chapter 6. The provider survey provided evidence that some incidents are not being reported, and the two most-frequently cited reasons for this were that learners did not tell providers about incidents, and that incidents did not appear sufficiently serious at the time to need reporting. The provider survey also provided evidence to support the factors identified in the literature review as contributing to under-reporting. The outcomes of the employer survey confirmed many of the factors identified by the providers and by the earlier stages of the work.

In chapter 7, the outcomes of the two surveys are discussed in the context of the previous literature and the issues raised during the regional manager interviews. Taken together, the findings from the different parts of the research programme served to confirm that organisational culture and supervision, individual attitudes and administration and communication were all factors contributing to the under-reporting of accidents. In addition, employers' understanding of health and safety requirements, in particular their understanding of their reporting obligations, was seen by providers as an issue. Lastly, there were calls for reporting to be made easier. However, in some cases it emerged that providers were not aware of the reporting options available to them.

Chapter 8 concludes the report with a series of good practice examples from providers and employers. These are followed, lastly, by a series of recommendations to the LSC for actions that may help to improve reporting.

1. Introduction

The LSC requires all funded institutions to report certain accidents or incidents involving learners that occur at the learning provider's premises (and, for those in work-based learning or on placement, at the work or placement premises). Fatal road traffic accidents involving learners also are required to be reported. For serious incidents that involve absence from the learning programme or work for more than three days (or that necessitate an employed learner taking on tasks different from their normal ones) the LSC operates an accident and incident reporting system that requires both provider and learner to send in details of the incident to a central incident logging system.[1]

For employees, there is a statutory requirement for employers to report any accidents that result in either three or more days' absence from work or necessitate a change to alternate duties until the employee is recovered. The requirement for such incidents to be reported is embodied in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, (RIDDOR) and such incidents are referred to as being 'RIDDOR-reportable'. The law requires all such accidents involving employees to be reported to the Health and Safety Executive (HSE).

In addition, college students are treated as members of the public when on college premises. If they need to be taken to hospital –- even if this is for treatment of a minor incident unrelated to their studies, such as a wasp sting –- this is currently considered to be RIDDOR-reportable.[2]

[1] http://www.safelearner.info/src/incident_report.asp

[2] It should be noted that the LSC is currently seeking clarification on this point. There is some uncertainty regarding whether everyone who is taken to hospital or whether reporting should be restricted to serious incidents. At the time this report was compiled a response from the HSE was still awaited. There is a similar 'grey area' regarding the status of sports injuries and whether these should be considered RIDDOR-reportable or not.

1.1 Under-reporting of accidents

The Health and Safety Executive (HSE) believes that accidents and incidents involving employees at work are significantly under-reported. That is, they are concerned that fewer accidents are reported than actually occur.[1] Their main reason for suspecting that this may be the case is that data from the Labour Force Survey, a quarterly survey of the British population, reveals that far more employees report having been involved in accidents at work (and having more than three days sick leave as a result) than would be predicted based on reports received by the HSE. Based on LFS data, the HSE has estimated there is between 57.1 and 52.0 per cent under-reporting of accidents by employers. In other words, fewer than half (between 43 and 48 per cent) of incidents leading to three days' absence from work are actually reported.

The LSC suspects that there may be similar levels of under-reporting amongst its funded institutions. This is of some concern, because, if accidents are not reported, there can be little certainty that appropriate steps will be taken by institutions to avoid similar incidents happening again in future. Neither will any general lessons be learned if only a partial picture of the nature of commonly occurring accidents is presented.

While some accidents may be unavoidable, or due to factors outside the learning institution's control, many can be traced to problems in supervision of learners or inadequate identification and assessment of risks in the learning environment. Indeed, the LSC's own database indicates that this latter point is the largest single underlying cause of accidents involving learners.

Unless incidents are reported and investigated, such problems are likely to remain, with the possibility of similar incidents recurring in the future. Without detailed knowledge of all incidents it is difficult to recommend or take actions that potentially could prevent major and possibly fatal accidents.

The LSC needs to be informed of learner incidents in order to be able to identify any emerging trends and areas of particular risk. This information is particularly of value in guiding health and safety managers and co-ordinators in planning and prioritising their seeking assurance visits[2] to providers.

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[1] Rather than seeking to suggest that the severity of incidents might be minimised in reports.

[2] Health and safety co-ordinators conduct seeking assurance visits to providers as part of the process of health and safety assurance for the LSC.

1.2 The programme of research

In 2004 the LSC awarded a contract to the Institute for Employment Studies to conduct a review of the current procedures and processes for reporting accidents and incidents involving learners. A review of the literature and analysis of statistics also formed part of the work. The aim was to identify factors that may contribute to under-reporting.

While learners are defined as all those on learning programmes funded by the LSC, the main focus of the project was to be mainly those on work-based learning, primarily apprentices and those on entry to employment (E2E) programmes. The programme of work agreed between the Institute and the LSC was to consist of six parts:

- a literature review
- interviews with LSC regional health and safety managers
- a review of the data on accident reports
- focus groups with learners
- a survey of learning providers
- a survey of employers.

In the event, despite several attempts to recruit learners to focus groups in four different local LSC areas it was not possible to proceed with this part of the work. Instead, a limited number of interviews with learners and with staff were conducted.

1.3 The report

The report therefore commences with a review of the literature on reporting of accidents and injuries among learners and young workers. This is followed, in chapter three, by a summary of the points that emerged from the interviews with regional health and safety managers. Chapter 4 provides a review and analysis of data from the Labour Force Survey and from the LSC's Individual Learner Record databases for the further education and work-based learning sectors. After this, chapters five and six report the outcomes of the surveys of providers and employers. In chapter seven, we discuss the survey outcomes in the context of the issues identified by the initial literature review and the interviews with regional health and safety managers. The discussion is illustrated with extracts from the interviews. In chapter eight we draw conclusions, identify issues that impact on reporting and make recommendations for future actions.

It should be noted that the term 'provider' is used throughout this report to denote both work-based learning providers and FE colleges, as well as other organisations such as group training

associations and chambers of commerce, who may be involved in delivering work-based learning.

We now move on to consider the literature on the under-reporting of work-related accidents and injuries among learners and young workers.

2. Literature Review of the Under-Reporting of Work-Related Accidents and Injuries Among Learners and Young Workers

The literature review considered existing research into reasons for the under-reporting of work-related accidents and injuries among learners/young workers. The materials reviewed included articles and reports by academic and applied researchers and by official bodies in the following main areas:

- the incidence of work-related accidents and injuries in the UK with breakdown by age
- extent of under-reporting and differences by sector/workers
- types of injuries and illnesses under-reported
- reasons for under-reporting.

2.1 Generating the literature

A combination of methods was used to generate the list of articles for inclusion in the review. The PsychInfo data base was searched using the search terms:

- learner accident
- occupational accident
- accident report (*)
- incident report (*)
- young, accident
- worker, accident.

The same search terms were used to identify any additional material using the search following engines and databases:

Google

Ingenta

Google Scholar

regard.ac.uk

agius.com/hew/links/

labordoc.ilo.org:

ericd.gov.

In addition, the research team drew up a list of specialist journals (the list is shown in Appendix 1) that were likely sources of articles in these areas. Content lists for the last five years for these journals were inspected to ensure that no relevant articles had been overlooked because they did not have the search terms in their title.

A copy of a report from the Robens Institute that had been commissioned in 1997 by the DfEE and was now out of print was supplied to the research team by the DfES.

2.2 The incidence of work-related accidents and injuries in the UK with breakdown by age

Data on the number of fatal and non-fatal workplace injuries is compiled from reports made to the HSE and local authorities under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). There are three categories of reportable injury to workers under the regulations:

- Fatal — deaths of all employed people and members of the public arising from work activity.
- Major — such as fractures (except to fingers, thumbs and toes), amputations, dislocations (of shoulder, hip, knee or spine) and other injuries leading to resuscitation or 24-hour admittance to hospital.
- Over three-day injury — such as injuries that lead to an absence from work or inability to do their normal job for more than three consecutive days not including the day of the accident. Non-fatal workplace injury data is supplemented by injury statistics from the Labour Force Survey (LFS). These figures provide estimates on the levels of workplace injury that, unlike RIDDOR, is not subject to under-reporting.

In addition, for students on college premises there is an additional category of RIDDOR-reportable injury, and this is where the learner is taken to hospital. This category exists because of an anomaly whereby students on college premises are treated as members of the public.

There is no single source of work-related ill health statistics. However, the HSE makes use of the following five main sources to estimate the extent of work-related ill health:

- Self-reported work-related illness (SWI) — household surveys of over 90,000 adults in Great Britain as part of the LFS.

- The Health and Occupation Reporting network (THOR) — voluntary medical surveillance schemes, which count new cases of ill health that, in the opinion of a specialist doctor, are caused by work.
- Industrial Injuries Scheme (IIS) — new cases of 'prescribed diseases' (those with a well-established occupational cause) under the Department for Work and Pensions run scheme.
- RIDDOR — the regulations list specific diseases occurring in employees that must be reported.
- Death certificates — deaths from occupational lung disease, such as mesothelioma (an asbestos-related cancer) and asbestosis (asbestos-related lung cancer) are recorded by the HSE.

The latest HSE figures (HSE, 2004) show that the number of people suffering from work-related ill health was lower in 2003-04 than in the previous year. However, the number of fatalities, major injuries and over-three-day injuries had all increased.

Work-related deaths increased by four per cent, from 227 in 2002-03 to 235 in 2003-04, although the tragedy at Morecambe Bay accounted for 21 of these fatalities. Major injuries were up nine per cent on the previous year, while there was a marginal increase (0.7 per cent) in the number of over-three-day injuries reported.

In terms of ill health, in 2003-04 an estimated 2.2 million people suffered from illness which they believed was work-related, compared with 2.3 million the previous year. The two main types of work-related illness continue to be musculoskeletal disorders (MSD) and stress. The incidence rate for MSD — that is, how many people per 100,000 who worked in the previous 12 months that became aware of the problem during that period — for 2003/04 was lower than for 2001/02. In 2003/04, 640 people per 100,000 (0.64 per cent) first became aware of a MSD, compared with 750 per 100,000 (0.75 per cent) in 2001/02. The rate for stress, depression and anxiety was similar.

HSE figures from the THOR monitoring scheme also reveal a continuing decrease in occupational asthma and occupational contact dermatitis for 2003, and a return to previous average levels of occupational infections following a large increase during 2002, which was partly caused by several large outbreaks of diarrhoeal disease. Deaths from both mesothelioma and asbestosis continue to rise in line with expected trends.

2.3 Age data

As Tables 2.1 and 2.2 illustrate, the rates of work-related illness and injury are generally higher among older workers than younger workers.

Table 2.1: Rates of non-fatal injury to employees, men and women by age band (2003-04 provisional) as reported to all enforcing authorities

	Major		Over-three-day		Total non-fatal	
Age band	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
16–19	144.1	55.7	472.9	185.4	617.0	241.1
20–24	171.1	54.2	646.6	216.7	818.3	270.9
25–34	152.0	43.6	691.3	217.5	843.3	261.1
35–44	158.9	45.2	764.4	264.2	923.3	309.4
45–54	154.9	61.6	672.4	282.5	827.3	344.1
55–59	167.2	86.8	624.3	268.4	791.5	355.2
60–64	178.4	101.6	640.1	238.4	818.5	340.0
65+	110.5	85.7	168.1	113.8	278.6	199.5
All ages	177.7	64.0	742.0	275.9	919.7	339.9

Source: www.hse.gov.uk/statistics/other.htm

Table 2.2: Estimated 2001-02 prevalence and rates (per cent) of self-reported illness caused or made worse by work, by age, for people ever employed

	Sample	Estimated prevalence (thousands)			Rate per 100 workers ever employed		
Age band	**cases**	**Central**	***Lower***	***Upper***	**Central**	***Lower***	***Upper***
16–24	228	121	105	138	2.6	2.2	2.9
25–34	676	351	324	379	4.4	4.1	4.7
35–44	982	467	437	497	5.3	5.0	5.6
45–54	1,127	518	486	549	6.9	6.5	7.3
55-59/64	880	404	376	431	8.5	8.0	9.1
60/65–74	787	325	301	349	5.4	5.0	5.8
75+	335	142	126	157	3.7	3.3	4.1
All ages	5,015	2,328	2,261	2,394	5.3	5.2	5.5

Source: HSE (2003)

Table 2.3: Estimated 2001-02 prevalence and rates (per cent) of self-reported MSD caused or made worse by work, by age, for people ever employed

	Sample	Estimated prevalence (thousands)			Rate per 100 workers ever employed		
Age band	**cases**	**Central**	***Lower***	***Upper***	**Central**	***Lower***	***Upper***
16–24	87	47	37	57	1.0	0.77	1.2
25–34	291	153	135	171	1.9	1.7	2.1
35–44	454	217	197	237	2.5	2.2	2.7
45–54	543	250	228	271	3.3	3.1	3.6
55-59/64	465	211	191	231	4.5	4.0	4.9
60/65–74	451	186	168	204	3.1	2.8	3.4
75+	148	63	53	74	1.7	1.4	1.9
All ages	2,439	1,126	1,081	1,172	2.6	2.5	2.7

Source: HSE (2003)

Table 2.4: Estimated 2001-02 prevalence and rates (per cent) of self-reported stress, depression or anxiety caused or made worse by work, by age, for people ever employed

Age band	Sample cases	Estimated prevalence (thousands)			Rate per 100 workers ever employed		
		Central	*Lower*	*Upper*	Central	*Lower*	*Upper*
16–24	65	35	26	43	0.73	0.55	0.91
25–34	234	118	103	134	1.5	1.3	1.7
35–44	344	162	144	180	1.8	1.6	2.0
45–54	327	148	132	164	2.0	1.8	2.2
55-59/64	160	75	63	88	1.6	1.3	1.8
60/65–74	56	25	18	31	0.25	0.18	0.32
All ages	1,186	563	530	596	1.3	1.2	1.4

Source: HSE (2003)

A similar picture emerges for the two most common types of work-related illness — musculoskeletal disorders (MSD) and stress (Tables 2.3 and 2.4).

The table of reported injuries to trainees and people on work experience over a three-year period (Table 2.5) shows that a larger number of younger people (those aged 16 to 19) on such schemes are more likely to suffer an injury than their slightly older (those aged 20 to 24) co-trainees.

The HSE was asked if they were able to provide information regarding the total numbers of young people in these two age groups who were on work experience or in training over this period. This information is not available. Therefore, although the number of incidents involving the younger age group is larger, this might be attributable to there being a larger number of these individuals.

Table 2.5: Injuries to trainees and people on work experience*, as reported to HSE's field operations division and local authorities, 2001–2004

Year	Status	Age bands	
		16–19	*20–24*
2001-02	Work experience	21	13
	Trainee	325	81
	Total	346	94
2002-03	Work experience	11	5
	Trainee	168	55
	Total	179	60
2003-04	Work experience	27	11
	Trainee	133	48
	Total	*160*	*59*

*Source: HSE (2005). * Identified by employment status codes 12 and 13*

The use of numbers of incidents rather than frequencies in this way can be misleading, as we demonstrate in our statistical analyses in the following chapter. It is not possible to draw any conclusions regarding the greater or lesser risk of young trainees and young people on work experience in these age groups being injured since it is not possible to calculate incidence rates.

2.4 Extent of under-reporting

We move on now to consider the data that are used to estimate under-reporting rates.

2.4.1 Overall extent of under-reporting

The HSE acknowledges that RIDDOR data is subject to under-reporting (HSE, 2004). A comparison between RIDDOR and Labour Force Survey[1] (LFS) data provides a measure of the extent of under-reporting in Great Britain, as the LFS routinely asks participants about absence due to ill health or injury in the previous year.

LFS figures tend to be presented as three-year averages to smooth any sampling error fluctuations. The average LFS rates of reportable injury are consistently higher than rates of RIDDOR-reported non-fatal injury. In 2002-03, the averaged LFS rate was 1,440 per 100,000 compared with a RIDDOR rate of 618 per 100,000. The figures indicate that only 42.9 per cent of reportable employee injuries were reported under RIDDOR (HSE 2004). The latest figures suggest RIDDOR reporting rates improved last year. The most recent RIDDOR-reported non-fatal injury rate was 629 per 100,000 (2003-04), while the annual (not averaged) LFS rate was 1,310 per 100,000. This indicates that, compared with the LFS, RIDDOR picked up 48 per cent of all reportable non-fatal injuries.

Under-reporting is not only a problem in Britain. US companies with at least 11 employees are required to record all work-related injuries and illnesses in a file known as the OSHA 300 log. However, one study of the previous reporting arrangement (OSHA 200) found that only 75 per cent of those establishments that were required to keep an OSHA 200 log actually did so (Seligman 1988). Even where logs were kept, injuries and illnesses were missed and the number of working days lost was regularly misrecorded (Oleinick *et al.* 1993). One US study estimated that 'far fewer than half of all occupational injuries are being counted' (Weddle 1996).

[1] The Labour Force Survey is a national sample-based survey conducted quarterly. Participants are asked a set of questions that address topics such as employment, training, qualifications, hours worked, illness, injury and absence. Responses are then weighted to provide population estimates for the UK population as a whole.

These general US findings have been reinforced by results from sectoral studies. Research among 372 hospital environmental service workers in the Baltimore area by Weddle (1996) revealed that 29 per cent of workers said they had a work-related injury in the previous year, but that 39 per cent of these had not reported one or more injuries. Similarly, a study in the US aerospace industry found that, while 69 per cent of workers suffered low-back pain, just 27 per cent reported this to their company's medical department (Jefferson and McGrath 1996).

2.4.2 Differences in under-reporting between industries/workers

Research reveals big differences in the levels of reporting between industries. The latest HSE figures (HSE 2004) show that the averaged LFS rate — that is over a three-year period — of reportable injuries in agriculture increased by 12 per cent in 2002-03 compared with the 2001-02 rate. Over the same period, however, the RIDDOR rate of reported non-fatal injury remained relatively stable, indicating that reporting levels had declined.

A similar picture emerges in other sectors. Earlier studies provided indications of the overall level of under-reporting. An HSE (1998) audit of RIDDOR reporting in the privatised UK coal mining industry revealed that two major injury accidents had not been notified and around 24 per cent of over three-day accidents had not been reported. Prior to the audit, some mines reviewed their reporting procedures, producing some late notifications. The combined audit and late notifications revealed an overall level of under-reporting of around 52 per cent.

A comparison between LFS and RIDDOR rates in manufacturing industries with data from the LFS in 2002-03 suggests the reporting level was around 60 per cent. In the health services sector the averaged LFS rate increased 11 per cent in the two years to 2002-03, while the reportable rate fell by seven per cent. Even in industries that have traditionally reported most non-fatal injuries, under-reporting is becoming a problem. This is the case in the utility supply industry. Historically, there has been near full reporting of such injuries in the industry. Averaged LFS rates for both 2001-02 and 2002-03 show the sector now suffers from under-reporting.

A 2004 HSE-commissioned survey of manufacturers — research that has now being extended to the service sector — sought to ascertain the level and pattern of reporting of injuries by matching RIDDOR records and the employers' questionnaire responses (HSE 2004, full report available in 2005). Preliminary findings show that the estimate of the reporting of all non-fatal injuries from the survey results is broadly in line with the averaged LFS rates.

However, some industries, such as transport, are improving their accident reporting levels. HSE (2004) statistics reveal that while the averaged LFS rate of reportable non-fatal injuries in the transport industry has remained relatively stable since 1996-97, the reported rate of non-fatal injuries (both major and over-three-day) has increased by 18 per cent. The same pattern is true of public administration. The rate of RIDDOR reported non-fatal injury in public administration rose by 27 per cent in 2003-04 compared with 2002-03, whereas the trend in the averaged LFS rate has been downward since 1996-97.

Table 2.6 illustrates the difference between the averaged LFS and RIDDOR 2002-03 rates of reportable non-fatal injuries for each of the main sectors.

There is some evidence that accident under-reporting is more common among older workers than their younger colleagues. Weddle (1996) found that older workers were more likely than younger workers not to report an injury. Pransky *et al.* (1999) also found that older workers often ignore symptoms of ill health through ignorance or fear. Pransky *et al.* found that older workers tended to attribute musculoskeletal problems to their age, with some being reluctant to report their concerns as supervisors might conclude they could no longer do the job.

2.5 Types of injuries/illnesses under-reported

The evidence supports the rational view that it is the less serious injuries that make up the bulk of unreported incidents. According to Weddle (1996), the most commonly unreported injuries were back injuries (37 per cent); soft tissue injuries such as contusions and abrasions (29 per cent); and sprains, including unspecified extremity injuries (20 per cent). Nonetheless, of the unreported injuries in Weddle's study, nearly two-thirds (64.4 per cent)

Table 2.6: Differences between LFS and RIDDOR rates for the main industry sectors, 2002-03

Sector	RIDDOR rate non-fatal injuries (per 100,000 employees)	LFS rate non-fatal injuries (per 100,000 workers)	RIDDOR rate as a proportion of LFS rate (per cent)
Agriculture	854.2	3,020	28.2
Utility supply	1,197.2	1,860	64.3
Manufacturing	1,156	1,930	59.8
Construction	1,142.9	2,280	50.1
Health services	608.7	1,520	40.0
Transport	1,710	2,160	79.1
Public administration	1,169	1,420	82.3
Retail/wholesale	424.8	1,380	24.9
Hotels/catering	255.2	1,350	18.8

Source: Adapted from HSE (2004)

required medical attention and 44 per cent resulted in lost work time. And it is not just minor injuries that go unreported. A study of young people's attitudes to health and safety at work by the Health and Safety Laboratory (HSL, 2002) uncovered the case of an agricultural student who broke his arm at work, but did not report the incident:

> *'I just went to hospital then went back to work'*

Other studies show that incidents resulting in only minor injuries typically go unreported. A study was commissioned by the former Department for Education and Employment on the reasons for the non-reporting of accidents among participants in training programmes. The research, conducted by the Robens Institute (1997) at the University of Surrey, found that many trainees regarded minor scratches and bruises as an accepted part of the job, only reporting an injury if it required immediate first aid or professional treatment. Trainees were also unlikely to report strains, sprains, bruises and other injuries if they could be endured and did not affect their ability to work.

The HSL (2002) study, which involved focus groups with students and young people who had participated in work experience schemes, also found that minor injuries are often ignored. The study found that minor incidents are the ones that most commonly go unreported. Members of the agriculture college focus group explained why they did not report minor injuries. According to one:

> *'You never, like, go and report it and then you forget all about it.'*

Another interviewee explained that:

> *'I only fill it [the accident book] in if I'm taking sick leave off because of it.'*

Trommelen (1991) also found that incidents that do not involve equipment damage or failure tended not to be reported.

Work-related ill health is even less likely than workplace injury to be under-reported. The HSE says that RIDDOR data on ill health is subject to far greater under-reporting than for injuries (HSE 2004).

While minor incidents such as those referred to in the HSL (2002) study do not need reporting under RIDDOR, the LSC requires providers (and, for work-based learners and those on placements, employers) to monitor all incidents involving learners. The LSC utilises ratios of reports of minor to major, and major to fatal, incidents to identify progress in reducing incidents. The literature review now focuses on the possible reasons why incidents –- both minor and major –- might not be reported.

2.6 Reasons for under-reporting

There are several reasons why incidents might not be reported. These range from reporting procedures to organisational culture and management attitudes to safety. We review the research for each of these different types of reason in the following sections.

2.6.1 Organisational culture

Reporting is hindered in industries and workplaces where a 'blame culture' exists, as people are often reluctant to report incidents for fear of it being used to apportion blame (Adams and Hartwell 1977). Health and safety managers who have to report accident figures to senior managers may be inclined to 'massage' the figures as a high level might indicate poor individual performance. Other studies have highlighted the importance of organisational culture in developing attitudes to safety and in the level of reporting of accidents and injuries. Lucas (1991) suggests that an organisation's safety culture will influence the reporting of incidents. The author contrasts a 'risk management' culture that focuses only on a few specific safety risks, with a 'systematic safety' culture that encourages the reporting of all potential problems.

Workers' attitudes to safety will be influenced by the prevailing organisational or industry safety culture and approach to risk. The 'macho' culture and work environment that exists in some industries, notably construction, often discourages reporting (Glendon 1991). The Robens Institute study suggested that trainees might be even more reluctant to report accidents in such a working environment because doing so would not correspond to how workers in the industry normally behave. The HSL (2002) study found evidence that peer pressure exerts pressure on how young workers deal with health and safety issues. One construction trainee described the following experience:

> *'I asked my boss for some gloves and all the other bricklayers were like "f***ing pansy, you don't need gloves, you're a brickie, harden your hands up".'*

Mullen (2004) reported that an individual's first few months with an organisation will shape his or her attitudes and commitment to safety. Where the experience is one that reinforces positive safety attitudes and behaviour, then the worker will adopt a similar approach. Where the organisational culture does not encourage a positive attitude to safety, then a new worker is likely to disregard safe working and safety procedures.

The importance given to safety by individual managers will also influence the level of reporting. Research in the pre-privatised rail industry by Clarke (1998) provides an insight to how workers' perceptions of managers' attitudes to safety influence the

reporting of hazardous incidents. Although the most commonly reported reason for non-reporting was that the incident was just part of the day's work and accepted as the norm, a significant proportion of drivers said they would avoid reporting a safety problem for one of the following reasons:

- nothing would get done
- managers would take no notice
- someone would get into trouble.

Clarke concluded that among drivers who commonly expressed one or more of these reasons for not reporting an incident, it was because they:

> *'Perceive that managers have negative attitudes towards incident reporting, and this perceived lack of concern with safety has led to reduced confidence in management, disenchantment with the reporting system and a reluctance to report even quite serious incidents.'* Clarke (1998) pp. 14 – 15

2.6.2 Individual attitudes

Within the prevailing organisational safety culture and the attitudes of supervisors and peers, individuals tend to make their own assessment of the seriousness of an injury and whether or not to report it. Powell *et al.* (1971) concluded that incidents considered to be just 'part of the job' were unlikely to be reported, while Weddle (1996) found that workers often did not report because the injury was too minor and they did not want to be seen as careless. Frederick and Lessin (2000) also report that workers are often reluctant to report injuries and illnesses for fear of being labelled an 'unsafe worker'. They quote research in one US company in which 70 per cent of workers indicated they were afraid to report injuries, claiming that if they did so they would: 'face an inquisition'; 'be humiliated'; or 'be blamed for the injury'.

Mullen (2004) describes one worker going to great lengths to ensure management did not become aware of the back injury she had suffered at work for fear of losing her position. The individual was also apprehensive about being reprimanded, as the injury had been sustained because she violated the safety procedures.

The Robens Institute (1997) study asked trainees in two regions — London and Yorkshire and Humberside (Y&H) — for the reasons why they did not always report accidents and injuries. Their responses indicated that trainees tended to resist reporting incidents that they assessed as not being serious. Many deferred either to their peers or their supervisors as to whether or not an incident was worth reporting. They were also reluctant to report accidents if they believe they were at fault. This latter point is likely to be particularly salient in organisations in which a 'blame

culture' exists, which Adams and Hartwell (1977) have suggested renders individuals more reluctant to report incidents.

There are two possible explanations why trainees might opt not to report incidents in which they are ostensibly to blame: fear of it having a negative affect on their employment prospects; and/or because they might be embarrassed by their behaviour.

2.6.3 Other reasons for non-reporting

While organisational culture and the attitudes of individuals and colleagues constitute major barriers to reporting, other factors also contribute to non-reporting. Time constraints — such as being too busy — can be one barrier to reporting. In addition, a lack of familiarity with, or ignorance of, the reporting procedures also stops incidents being recorded.

Under-reporting of accidents and injuries might also be due to a lack of time to complete the necessary paperwork or online reporting process. Completing the reporting forms may require more information than is readily available, and involve further time-consuming investigation.

Table 2.7 lists the main reasons for not reporting incidents that were given by trainees participating in the Robens Institute study.

Table 2.7: Reasons given by trainees for not reporting incidents

Responses	All %	London %	Y & H %
The trainee …			
doesn't think it is worth it/serious enough	82	79	84
was doing something they shouldn't	68	56	78
doesn't know it is necessary to report	68	61	75
doesn't want to make a fuss	64	61	67
was told by workmate it's not worth reporting	46	44	48
doesn't know what to do	43	37	33
believes it is their own fault	42	37	47
doesn't know who to report to	34	27	41
doesn't have time/too much work to do	18	17	19
was not sure what happened	18	13	2
The supervisor …			
says it's not worth reporting	36	35	36
doesn't have time	23	23	23

Source: Robens Institute (1997), An investigation of the reasons for the non-reporting of accidents to participants in training programmes funded by the DfEE, University of Surrey

2.6.4 Administration and communication problems

In addition, the lack of proper in-house procedures and communication may be a barrier to reporting because accident information fails to reach the right person.

Glendon (1991) found that onerous and time-consuming reporting procedures deterred reporting. Pransky *et al.* (1999) also report administrative barriers to reporting. The Robens Institute (1997) study suggested that a combination of pressure to maintain output and unfamiliarity with the appropriate forms could deter employers or trainers from following the required reporting procedures.

The HSE (1998) examination of RIDDOR reporting in the coal industry uncovered the following internal administrative procedures and communications failures that hindered reporting:

- An absence of suitable systems to follow up injuries that could become reportable.
- The use of 'back-to-work' schemes, which encourage prompt return to work on 'light duties' following an accident, led to under-reporting because redeployment was ad hoc, and the responsibility of supervisors rather than those responsible for the reporting of accidents under RIDDOR.
- Managers interpreted RIDDOR requirements differently or misunderstood what was required of them. Both of these contributed to under-reporting.
- In some cases, a lack of communication between personnel and a lack of an adequate investigation of an incident led to under-reporting. The HR department reviewed, for example, self or GP certification but the relevant information was not always forwarded to those responsible for accident reporting under RIDDOR.
- Assessments of injuries were not always properly recorded. There were examples of employees with potentially reportable injuries being referred to hospital for treatment, but no information was recorded. There were also examples of those responsible for reporting under RIDDOR failing to respond to information on accidents passed to them.

Gyi *et al.* (1999) also discovered from interviews with senior health and safety managers in the construction industry that inconsistencies between sites meant that some of them reported every incident, including minor injuries, while others only reported serious injuries.

2.6.5 Safety incentives

Incentives to reduce accidents and injuries may also serve to reduce the numbers of incidents reported. A US study found that enforcement policies introduced since the Occupational Safety and Health Act 1970 have to all intents and purposes provided an incentive to organisations to report fewer of those injuries that result in lost work days, as organisations that report fewer than the cut-off amount can become exempt from inspections (Weddle 1996). The OSH Act requires businesses with 11 or more employees to maintain an annual log of all workplace injuries and illnesses. The only exceptions are minor injuries requiring only first aid.

Although there is no similar enforcement exemption in the UK, employers are well aware that unless they are in a high-risk industry or there is a serious workplace incident or there are high levels of injury then they are unlikely to face inspection from either the HSE or local authority inspectors. Indeed, there is evidence from the HSE (Bourn 1994) that some employers report fewer injuries and illnesses in an attempt to avoid inspections. The Robens Institute study acknowledged that if an employer believes that submitting an accident report will lead to a visit by an inspector, they may be reluctant to do so for fear of the consequences. The report also recognised that employers may be less inclined to report if, on balance, the consequences of not reporting, such as minimal fines, outweigh the potential risks of an official investigation.

More recently, the HSC acknowledged that future inspections will be targeted at higher-risk industries in order to make best use of the limited resources of the HSE and local authorities. It said: 'HSE and LA resources are limited, spread too thinly and need, therefore, to be targeted to where they can have the most impact. Where the proper management of risks can be assured, HSE and LAs will not intervene proactively. This means we will discourage HSE and LAs from putting resources into issues where the risks are of low significance, well understood and properly managed' (HSC 2004).

As well as such external incentives not to report, there may also be internal inducements to under-report. The existence of financial rewards, such as bonus schemes that include safety in the performance criteria, for example, can reduce reporting. The premise for such schemes is that the potential financial reward will spur employees to work safely. An unintended consequence, however, is that fear of losing the payment may suppress reporting. A report on bonus schemes by Incomes Data Services (2003) reveals several examples of incentive schemes that include safety objectives (including BP Grangemouth and Kimberly-Clark in Barrow Mill), although the report does not draw any conclusions on the impact on reporting.

Pransky *et al.* (1999) looked at the impact of safety incentive programmes on reporting in one company. According to the study, the firm's OSHA 200 log for the previous year revealed that only five per cent of their packers reported musculoskeletal problems. Yet, a survey of the firm's packers using a symptoms questionnaire developed by the National Institute of Occupational Safety and Health found that 30 per cent of all respondents had conditions that were OHSA-recordable. The company's safety departments had a target of sustaining less than two recordable injuries per year per 100 manufacturing workers. Managers routinely received bonuses, which were dependent, in part, on the company's OHSA-recordable injury rate. The authors of the study concluded that the existence of such internal incentives to improve safety encourage under-reporting:

> *'The corporate and facility safety incentives appeared to have an indirect, but significant negative influence on the proper reporting of workplace injuries by workers.'*

Taken together, the Pransky *et al. (ibid.),* Incomes Data Services (2003) and Bourn (1994) studies suggest that the possibility of reduced inspections or reduced insurance premiums can lead employers to consider providing incentives to workers to not report incidents. Evidence to support this view, that incentives can lead to reductions in the reporting of, rather than the numbers of, accidents is now starting to emerge from the US. A recent report suggests that the supposedly 'excellent' health and safety record of a company working on a large construction project had more to do with bribes, threats and other 'behavioural safety' initiatives than with good practice. The company gave out between $100 and $2,500 (£53-£1,320) bonuses, depending on the number of worker hours logged without a recordable injury. Because insurers give discounts on insurance premiums for companies with safe track records, it has been estimated that low numbers of worker injuries could save this particular venture up to $7 million (£3.7m) a year on its compensation insurance bill. At least three of the eight workers who reported injuries requiring more than basic first aid during 2004 were suspended for one or more days without pay. In one case, a worker's entire 16-member crew was suspended for a day after he sliced his ear after slipping (Tucker and Holstege, 2005).

Gyi *et al.* (1999) has also suggested a further economic incentive for firms to under-report. They suggest that high levels of reporting in the construction industry can be seen as a reason for not selecting a company when tendering for contracts.

2.7 Summary

The review of literature was conducted to form the basis for research for the LSC to explore the reasons for non-reporting of accidents involving apprentices and learners on placement. While

the LSC's main concerns lie with the central reporting of RIDDOR-reportable incidents (*ie* more serious occurrences) it also requires providers (and learners and employers who employ or provide placement opportunities to learners) to monitor all incidents in order to improve the available data so that the LSC may better monitor improvements to management of learner health and safety.

The literature review reported on recent HSE statistics that confirm that there are grounds for suspecting significant and widespread under-reporting of accidents. The statistics indicate that fewer than half of all potentially reportable incidents may be reported.

Older workers are however, more likely not to report an incident than are younger workers. For them, fears about incidents being seen as implying they were no longer capable of performing their job often underlay non-reporting.

Many younger workers failed to report injuries, either because they did not think it was important or was just part of the job or because they just continued working and then forgot to report. Organisational culture is a major factor identified as inhibiting reporting, and this is particularly the case where a 'blame culture' exists. A 'macho' culture, such as exists in some male-dominated sectors, can lead young workers to disregard health and safety issues and be reluctant to report accidents.

Workers may fail to report accidents if they feel no action would be taken or if reporting would get someone into trouble. Similarly, where young workers feel that reporting the incident would make their colleagues view them as careless, then incidents may not be reported.

Completing the reporting forms may require more information than is readily available, and involve further time-consuming investigation. In addition, the lack of proper in-house procedures and communication may be a barrier to reporting because accident information fails to reach the right person.

Managers interpreting RIDDOR requirements differently or misunderstanding what was required of them could contribute to under-reporting. Inconsistencies between sites could mean that some sites reported all incidents, including minor injuries, while others only reported serious injuries. A failure to recognise the seriousness of an incident in the first place, followed by an absence of any system to follow up injuries if they became reportable could contribute to under-reporting.

Lack of knowledge about the reporting process can prove a barrier to reporting, as can cumbersome administrative systems for reporting. Simple failures of communication, or failure to act on

information reported, could also lead to non-reporting. Time constraints too can prevent accidents being recorded.

There is a range of attitudes that may lead to incidents not being reported. For trainees, the potential embarrassment at being viewed as careless or unsafe can lead them to cover up incidents for fear of consequences, which can include the incident negatively impacting on their employment prospects. Fear of consequences may also deter employers for reporting incidents to the HSE. Incentive schemes that aim to reduce incidents may serve only to reduce reporting, rather than encourage improved safety management.

These points helped inform the subsequent development of the questionnaires for surveying providers and employers.

3. Interviews with Regional Health and Safety Managers

To gain an understanding of the issues surrounding current reporting of incidents centrally and regionally interviews were conducted with regional health and safety managers. An interview schedule was drafted by the research team and finalised in agreement with the LSC National Advisor for Health and Safety, Jill Joyce. The intention of the interviews was to gain a view of how the system currently worked in practice and to gain the views of the managers on where problems were arising and potential ways forward. A copy of the interview schedule is attached at Appendix 2.

Interviews were conducted with all regional managers during November and early December 2004.

3.1.1 Background

The health and safety management structure had been in place for just a year at the time at which the interviews were conducted and was still under development. The interviews indicated the majority of regional managers (RMs) oversaw a team of health and safety co-ordinators (HSCs) who were located within the local LSCs within their region.

In addition, many of the RMs had only recently completed appointing a full complement of HSCs to their teams and two still did not have the full (*ie*, planned) number of staff when interviewed. In several regions this meant that there had been resource constraints as one person covered posts in two local LSCs (LLSCs), or that part-time consultants were covering for vacant posts.

For the first year of operation, there had not been any direct line management between the RMs and the local HSCs. While local HSCs reported to the RM, they were line managed by executive directors or quality managers within their own LLSC. At the time of the interviews the line management structure was in the process of being revised to give RMs direct line management responsibility for health and safety co-ordinators (HSCs) in their region. New line management arrangements had just been

introduced in two regions (London and West Midlands), which meant that the local HSCs were now directly line managed by the RM. Introduction of this more team-based approach was being discussed in some of the other areas at the time the interviews were conducted and it was anticipated that team-based line management arrangements now would be introduced across all regions. Since the interviews were conducted it has been confirmed that direct line management is being introduced from April 2005.

It therefore should be noted that the interviews reflected individuals' experiences of arrangements that had been in place for a relatively short space of time and which were about to change once again. Any conclusions drawn or suggestions made should therefore be seen as tentative.

3.1.2 Reporting, investigation and discovery

The main focus of the research as commissioned was to consider the factors that influence under-reporting of accidents. However, it emerged early on in the interviews that there are two further processes that directly impact on reporting. One of these is the extent to which providers investigated accidents that occurred on their premises (and the quality of those investigations), while the second was the extent to which providers took steps to find out if any accidents had happened to apprentices on employer premises. The latter point, of trying to establish if any incidents had occurred, was viewed as being of particular importance in the context of learners based within the workplace, with these learners including apprentices, E2E and work experience placements. It is probably fair to say that these three points -- not reporting, not investigating the circumstances, and not determining if any incidents had happened away from the provider premises — were viewed by most RMs as being of almost equal importance.

The rest of this report is structured into two main sections: in the section that follows, the main findings from the interviews are reported. These are largely descriptive and comparative. In the final section of this chapter, we make observations on the main issues to emerge.

3.2 The interviews

Of concern to the LSC is the fact that there are currently very different reporting rates and ratios in the eight LSC health and safety regions. This may be related to different approaches taken by health and safety teams in the various regions. For this reason we explored the way in which teams were managed and developed.

3.2.1 Team communications

In most regions the health and safety co-ordinators are usually based in each of the local LSC offices in the region and were overseen by the regional manager. In two regions a formal line management link between the RM and the team of local co-ordinators had recently been put in place.

There is some variation in the extent to which RMs meet with the local co-ordinators. Team meeting frequency is generally once a month or every two months. In addition, RMs reported meeting one-to-one with their local co-ordinators at varying frequencies: once a week, once every two weeks or once a month. However, in one region that was experiencing continuing staff shortages these meetings were not taking place at the moment.

Meetings of the local co-ordinators and RM usually feature a regular agenda item on reporting of incidents. In some teams, co-ordinators report on visits that have been made following an incident and the actions the provider has taken.

3.2.2 Developing the team

Although the teams were new, many had recruited staff with previous health and safety experience from working within the older Training and Enterprise Council (TEC) system. Other staff had been recruited externally. Clearly though it is in the LSC's interests to be assured that all teams are developing their staff to the same level of competence and officers are taking a consistent approach in their dealings with providers. In this section then we focus on the way in which staff are being developed and consider the extent to which development appears aimed at achieving the same outcomes.

Induction

It was customary for RMs to accompany new staff on their first few visits to providers. All RMs were using some form of graded introduction or mentoring system, with similar approaches being taken across the regions:

> *'When new people are recruited the new person spends a while shadowing me and then I shadow the new person.'*

RMs reported that procedures needed to be more closely specified to remove any ambiguities. At the time of the interviews, it was common for new recruits to need assistance to understand the LSC's own quality assurance procedures:

> *'If a new person starts, we have to guide them through. You have to read between the lines, the way they are written now they are not precise and not clear enough. There is not enough clarity to say exactly*

what lengths they should go if they find issues. There should be a clearly laid-down process for that.'

'There should be a laid-down process regarding what should happen if there was an incident. Such as you should discuss it with the provider, then you should put it in writing, an action plan etc. *We used to have a corrective action report or quality improvement report that the provider would agree but there is now no consistency or commonality in each local office regarding what the local office person would do. There are existing procedures but they are not definitive.'*

In fact, since the interviews were conducted this issue has in fact been addressed. A working group has been developing new guidance along with flow charts to facilitate understanding. Mandatory instructions were also being re-issued at the time this report was written. An evaluation of the new procedures will be undertaken in the near future.

Training and development

There was some variation in the training and development that RMs expected their local HSCs to undertake. Concerns were expressed over the lack of consistency regarding induction and training for local co-ordinators:

'There should be a proper induction programme for local officers; there is nothing anywhere written down regarding what that should be. We have raised concerns about consistency and commonality of approach … there is no laid-down programme or [identification of] training needs. We have discussed it but we have not put anything in place for induction or continuing development.'

The job requires a particular set of interviewing skills that may take time for new recruits to develop:

'They have to build up confidence and health and safety is a difficult area, it's something that people may not want to speak to you about and you can get into confrontation. Staff need to be able to cope with that and should have appropriate training.'

One RM required new staff to attend seeking assurance workshops that were run for providers, which the HSCs in that region told him they found helpful.

The HSQ1[1] is used as the basis for visits, and the responses made on the form are used as the basis for questions asked by HSCs during visits. However, RMs believed it requires experienced judgement to understand what extra questioning may be needed or evidence required from a provider for a HSC to be sure they are adhering to safe practice. One RM was developing training on interviewing and reporting techniques at the time of the

[1] Providers are required to complete the Health and Safety Questionnaire (HSQ1) and this serves as the basis for the seeking assurance visit.

interviews. One region was putting together guidance for newer staff on what to look for during a seeking-assurance visit, who they might want to interview, documents that co-ordinators might want to look at and additional questions they might want to ask:

> *'For example, if the policy does not mention work-based learning, there would be no acknowledgement of those aspects of the role where the tutor goes out and inspects the workplace. This would potentially be a "blind spot" in their H&S procedure.'*

> *'When they look for instance at the H&S policy, if the policy mentions the learner, it is signed by the senior executive and is current-ish, then they [the HSC] will probably be reassured. But this requires an experienced judgement – 2,000 would probably be seen as ok; 96 probably not -- and it is related to occupational risk level as well. In a high risk industry by not reviewing/revising the policy, they may be missing changes to procedures, codes of practice or legislation.'*

To address this problem one region was trying to develop a proforma for visits that would be based on, but go beyond, the HSQ1, to try to control for variations in what HSCs asked. The intention was to try to standardise the approach taken to seeking assurance, although they were aware that it was necessary to avoid 'slipping into inspector mode'.

At the time of the research, a small working group was looking at developing a standardised approach to reporting, although not all RMs agreed with such an approach:

> *'You need flexibility and they [co-ordinators] should be able to complete/write up forms/reports. So yes there is probably a training need here.'*

Since these interviews were completed, new, interactive workshops had been devised on provider procurement and a 'seeking assurance' working group had met. This programme of workshops is now being rolled out by the LSC to all funded organisations.

Qualifications

Several RMs referred to various types of qualification they expected new staff to gain. Here there was quite some variation in what RMs saw as appropriate:

> *'Newer staff are trained to NVQ level 3, and four of the six have equivalent to level 4.'*

> *'My staff need to do a quality assessor's course.'*

Although the available qualifications were seen as useful, the role of the health and safety co-ordinator is felt to be wider than the competence developed by many of these awards:

'The problem is the job we do is so different, you are working with the A to Z of H&S, any aspect of H&S you mention we have to deal with. So they need a proper induction to help them deal with that.'

'The assumption to date has been that putting them in for the level 3/NEBOSH awards prepares them adequately but it does not.'

However, the lack of a direct management reporting line had led some RMs to believe they were unable to direct the continuing development of their co-ordinators:

'The co-ordinators have a free hand as to how they arrange their on-going CPD. If I was their line manager then I would ensure this was consistent.'

The move to a direct line management relationship should presumably resolve this issue.

History

Some staff with experience of the older TEC approach had taken a while to become accustomed to the new ways of working and the shift from an auditing approach to seeking assurance. While a few problems remained, mostly these individuals had now grown used to the new approach and in some cases were now helping to induct newer staff into the working practices.

3.2.3 LSC policy and practice

Prior to establishment of the LSC, the TECs had audited providers and had provided training where they saw a need. Providers had not been required to be proactive about reporting health and safety incidents, nor had they been required to take responsibility for improving their own performance in this area.

The change from the auditing approach of the TECs to the 'seeking assurance' approach of the LSC, while giving increased autonomy to providers, also meant that (in many cases) providers now needed to gain competence in health and safety management. The experience of the RMs and their teams suggests that many providers still lack competence in this area.

RMs emphasised that providers had not just been 'cast adrift' at the time of the change. The LSC had expended some considerable time and money on workshops to help providers. Workshops had covered self-assessment and managing health and safety management systems, as well as a further round of workshops to help with the introduction of the Learner Incident Management System (LIMS).

However, there were concerns that the workshops mainly served to give providers information and were insufficiently interactive to allow providers to develop a full understanding of what they

needed to do. The workshops apparently had not been fully evaluated. Were events to be run in the future there is perhaps scope for regions to organise some form of utility assessment themselves, although obviously this would be better done consistently on a national basis for national collation of strengths and weaknesses of the training. Where training is concerned with matters of health and safety it should perhaps be for the regional health and safety managers to agree a means for evaluation, both on the day and in follow-ups over time to discover whether any gaps in knowledge emerge subsequently.

Two regions had sent out copies of HSE guidance (HSG 245) as a benchmark for the minimum standard of reporting that would be acceptable by providers. This document was unanimously felt by providers to set out clear guidance, although there was no guarantee that providers would produce an appropriate report by following it:

> *'They are unlikely to go wrong if they follow this, but it's possible.'*

Despite the fact that the LSC had run workshops to introduce LIMS, RMs believed that many providers remained confused. They were confused on several points: over whether they were required to report, the status of the LSC documents and the requirements for investigation:

> *'Even now, you will get a provider come up and say "Does this mean you want RIDDOR-reports from people in college too?"'*

> *'Providers are taking the LSC form and thinking this is an investigation form. It's going to be quite a learning curve for them.'*

> *'A lot of providers have confused LIMS with an investigation system, the expectation is that they would also have an investigation as well. Smaller providers in particular tend to confuse the two.'*

While there was generally felt to be sufficient information and guidance available for providers, a concern was that many providers either did not look at it or did not know from where the information was available.

The Safe Learner website was felt to be very good by most of the RMs, and this is apparently supported by informal feedback they have received from providers. In addition, many of the regions had distributed paper-based resources such as the HSE reports mentioned above:

> *'The HSE guide for small businesses is very good, I take a pack of these with me when I go to small [providers].'*

Some RMs also gave out folders of information following on from workshops they had run. In some cases CDs had been distributed too which duplicated the documents in the information packs. However, there was evidence that, once back in the college or

training organisation, providers failed to look at these information sources:

> *'We gave them a folder of papers and they said this was too much. So we gave them four or five pages and a CD-ROM and they asked for extra copies of the notes and forms* etc., *to which we told them "Everything in your pack is on the CD-ROM!" They hadn't even looked.'*

Moving to the newer system was felt by some to have led to a decline in detection of accidents.

> *'How well does the reporting [system] work? Not brilliantly. When we first started with LIMS we were getting information in from the local offices but it has dropped off. When it first started they would call to say "such and such has happened" but this has waned now.'*

> *'One college in the first six or seven months of a year had not reported a single incident, but during the [time of the] TECs they reported around six or seven a year.'*

While not directly related to reporting, RMs observed that the area with which providers were felt to have particular difficulties was with young person risk assessments. This is turn is likely to affect the numbers of incidents that occur, and thus, potentially may be reported.

3.2.4 Seeking assurance

Interviewees confirmed that visit frequency was calculated on the basis of occupational risk category and overall quality of management. In one region the deaths of apprentices had led them to focus their efforts particularly on the work-based learning sector. Number of learners was also a factor. High risk programmes such as construction receive more frequent visits and also those providers/colleges with weak management systems. One RM reported that a spreadsheet to help calculate visit frequencies had been developed.

Conducting the visit

Where the provider is considered high-risk, RMs typically would accompany the health and safety co-ordinator or conduct the visit themselves. For the LSC the important thing to get right is to balance the risk of a complaint from the provider against the risks to the learner.

Some RMs had concerns that not all LLSC health and safety co-ordinators currently visit providers.

> *'The only way you can be sure that what they describe is operating in practice is by visiting them. I have seen examples of officers forming judgements on the basis of the SAR and limited information from ALI and have never been out to look at the situation.'*

'We have to go back to getting local officers out to visiting providers and seeing learners and asking about health and safety under-reporting and what to do when they have an accident and ensure they report it to us.'

Although RMs had concerns that such 'custom and practice' issues played a part, resource constraints were identified as the main factor impeding the ability of local officers to visit providers. Shortage of HSCs had led in some cases to new providers gaining approval with no visit by the HSC. Even where HSCs were in post they were often not fully included in approval processes:

'Local H&S staff have great difficulty making sure they are fully part of the local office, for instance in the contracting process, a new provider comes on board and may be approved and it is six months until the H&S person finds out, the other staff leave them out of the loop.'

'Local offices need to see H&S as a key issue, it was only learners being killed that really got it back on the agenda … equality and diversity features as part of management [in inspections], but people do not die from this, yet H&S doesn't.'

Indeed, some felt that this message regarding health and safety was not being taken seriously by National Office which had implications for programme design:

'National Office needs to get the message across that H&S is important so [providers] think twice about not reporting accidents … when they are developing new programmes it is only by the intervention of people such as ourselves who say "Have you thought about learner H&S?" that makes them think, "Gosh, we should think about that". We get new programmes developed that make no mention of health and safety.'

If health and safety is not taken seriously then the likely message to emerge is that providers too do not need to concern themselves unduly with this, with obvious implications for reporting.

Following an incident

Following a report of an incident, the local HSC should seek assurance that the provider has taken steps to investigate the incident and address the circumstances that allowed the incident to occur. However, some RMs were concerned that the current procedure, which requires the provider to notify the LSC of the incident and the actions taken, does not allow the HSC to readily gauge whether the actions taken are appropriate:

'The incident recording form has been discussed at length nationally. We do not ask them to list the causes on the form but we do ask them to list the improvements made, either by the employer or by the provider themselves. It could be to the work environment, the machine, training. But you cannot make sense of the improvements made if you do not know what the causes are.'

At present, the provider is required to review the risk assessment and quality assure the learning setting following an incident. The HSC draws on this information from the provider to complete the 'lessons learned' form. There was a view that this responsibility should lie with the provider, but this policy had arisen as the result of a direct request by Ivan Lewis, Minister for Young People and Skills, and so was unlikely to change in the near future.

Current LSC policy therefore is that the local HSC makes a judgement on the underlying causes and enters their judgement on the 'underlying causes' section of the form and then completes the 'lessons learned' form. However, often HSCs left the 'underlying causes' section blank and there were concerns that removing this responsibility from the provider meant that providers did not fully think through the issues arising from the incident.

> *'We shouldn't have a separate "lessons learned" form, when they submit the form to us you should be looking for what can be done to prevent such an accident happening again in the future, and agree the action with the provider, and that should be detailed on the report.'*

Sanctions

RMs were divided over whether there was any real sanction available when faced with a provider with poor health and safety standards. While they are able to terminate contracts on grounds of health and safety, taking such a drastic step would have further implications for the LSC:

> *'We have to tread carefully but if someone is at risk we are able to put something in place. There was one large WBL hair/retailing/warehousing provider that the LSC discovered were not doing appropriate suitability assessments of employer premises, those they did do were very poor quality. They were given several opportunities to put action plans in place to improve but they were really diabolical. Their contract was finally terminated on grounds of health and safety.'*

> *'They had around 750 learners, the backlash was very time-consuming for the LSC –- they had to help other providers to take on these additional learners.'*

Some RMs therefore believed it was not really feasible to remove funding from errant providers. While it is possible, it is not a step that any LLSC will take lightly.

3.2.5 Provider practice

In the previous section we alluded to the possibility that provider confusion over their reporting responsibilities can lead to under-reporting. This point was reinforced throughout the interviews. As well as institutions being unsure as to what severity of incident they were required to report and when, RMs also gave examples of institutions that reported almost every incident that happened

on the premises, including incidents that did not involve any harm to a person and that did not need reporting to any external body.

In addition to problems of non-reporting, there was a view that the current reporting requirements lead to the reporting of incidents that might be viewed as irrelevant, that is, incidents that do not relate to the programme funded by the LSC. Examples cited included apprentices who had had accidents while taking part in leisure activities on the employer premises, while taking part in sports activities, or at a bus stop outside college premises. Other examples, such as wasp stings followed by a trip to hospital, although involving learners on provider premises, are reported under current regulations but there is a view that they should not be.[1] We have noted earlier in this report that the LSC is keen to gain clarification on these situations from the HSE (since technically they appear to be required by RIDDOR) but has so far failed to obtain a response.

There was a view that, if the LSC wants to use accident reporting rates as a benchmark in future, the issue of such 'spurious' reports will need to be addressed as a matter of some urgency.

> *'We have had the LIMS in place since April. This variability of decisions over whether or not to report is becoming an issue since we want to use LIMS for benchmarking. If there are lots of meaningless incidents like this it could lead to a false benchmark. We really need to set a standard for the reporting of student incidents. It will lead to arguments but I would like to see some sort of new criterion such as "if the student is sent to hospital for more than 24 hours", but even then I can see it would still be problematic.'*

RMs acknowledged that potentially there would be a conflict if reporting becomes part of benchmarking and seeking assurance procedures, as incident rates will increase if reporting improves:

> 'We are *trying to strike a balance between conflicting issues. We are planning on using accident rates as a performance criterion for providers, but we also want to encourage them to report, even if they report late. So there is potentially a conflict there.'*

Some RMs felt that confusion about whether or not to report, and what to report, may be increased by the fact that providers are asked to report separately to the HSE and LSC:

> *'They said he had got confused because the HSE was involved and thought this meant he did not have to report it to the LSC.'*

[1] While it is noted that wasp stings can in some cases (particularly where there is an allergic reaction) be serious, the point being made here is whether such incidents need reporting to the LSC.

Indeed, providers are required to give more information to the LSC than to the HSE, and RMs questioned whether this was entirely necessary:

> *'Do we need to have more information than they supply to the HSE?'*

> *'We need to look at what we ask for and why we ask for it and do we need it? But if the law requires them to report to HSE on F2508 then why is that not enough for us? If more information is required then we could go out there and get it through visiting.'*

There are of course different issues for the LSC than for the HSE since the LSC is funding the organisations in question. The LSC in fact will accept the HSE report with extra information being submitted separately. The additional information relates to ensuring the safety of the learning environment. There are five questions that need to be completed in addition to the information contained in the HSE F2508 form, and these are as follows:

1. When did you last ensure the learner was in a safe, healthy and supportive environment?
2. As a result of the incident do you consider the environment to be a safe, healthy and supportive one?
3. When did you last monitor, review or assess the learners health and safety understanding and/or capabilities
4. Are you satisfied the learners understanding and capabilities were suitable and sufficient for the environment and/or task?
5. Are you satisfied that effective supervision was in place for the learner (bearing in mind his/her age, experience, capability, risk *etc.*).

These additional questions are needed because of the LSC's duty of care towards learners and the need therefore to contract only with safe organisations.

Provider action following an incident

Providers also are weak on investigation. We noted earlier that some providers confused 'reporting' with 'investigation' and subsequently assuring the safety of the learning environment. RMs believed that there were particular shortcomings in this area:

> *'It is up to the funded institutions themselves, it is up to them to ensure they have the competent staff and investigate accidents appropriately. If they have been through the proper training they should be trained in the principles of accident investigation but some are not as competent as they should be.'*

Some RMs believe the way to address such difficulties is for local LSC staff to become more proactive in helping providers reflect on what were the reasons for the incident and what might be changed following an incident. Interviewees who expressed this

view believed that it would be of benefit to the LSC as better quality information would be obtained as a result:

> *'The local office staff need to be more involved in the investigation doing it in partnership with the providers, so as soon as an accident is reported … the local office staff should go out immediately and discuss it with the provider, how are you going to start your investigation off if you haven't already done so, and be part of the whole system. This is part of how the system falls down as I see it, the local office staff are not proactive enough, they need to get more involved with accidents. The bottom line is, provider staff themselves are not always competent in pulling their report together, so they do need a bit of support in doing that. Because some of them might only have one accident a year, so that's where the local offices could get more involved, to make sure that the report that is generated and sent back to them is of the standard that we want. There's a wealth of information that could be gained..[we] should support them during this process, it's our system and we've got to make it work. We've got to be a bit more active in helping them use the system.'*

However, it should be noted that there are legal reasons for LSC staff not becoming involved in accident reporting as suggested by the above interviewee. If the LSC became involved in the way suggested above, then this could mean the LSC might take on a greater duty of care than it has. The LSC has responsibility for contract compliance and needs to seek assurance that providers have satisfactory arrangements in place for learner health and safety. At the end of the day, employers themselves need to become competent in investigating accidents and assuring the safety of the workplace. Providers need to be competent to seek assurance that employers have adequate arrangements in place for learner safety and also to investigate accidents, if they happen on their premises. However, it can be difficult to define exactly what is meant by 'competent' in this respect, as there is no contractual requirement for a qualification in this area:

> *'We may ask how competent the provider placement officer or manager is, and we do have some concerns about them … the LSC expects a Placement Officer or Manager to have attained unit D or equivalent. But you can't stop them [from getting funding] because they do not have a qualified H&S person. All you can do really is recommend they get the qualifications.'*

In particular, it was considered unreasonable for smaller providers to be required to attain some form of health and safety qualification, as accidents may happen only occasionally at small organisations. Nonetheless, providers do need to be in a position to address health and safety issues and investigate any incidents that do happen. RMs reported two ways in which providers were starting to develop competence or consider ways of obtaining advice and guidance:

- In one region with active provider networks the providers had identified several people as competent incident investigators

and were encouraging providers to go to those people for advice.

- In another, providers were considering forming groups or networks who could then buy in a share of a health and safety consultant's time.

Competence at investigation is particularly needed in WBL tutors, as they may be required to investigate incidents that occur at the employer's premises. One example was given where a provider had found that an apprentice had been injured because the employer used unsafe working practices. In their report they had said 'no further action needed' where clearly a competent investigation would have identified changes needed.

In general, WBL was seen as being better at reporting than FE. In one region, all of the reports came from just 15 per cent of colleges and other regions reported similar variations:

> *'In one college that does catering, we get lots of accidents reported but from a hotel and catering provider we get no reports – so alarm bells ring. It is very variable. Two colleges report lots and five report nothing.'*

One suggestion was that an effective approach might be to specifically target those colleges that do not report any incidents and ask if there have been any.

Feedback loops

A further issue was the way in which organisations used their data on accidents. One RM observed that while it is all very well having data recorded, if the data is not used in any way then it will not contribute to bringing about improvements.

> *'I would ask them, what do you do with the accident records? Are they analysed and reported, or discussed or acted on in any way? Does anyone consider whether there are differences between different departments and the implications this might have for further actions? Is anything done about this?'*

The existence of accident statistics on their own will do little to bring about change in practice. What is needed is some form of feedback loop so that accident statistics are brought to the attention of relevant people in the organisation so that appropriate actions may be taken. In the absence of such a feedback loop change is unlikely to occur.

Talking to learners about incidents

One of the reasons why incidents amongst work-based learners may not be reported is that tutors do not question learners appropriately when they visit them at employers' premises. RMs were concerned that tutors either did not ask learners if they had

had any accidents, or, if they did, the question was phrased in such a manner that discouraged the learner from telling them about any incidents that had occurred:

'You haven't had any accidents, have you?'

Such issues regarding the phrasing of questions assumes in the first place that work-based learners are seeing their tutors regularly. The contractual requirement is for work-based learners to see their tutors at least once every 12 weeks. RMs had fears that this was not the case for many learners. Where there are extended periods between assessor visits there is an increased chance for learners to forget incidents that had occurred some months previously.

Additionally, RMs had doubts about the quality of information that learners received at induction:

'I haven't got a great deal of confidence that learners are being given proper information. They might be given information on the things they have to do, some providers are very good, but this doesn't happen with every provider. I've got examples where learners have started on a programme and the health and safety consists of they get the safety book chucked at them and told "Have a read of that!". A lot of accidents happen in the first day or first week and the reports say "Did you get H&S information?" or "Were you provided with protective equipment?" and the answer is "no". I don't think the LSC is doing enough to make sure that when a learner starts on the programme this is the sort of thing you should be telling them, especially in high risk areas like construction.'

Provider networks

Provider networks operated in most LSC regions and LSC staff typically attended these. One of the purposes of these meetings is to promote good practice and discuss regional incident reporting data. Discussions on how to improve reporting and health and safety management practice also feature as topics in these meetings.

A key question however, is that of who attends such network meetings, both in terms of institutional representation and also level/position of the individual who attends. RMs reported that some providers simply never attended such meetings. They suggested that those who do not should have more emphasis on key areas when they are subsequently visited by HSCs. RMs also reported that while work-based learning providers tended to send senior people with a health and safety remit (who could then subsequently cascade any updates to tutors) colleges sent a range of people who typically were not directly or mainly involved in health and safety issues. There were implications arising from this regarding how effectively any information gained would be further disseminated within institutions, if individuals were not in an appropriate post.

RMs had a range of experience with regard to the reasons that providers gave for non-reporting. Some of these, such as confusion, lack of understanding of reporting requirements and not questioning learners appropriately, have been mentioned in the preceding sections. However, one RM spoke of colleges that simply refuse to report incidents. RMs also reported that some institutions fear litigation if they report incidents. Even where RMs and/or local officers are aware of such attitudes, it would most likely be difficult for them to gain information from institutions in order to prove non-compliance with contractual obligations. Such attitudes emphasise the need to gain provider confidence in benchmarking procedures and reassure them regarding the reasons why the information is needed.

3.2.6 Employers

For work-based learners, the majority of incidents occur at the employer premises. Providers therefore need to question learners to find out if any incidents have taken place. Several of the issues raised in the preceding sections contribute to learner accidents at work not being reported or discovered:

> *'Colleges and Providers need to have effective monitoring systems in place so that they discover incidents that have not been reported when they carry out their 12 weekly reviews of Learners. [They need] to encourage employers, supervisors and learners to report. This is an educating process and many employers/ learners still believe that they only need to report if someone is carted off to hospital in an ambulance.'*

Encouraging providers to monitor incidents at employer premises is not an easy task. RMs acknowledged several issues that, at present, impede reporting. The first of these is organisational culture:

> *'Many employers are not vigilant enough about health and safety issues, especially the very small businesses ("one man and a van"). Accidents are seen as a normal part of the "rough and tumble" of the job. Something like a cut on the hand will not be seen as important. There is a "laddish culture" in occupations / sites where men predominate and the messages given to these young people by colleagues is "Don't make a fuss, don't be a wimp". I have seen people with broken fingers, and open arteries who seemed to think (or their colleagues seemed to think) that they shouldn't make a fuss.'*

In addition, one RM said that they had heard accounts in their region of employers offering a bonus to employees if no accidents were reported in a year. A strong financial incentive exists for employers not to report incidents, since their Employer Liability Insurance premium may increase by up to £6,000 following a report. Under such circumstances it is perhaps not surprising that for small employers, offering in the region of a £250 bonus for not reporting makes economic sense.

While employers and senior managers may be pleased to take on an apprentice, the responsibility for day-to-day supervision normally falls to a supervisor or other shop floor colleague. RMs expressed concerns regarding the extent to which such individuals are adequately prepared for the responsibility of supervision. Poor supervision can lead directly to mishaps or to the young worker becoming bored, not paying attention, and suffering a mishap because of this. Despite this issue being recognised for many years, the problem still persists and results in many young people being inadequately supervised and having accidents as a result.

Some providers did however take the need to select employers and placement organisations very seriously. One RM spoke of a college that had started to apply health and safety standards when selecting placement/employer organisations. As a result, they had found that many employers that did not even have a health and safety policy. However, such rigour has its price:

> *'So now they are being very rigorous, they tell employers that they cannot have an apprenticeship. They have lost around 50 placement places as a result.'*

RMs acknowledged that, at present, more scrupulous providers were therefore likely to lose out to less scrupulous ones. One said:

> *'Employers will tell providers where to go if they ask too many questions.'*

3.3 Summary of issues

The interviews served, firstly, to confirm that many of the issues identified by the literature review contributed to under-reporting, but indicated also that there are specific issues that apply in the current situation regarding learners.

In keeping with the previous research, RMs identified organisational culture as a major factor influencing reporting. While such comments related primarily to the culture of employing organisations, the implication was that trainees or apprentices in such organisations would be discouraged from reporting incidents (and from taking appropriate actions in line with health and safety factors). The review identified the possibility that, while reduced insurance premiums were being offered as an incentive to improve safety performance, this could instead lead employers to encourage employees not to report incidents. In line with this suggestion, the interviews revealed that RMs were starting to hear of employers offering bonuses to employees for there being no accident reports in a year.

Many of the other points raised in the interviews however related to specific aspects of LSC policy and provider systems and some of these points informed design of the questionnaires to be used in

the later survey phase of the work. We now go through the main issues raised in the interviews that relate to LSC operations and its communications with providers, and indicate ways in which these might start to be addressed by the LSC health and safety group.

3.3.1 Overview of issues and recommendations

As noted at the start of this section, from April 2005 direct line management of local health and safety specialists by regional health and safety managers has been approved in all regions except the South West. Service level agreements are in place and implementation of the new reporting structure (apart from the South West) should be completed by September 2005.

Since this research took place, the health and safety team has been actively pursuing a number of initiatives aligned to the LSC priority 2 for 2005, which is to improve the quality of the learning experience for learners. These include the Safe Learner help line, Safe Learner consultation paper and Safe Learner framework pilot project.

The national health and safety team has also aligned itself with the Adult Learning Inspectorate and the Health and Safety Executive in the form of partnerships, the objective of which is raise learner health and safety standards provided by those the LSC fund.

A number of working groups have been established to progress the recommendations contained within the Bureaucracy Task Force May 2004 report. These include the single validation principle and the procurement standards for health and safety. All regions are rolling out interactive briefing sessions, which are aimed at helping funded organisations with the process of assuring the safe learning environment. Other working groups are looking at work experience, the rewriting of internal quality procedures, upgrading of the Safe Learner website and at the production of materials to assist the wider health and safety team with seeking assurance.

Given the backdrop of these initiatives by the LSC the recommendations focus largely on actions that are additional to those already under way.

Developing the LSC health and safety team

The first set of observations and recommendations concern developing the health and safety team within the LSC.

- *Improve consistency of approach nationally*. A major issue that emerged was that of consistency of approach –- between health and safety co-ordinators, between local offices and between regions. There were several examples of regional initiatives to improve training and induction of new staff,

which included plans to develop training in interviewing techniques and reporting. We suggest several approaches/ strategies to improving consistency here:

- *Identify job competencies.* We note that none of the of the existing qualifications was viewed as covering all of the activities involved in the job of the HSC (or, presumably, RMs). The role of RM and HSC is virtually unique and therefore has its own set of development needs. In order to help identify staff development requirements, it would be useful as a first step to develop an occupational map for these jobs. The occupational map would identify activities that the job entails and the knowledge and skills that underpin these activities. Existing qualifications could then be mapped against this. Mapping existing qualifications against the job requirements would help RMs identify the areas that remain for which development is needed. To achieve this we suggest that RMs undertake a group exercise to elicit and synthesise their own knowledge and best practice. By helping to identify development pathways this information could help new staff to interpret and understand the existing guidelines and regulations.
- *Identify training needs and draw up a national training and development plan.* Most RMs were developing training (or discussing development with other RMs) based on their own extensive experience. Many of the people we interviewed had 20 or more years' experience. We suggest it would be useful to supplement this information by conducting a training needs analysis amongst health and safety co-ordinators themselves to ensure that some, perhaps more basic training needs, are not being overlooked. RMs could then work with this information to design and agree a common strategy, framework, content and training approach for induction and CPD. Each RM could then deliver or arrange delivery of the relevant components within their own region to fit in with local preferences.
- *Share regional developments*. We were told of developments in the various regions that seemed useful and sensible, such as development of the interviewing techniques course. Also, some small working groups were working to develop practice that might be rolled out nationally. We recognise that all LLSCs have autonomy over staff development but it would also seem wise to maximise the outcomes from such initiatives. One possibility might be to set up a CPD information page on the LSC intra-net to facilitate sharing of knowledge about courses provided/undertaken (perhaps with ratings of their value given by staff who have attended) and explore as a group the ways in which training and development activities might be shared across the various regions. Where an RM identifies a development need in her or his officers (and develops or identifies a programme to meet these training needs) it would be useful if this information was

shared with other RMs. We therefore suggest (assuming this is not already the case; we did not ask this question explicitly) that staff development (identification of training needs and development of training/CPD) becomes a regular item on the agenda for the RM meetings. This has few resource implications but would help ensure the spread of good (and consistent) practice across the regions.

- *Developing seeking assurance competence in new staff.* Mentoring and accompanied visits were being carried out by RMs. One additional useful suggestion was that new staff might also conduct their first visits in pairs until they have gained in confidence.

Improving the reporting process

The next set of recommendations concern the reporting process itself and the ways in which providers communicate with the LSC.

- *Make reporting easier.* Some of the comments made in the interviews related to the process of reporting. Comments included the suggestion that the LSC should consider using or accepting the HSE F2508 accident reporting form. While the LIMS email submission of accident reports is not difficult, it nonetheless constitutes an additional piece of work for providers. Using the HSE form would reduce the need to duplicate information. Managers suggested that the LSC should consider whether it needs all of the information it currently requests.

These comments were made in by senior health and safety staff in the interviews. However, it emerges from subsequent consultation with the national health and safety team that the HSE F2508 reporting form is in fact accepted by the LSC. It should be noted that, if even senior LSC staff are not aware of this, then many providers also are likely to be unaware of this option. We therefore recommend that the LSC takes steps to publicise this option to providers.

- *Reduce spurious reporting*. In addition to under-reporting there does appear to be a problem of spurious reporting of accidents that are not related to the learning programme funded by the LSC. One possible solution that the LSC may wish to consider is to require a lesser initial amount of information for this type of incident, to be supplemented only if LSC officers decided this was needed after seeing the report. This would also allow HSCs to determine whether such incident reports should be forwarded to the national database, and also which types of incident should be used for any future benchmarking processes.

- *Health and safety to be incorporated within SAR and ALI inspection.* As a result of the interviews we recommended that health and safety management become integrated into the overall 'management' strand of the Self Assessment Report (SAR) that providers are required to submit to LSC and ALI as part of the cycle of inspection, and also incorporated into the inspection regime. In the intervening period between the interviews and the publication of this report new guidance for self assessment and new criteria within the Common Inspection Framework has been produced. The new guidance states that:

  'Health and Safety are integral to quality improvement. Providers are expected to meet legislative/statutory and contractual requirements for learners' health and safety. The self-assessment report will include a statement of the arrangements for learners' health and safety and indicate how providers are promoting the concept of the safe learner. The funding bodies will seek assurance that providers have systems in place to ensure that learning takes place in a safe healthy and supporting environment with satisfactory supervision.'

  In future the CIF criteria will include the requirement that providers are able to demonstrate '*evidence of promoting the concept of the safe learner and that sufficient and suitable arrangements for learner health and safety are in place.'*

- *No contracts to be issued without health and safety approval*. There were reports of providers gaining approval with no input from the HSC. In some cases this was due to health and safety staff not being in post, although there were concerns about HSCs being generally excluded from provider approvals. Hopefully the gradual move to a team-based structure, and the flexibility this should bring, will mean that staff shortage can no longer be a reason for non-involvement. It would appear an important principle that providers should not receive contracts without first receiving health and safety approval. If this is the case, we suggest some central representation to make health and safety approval a formal requirement prior to issuing of a contract.

Publicity and reminders

In the earlier sections of this chapter we noted the need for improved publicity. Below we cite several examples of types of publicity and awareness-raising that appear, according to health and safety managers, to work, and would be worth rolling out across England:

- *Newsletter*. One of the regions issues a regular health and safety newsletter. It was suggested that this could be adopted nationally. The newsletter could carry features on good providers and also remind people of their reporting obligations.

- *Regular reminders*. Reminders do appear to work. Those who had tried sending out letters to all providers, or had written to specific colleges about their reporting performance, did report a subsequent increase in reports. If these letters were emailed out, a copy of the reporting forms could be attached.

In addition to general publicity approaches such as those suggested above, more use could be made of regional data to target providers for follow-up. For example, in one region all of the accident reports were coming from just 15 per cent of colleges. We would suggest that regions analyse the sources of reports and then targets and writes to non-reporting providers to raise the issue of non-reporting.

Improving provider competence

While improved provider competence in health and safety is desirable in principle, for some providers, particularly small organisations, it may be impracticable for them to achieve full competence in health and safety. We therefore identify some approaches recommended by RMs and suggest the LSC considers disseminating these approaches nationally:

- *Buddy system*. Some providers are good at reporting and understand the need to identify incidents and report them. Others are less competent and do not know how to set about gaining more information. The LSC might consider helping providers set up a 'buddy' system so that a good provider is assigned as a potential advisor to a provider that wishes to develop its capability.
- *Buying-in support*. A further suggestion was for a provider 'hit squad' to help poor providers improve their reporting and investigation procedures. This is unlikely to be approved, but there was a suggestion that providers might form themselves into groups who then would be able to buy a fraction of a health and safety consultant's time through a 'pool' arrangement. Another suggestion was that inexperienced providers might draw on the services of a team of more experienced providers. This is effectively a slightly more elaborate version of the buddy system suggested in the previous point. An additional point is that it is difficult to see why providers 'supplying' this service should not be able to charge for this. Making health and safety competence a marketable commodity in turn is likely to make attainment of such competence more attractive to providers. These suggestions would appear to offer lower-cost ways of supporting providers that do not have an appropriate level of competence. The LSC might wish to consider whether these services could be advertised via the Safe Learner website.

Culture and understanding

- *Culture*. A main problem remains the culture of many of the industries in which the majority of these accidents occur. The LSC is not alone in their concerns on this point. The CITB sends a roadshow around the country to promote safe behaviour on construction sites. The health and safety RM group and the national manager and national advisor might consider inviting SSC representatives from the high risk sectors to discuss possible joint actions on this point. We recognise though that this is a difficult issue that is unlikely to change in the short term and there is little that the LSC can do to resolve it directly.
- *Raising awareness in young people*. There are concerns about the extent to which young people really understand health and safety issues. One RM spoke of a video game, designed to appeal to young men, that requires them to spot accidents in a simulated workplace. This was seen to be an innovative and appealing approach that helps get round the concern that young people may not listen when being 'told' about health and safety. It would also seem to go some way towards addressing some of the 'laddish' culture issues identified in the previous point. It should be noted that the LSC itself has produced a DVD and video along similar lines and is currently developing a CD-ROM, with the possibility that this might be linked into the LSC website in future. There is likely to be further publicity for such products next year (2006) as this has been designated the Year of the Young Learner. While the LSC itself is prevented from promoting commercial products such as the video game identified above, it would presumably be possible for the provider network meetings to feature a regular agenda item on innovative products that providers have encountered, so that useful products become more widely publicised amongst the networks. In addition, the LSC's own products could perhaps be more prominently publicised on the Safe Learner website and with frequent reminders in newsletters. Again, it is important to remember that publicity needs to be regularly reissued to ensure that new provider staff are made aware of the support materials available to them, as this information is easily lost when staff move on.

Such issues informed design of the questionnaires used for conducting surveys of providers and employers. In chapters five and six we report the findings of these surveys. In the following chapter we report the outcomes of analyses of the Labour Force Survey, Individual Learner Record databases and the LSC Learner Incident Record database.

4. Analysis of Statistics Relating to Learner Accidents and Fatalities

4.1 Introduction

As we set out in the introduction to this report, the LSC requires all funded institutions to report certain accidents or incidents involving learners that occur at the learning provider's premises (and, for those in work-based learning, at work). In addition, fatal road traffic accidents involving learners must be reported. For serious incidents, involving absence from the learning programme or work for more than three days (or requiring an employed learner to take on a different job than normal) the LSC has introduced a central accident and incident reporting system that requires both provider and learner to send in details to a central incident logging system (http://www.safelearner.info/src/incident_report.asp).

As indicated in the introduction and literature review, there is a statutory requirement for employers to report any accidents involving employees that result in either three or more days' absence from work or necessitate a change to alternate duties until the employee is recovered. Under law, all such accidents involving employees must be reported to the Health and Safety Executive (HSE).

4.1.1 Under-reporting of accidents

We reported in chapter 2 that the HSE believes that fewer accidents involving employees at work are reported than actually occur. Their main reason for suspecting that this may be the case is that data from the Labour Force Survey, a quarterly survey of the British population, reveals that far more employees report having been involved in accidents at work (and having more than three days sick leave as a result) than would be predicted based on reports to the HSE. Based on LFS data, the HSE has estimated there is between 57.1 and 52.0 per cent under-reporting of accidents by employers. In other words, fewer than half (between 43 and 48 per cent) of incidents leading to three days' absence from work are actually reported.

The LSC suspects that there may be similar levels of under-reporting amongst its funded institutions. This is of some concern, because, if accidents are not reported, there can be little certainty that appropriate steps will be taken by institutions to avoid similar incidents happening again in future. Neither will any general lessons be learned if only a partial picture of the nature of commonly occurring accidents is presented.

While some accidents may be unavoidable, or be due to factors outside the learning institution's control, many are often traced to problems in supervision of learners or inadequate identification and assessment of risks in the learning environment. Indeed, the LSC's own database indicates that this latter point is the largest single underlying cause of accidents involving learners. Unless incidents are reported and investigated, such problems are likely to remain, with the possibility of similar incidents recurring in the future. Without detailed knowledge of all incidents it is difficult to take action that potentially could prevent major and possibly fatal accidents.

As we have indicated, the LSC needs to be informed of certain learner incidents for several reasons. First, they need this information in order to be able to identify any emerging trends and areas of particular risk. Second, the data is needed to help guide the planning and prioritising of health and safety managers and co-ordinators' seeking assurance visits to providers. Thirdly, the intention is to use such data for benchmarking procedures in the future.

The LSC's informal examination of its own data in November 2003 revealed the incident ratio of 'fatal/major' to 'over three day' accidents was 1:5.2 (LSC national average). The HSE's statistics for employees generally in the UK show a ratio 1:5.8 (and, as indicated above, the HSE acknowledges some 56 per cent under-reporting based on its own comparisons with LFS figures). Data supplied by the LSC for work-based learners indicate that, for 1 April 2003 to 31 March 2004, the ratio of 'fatal/major' to 'over three day' accidents was 1:2.3, while the same ratio for 2004-05 is 1:3.3. It is possible the ratio for 2004-05 may yet change, as it is not uncommon for the LSC to receive late reports; nonetheless it should be noted that the ratios for work-based learning for both 2003-04 and for 2004-05 appear to be significantly less than the ratio calculated by the LSC in 2003 for the learner population as a whole. While this may be due to fewer incidents occurring, it may also be viewed as evidence to support the LSC's fears that incident reporting rates are falling.

Of further concern to the LSC is the fact that, regionally, there are variations in the LSC's 'major/fatal': 'over three day' ratio. This varies from (in the regions) 1:11.5 to 1:2.4 for the National Contracting Service. Ratios in the various regions should be broadly consistent, and this range suggests there may be a

significant number of unreported learner incidents in some regions.

In addition, there have been reductions over the last ten years both in the learner incident reporting rates for accidents resulting in over three days loss of time (from 665 in 1993-94 to 386/100,000 learners per annum in 2003-04) as well as in the ratios (1:7 in 1993/94). This suggests that it is the reporting rate, rather than the rate of incidents, that has reduced.

As part of its work for the LSC to investigate under-reporting of accidents and incidents the Institute for Employment Studies undertook to analyse the LSC's databases and the Labour Force Survey. In examining these data sets IES sought to establish whether these data provide any further grounds for suspecting under-reporting, and if so, in which sectors, and to which groups of learners, this may be happening the most. These analyses are reported in the following section of the report.

4.2 Analyses

4.2.1 Analysis of the Labour Force Survey

The 2003-04 Labour Force Survey dataset was analysed to provide the context for analysis of the LSC's own data sets. The LFS is a sample-based survey of individuals in the labour force, weighted to provide representative statistics for the UK population as a whole.

One of the LFS questions asks respondents if they are 'currently registered on a recognised trade apprenticeship'. The LFS also asks respondents if they have been involved in an accident resulting in injury at work in the last twelve months. Using these questions it is possible to group respondents and then to cross-tabulate and compare the injury rates for those in apprenticeships compared with other workers. The LFS also allows these data to be compared across industrial sectors and for different age groups.

Analysis of the LFS data showed, firstly, that across all apprentices, 6.1 per cent reported that they had been involved in some type of accident at work in the last year. The apprentice group as a whole includes a sub-set that has completed their apprenticeship in the last year. Apprentices who had completed their apprenticeship were less likely to have had an accident than were continuing apprentices. The accident rate at work for employees who had completed their apprenticeship was 5.7 per cent, compared to 6.4 per cent for the less-experienced group.

The figures presented in Table 4.1 are the reported accidents for all individuals who said that they were registered on a 'recognised trade apprenticeship'. However, a further question within the LFS

Table 4.1: Comparison of accident frequencies for continuing and completed apprenticeships

	Completed apprenticeship	Continuing apprenticeship
Accident resulting in injury at work in previous year	7,083	6,750
No accident in previous year	118,355	98,072
Total (accident + no accident)	125,438	104,822
Accident rate (per cent)	5.65	6.44

Source: Labour Force Survey, 2004

asks whether this is part of a modern apprenticeship.[1] When the figures for those who report that they are registered on a modern apprenticeship are separated out, it would appear that these individuals have, on average, 18.8 per cent more accidents than would be expected for people of the equivalent age range in that sector (Table 4.2). It should be noted, however, that this analysis is based on a very small sample and should be treated with caution.

There are also significant differences in the accident rates for workers of different ages that should be taken into account when

Table 4.2: Comparison of actual with predicted accident rates for apprentices across industrial sectors

Industry sector	Number of current MAs in sector	Predicted number of accidents per sector for this number of employees
Agriculture & fishing	1,029	101
Energy & water	0	–
Manufacturing	21,790	942
Construction	47,016	3,742
Distribution, hotels & restaurants	20,152	710
Transport & communication	1,877	65
Banking, finance & insurance etc	5,478	90
Public admin, education & health	6,358	171
Other services	11,051	396
Total	**11,4751**	**6,219**
Total estimated accidents (based on sectoral composition)		**6,219**
Total actual accidents reported by current MAs		**7,389**
Ratio of actual: estimated accident rate		**+18.8%**

Source: Labour Force Survey 2004

[1] It should be noted that the name of these awards has recently been changed to 'Apprenticeship' (formerly the Foundation Modern Apprenticeship) and 'Advanced Apprenticeship' (formerly the Advanced Modern Apprenticeship').

Table 4.3: Rates for accidents resulting in injuries at work for employees aged 16-25 compared with employees aged over 25

	Accident resulting in injury at work						
	Workers aged 16-25			Workers aged over 25			Difference in rates 16-25/26 and over (%)
	Yes	No	Rate	Yes	No	Rate	
Agriculture & fishing	3,692	33,869	9.8	13,854	260,862	5.0	1.95
Energy & water	513	28,736	1.8	12,234	213,062	5.4	0.32
Manufacturing	18,178	402,261	4.3	140,790	3,062,440	4.4	0.98
Construction	23,780	274,966	8.0	82,228	1,610,084	4.9	1.64
Distribution, hotels & restaurants	55,824	1,527,580	3.5	138,316	3,488,495	3.8	0.93
Transport & communication	6,764	187,587	3.5	78,743	1,472,027	5.1	0.69
Banking, finance & insurance *etc.*	9,342	556,947	1.6	59,092	3,406,389	1.7	0.97
Public admin, education & health	17,946	648,667	2.7	230,642	6,412,160	3.5	0.78
Other services	11,280	303,815	3.6	31,352	1,201,521	2.5	1.41
Workplace outside UK	–	1,054	0.0	–	6,881	0.0	0.0
Across all sectors	147,319	3,965,482		787,251	21,133,921		

Source: Labour Force Survey 2004

interpreting the figures for apprentices. The LSF figures for accident rates at work for workers aged 25 and under, and for those and aged over 25, are shown in Table 4.3.

In construction, the likelihood that a person aged under 25 will have an accident at work resulting in injury is two-thirds higher than that for people aged 25 or over. In agriculture and fishing, young employees are almost twice as likely to have an accident as are older employees.

Apart from these sectors and 'other services', in general younger workers have roughly similar accident rates to those of older workers, although the 'energy and water' sector is one notable exception. This finding is in keeping with that reported by the HSE in 2001, namely that there is no evidence to suggest that there is any higher rate of reportable injury (over four days absence) amongst younger workers compared with older ones (Russell, 2001).

Taking these figures into account changes the picture regarding the accident rate for those in apprenticeships. Table 4.4 shows the numbers of employees in each industrial sector who were registered for an apprenticeship (*ie* all apprentices, not just those who report they are registered on a modern apprenticeship) at the time they were interviewed for the LFS, along with the predicted number of accidents that would be expected to occur amongst that

Table 4.4: Comparison of accident rates for all apprentices with those for young employees

	Number of current Apprentices registered in each sector	Predicted number of accidents per sector for this number of young employees
Agriculture & fishing	1,029	101
Energy & water	1,406	25
Manufacturing	34,059	1,473
Construction	74,908	5,963
Distribution, hotels & restaurants	34,578	1,219
Transport & communication	3,278	114
Banking, finance & insurance etc	8,545	141
Public admin, education & health	9,053	244
Other services	26,380	944
Workplace outside UK	–	–
Total	*193,236*	*10,224*
		Difference between estimated and actual accident rates
Total estimated accidents (based on sectoral composition)	10,224	-7.2
Total actual accidents among current Apprentices	9,483	

Source: Labour Force Survey 2004

number of young employees in that sector, given the known sectoral accident rates for people of that age range.

This analysis shows that, compared to young employees employed across these sectors, apprentices as a group have a relatively reduced likelihood (-7.2 per cent) of being involved in an accident at work.

Summary

Analysis of the LFS shows, firstly, that those who are still in training (continuing apprentices) have a slightly increased likelihood of having an accident at work, relative to those who have recently completed their apprenticeship. This is in keeping with the idea that as skill and experience increases, likelihood of having an accident decreases.

When the age composition and general accident rates within sectors are taken into account, apprentices as a group are seen to have a slightly reduced likelihood of having an accident (-7.2 per cent). However, the analysis also shows that, compared to all workers across sectors, modern apprentices have a significantly increased probability (18.8 per cent higher) of having an accident at work. However, these data do need to be treated with some caution given that they are small numbers and distortions can be caused by the weighting process used in scaling up the LFS data.

4.2.2 Analysis of LSC datasets

The LSC maintains several data sets that provide sources of information on learner accidents and deaths. In this next section we explore these data and compare them to data for the wider population. Three data sets were used: the LSC Learner Incident Record; the LSC Individual Learner Record for Work-based Learners and the LSC Individual Learner Record for Further Education and Other Providers.

The LSC Learner Incident Record (LIR) provides a cumulative record of all incidents and accidents that are reported centrally to the LSC using reporting forms available from the Safe Learner site. There were a total of 768 records for the year 2002-03 and 277 for 2003-04.

The Individual Learner Record (ILR) is a central database on all learners. The database is compiled by the LSC based on an annual return to the LSC that all colleges and learning providers are required to submit. Each institution's returned ILR should report on all learners registered with them in the previous year. The LSC Data Services Division provided the researchers with the ILR dataset for the work-based learning sector for 03-04 to supplement the FE dataset that IES already had permission to access from the LSC as part of another research project being undertaken for them.

The LSC Learner Incident Record

The LSC provided IES with a copy of the Learner Incident Record for the calendar year January to December 2004. It should be noted that, prior to April 2004, FE colleges had reported via the HSE F2508. From April 2005 they were required to move to using the LIR. These data were used as the basis for the analyses reported below and an attempt has been made to correct for the fact that the FE dataset covered only nine months.

Analysis by type of provider

Existing analyses of these data performed by the LSC had revealed that over 42 per cent of reported incidents (117 incidents) were reported by private sector providers (these are largely, although not exclusively, providers of work-based learning). Some 73 incidents were reported by the further education and tertiary college sector (just over 26 per cent of all reported incidents that year). Given that the FE sector was only required to report through LIR in April, we have corrected that figure by multiplying by 1.333 to give an estimate of numbers for a whole year. This gives an estimated figure of 97 incidents for FE. When these amended figures are considered, this gives a hypothetical total (adding together the numbers of reports from WBL and the corrected number of reports for FE) of 214 incidents. This would

Table 4.5: A comparison of incident reports during 2004 from the work-based learning and further education sectors

Provider type	No. of incidents	No. of incidents reported by type of provider as a percentage of all provider reports to LSC	No. of learners registered in sector in 2003-04	No. of reported incidents as a percentage of all learners in that type of learning provision
Private sector provider	117	54.67	405,630*	0.029
General FE and tertiary colleges	97**	45.33	7,785,000†	0.00124
Ratio, WBL: FE	1.21	1.21	0.052	23.39

*Source: *ILR for WBL sector; †Source: ILR for FE sector **note corrected to give estimate for whole year*

mean that the FE sector accounted for 45 per cent of reports and the private sector accounted for 55 per cent of incident reports.

Taken at face value, there appears to be only a moderate difference in reporting rates between these two types of provider. However, what also should be taken into account when considering these data is the number of learners in these sectors. A comparison of reporting rates in the two sectors, taking into account the different numbers of learners in the two sectors, is shown in Table 4.5.

The second and third columns in Table 4.5 shows that, in 2004, the work-based learning sector submitted more than half of all incident reports to the LSC database while the FE sector accounted for 45.3 per cent of reports submitted.

However, inspection of the data in the fourth column (number of learners registered in WBL and in FE, based on figures obtained from the LSC's ILR databases) shows that the WBL sector has only around a twentieth of the number of learners registered. Taking these learner numbers into account the figures shown in column five were calculated. These figures show that, once number of learners in each sector is considered, the work-based learning sector is in fact currently reporting incidents at 23 times the rate of the FE sector.

It is impossible to tell whether this disproportionate rate of reporting in WBL arises from more incidents occurring in the WBL sector than in FE or is due to significant under-reporting from FE, or, as is perhaps most likely, a combination of the two. Even allowing for possible differences in sectoral composition between the populations of WBL and FE, it would seem likely that, under these circumstances, there should be more incident reports emanating from the FE sector.

Analysis by sector

We referred above to the possibility that there are sectoral differences in the composition of learners registered in the WBL

and FE sectors — perhaps more construction workers registered in WBL and more administration apprentices registered in FE. Accident rates do differ across the various industrial sectors, as was shown in Tables 4.2 to 4.4. The LSC incident database allows analysis by sector and these analyses show that there are indeed some differences between the various sectors. As might be expected, construction appears to be a particularly hazardous area for learners. Analysis by the LSC using SIC[1] codes reveals that over one-third of reported incidents involving work-based learners came from this sector (78 out of a total of 218 reported incidents).

It is important to note that, once again, such figures need to be considered in the context of the number of learners registered in a sector overall.

For some sectors, the SIC codes map reasonably closely to learning frameworks, making it possible to gain an estimate for the population of learners to whom these incident reports refer. Construction is one such sector. Similarly, work-based learners employed in occupations covered by the SIC code for hotels and restaurants are likely to be registered under the hospitality learning framework. For sectors such as these it is therefore possible to gain a reasonable, if not perfect, estimate of the percentage accident rate for learners in these sectors. For the four areas for which it is possible to map SIC codes against learning framework, incident figures are displayed in Table 4.6.

Here, although taking learner numbers into account does not have quite such a striking impact, nonetheless it does modify picture

Table 4.6: Incident reporting rates by sector

Sector	No. of incidents*	No. of incidents as percentage of all incidents reported to LSC	No. of learners in equivalent learning framework	% of incidents as proportion of all learners in framework
Construction	78	35.78	34,639**	0.225
Health and social work	10	4.59	20,548‡	0.049
Hotels and restaurants	7	3.21	41,290†	0.017
Manufacturing and Manufacture of machinery & equipment$	7	3.21	33,680$	0.021

*Source: *Learner Incident Record ** ILR dataset for WBL 'Construction'; ‡ ILR dataset for WBL 'health and social care'; † ILR dataset for WBL 'hospitality'; $ ILR dataset for WBL 'engineering manufacture'*

somewhat. Thus, while, nearly eight times the number of incident reports emanate from construction than from health and social work (the exact ratio is 7.8), when learner numbers are taken into account to give percentage reporting rates, this ratio is reduced to

[1] Standard Industrial Classification codes derived from the Labour Force Survey that indicate an individual's area of work

4.6 (*ie* construction reports incidents at just under five times the rate of health and social work). Similarly, while there is little numerical difference between the numbers of incidents reported from the health and social work sector (ten) and hotels and restaurants (seven) and from the combined manufacturing and manufacturing machinery and equipment sectors (seven) when numbers of learners in these sectors are taken into account, it becomes clear that health and social work is reporting incidents at over twice the rate of either of the other two sector groupings.

4.2.3 The Individual Learner Record (ILR)

The ILR gathers information on learner registrations, their programmes and learning outcomes. It also seeks information on student destinations and reasons for learners not completing programmes.

While FE colleges have been required to complete and submit the ILR (and its forerunner, the Individual Student Record, ISR) for several years, the requirement for work-based learning providers to complete this was only introduced in 2003. For this reason, we have looked only at the FE and WBL data sets for 2003-04.

Given the concern within the LSC regarding deaths amongst apprentices that prompted this research, and the fear that there may be significant under-reporting of accidents, we were particularly interested in seeing whether the ILR would throw any further light on patterns of fatality amongst young learners. 'Learner death' is one of the categories included under 'destination'.

The ILR does not give details on cause or location of death. It is very likely that many of the deaths will be unrelated to the young person's type of work and area of study. Meningitis, suicide or road traffic accidents are all possibilities as reasons for the death of young people and may be entirely unrelated to their participation in work or study. Nonetheless, the research team was interested in exploring whether any patterns of fatality emerged from the data; in particular, whether deaths tended to be clustered in certain sectors. Were this to be the case, this might suggest that further investigations need to be made by the LSC or perhaps by the HSE, to determine whether these deaths are related to work or study and should have been reported under current legislation.

The ILR for WBL

Analysis of the ILR dataset for work-based learning revealed that, in total, 100 work-based learners had died during the year 2003-2004. This equates to an average death rate of 0.0247 per cent (or 0.25 deaths per thousand) across the 405,630 learners for whom records are available through this database.

All of the 100 deaths occurred in just 23 learning frameworks. At the time the analysis was conducted there were 107 learning frameworks in total. Of these 100 deaths, nine were single reports of deaths from nine frameworks. We have not included these single occurrences within the following analyses. The remaining 91 learner deaths had involved learners in just 14 framework areas, with over one-third of these (34) occurring to learners in just two: motor industry (18) and engineering manufacture (16). Another two sectors between them accounted for a further 17 deaths: construction (nine) and hospitality (eight).

Table 4.7 displays the ILR WBL data for these 14 frameworks. In the second and third columns these data are shown for each learning framework overall. In the subsequent columns the data are shown broken down to show the different death rates by three age groupings: 16 to 18, 19–20 and 21–25. For each framework as a whole, and for each of the age groups, the table shows both the number of deaths and the percentage death rate; that is, the number of deaths divided by the total number of learners in that category. Table 4.7 displays these data ranked by total number of deaths in the sector.

There are several points to be made. Firstly, two sectors have what would seem to be quite extraordinarily high numbers of learner deaths that would appear to warrant some further investigation. It is very difficult to believe that these clusters are entirely unrelated to occupation, sector and area of learning.

While the *number* of deaths involving 16 to 18 year olds is higher (at 55 overall) than for 19 to 20 year olds (33) and for 21 to 24 year olds (12), the percentage death rate for this group is in fact slightly lower than for the 19 to 20 age group (.028 compared to .031). The death rate amongst 21 – 24 year olds is considerably lower than that for both the 16 – 18 and 19 – 20 year old groups.

When death rates based on the number of learners in each framework are considered, it can be seen that the motor industry has both a high rate of deaths and, when numbers in the sector are taken into account, this translates also into a high percentage rate of deaths.

Plumbing and telecommunications also have high frequencies of deaths amongst learners. Although there are not large numbers of deaths involving learners in these sectors, the relatively small numbers of learners means the percentage rate is relatively high.

Table 4.7: Total death rates for learning frameworks having more than one learner death in the year 03- 04. Data displayed first for all learners aged 16-24, then by age group (16-18, 19-20 and 21-24). Data are shown ranked by total deaths in learning framework.

Learning framework and number of learners	Total deaths	Deaths as percentage of number of learners aged 16-25 in framework	No. of deaths in age range 16-18 in framework	Deaths as percentage of number of learners aged 16-18 in framework	Higher or lower than average for age group overall	No. of deaths in age range 19-20 in framework	Deaths as percentage of number of learners aged 19-20 in framework	Higher or lower than average for age group overall	No. of deaths in age range 21-24 in framework	Deaths as percentage of number of learners aged 21-25 in framework	Higher or lower than average for age group overall
Motor Industry N = 28,337	18	0.0635	12	0.0641	2.287807	5	0.0722	2.35146	1	0.0489	3.847079
Engineering Manufacture N = 33,680	16	0.0475	8	0.0516	1.842857	6	0.0564	1.838346	2	0.0279	2.189909
Construction N = 34,680	9	0.026	8	0.0351	1.251714	1	0.0122	0.396162	–-		
Hospitality N = 41,290	8	0.0194	6	0.0414	1.475013	2	0.0164	0.533974	–		
National Electrotechnical Industry N = 17,606	6	0.0341	2	0.0239	0.853367	3	0.0523	1.703579	1	0.0296	2.329456
Plumbing N = 9,927	5	0.0504	3	0.0514	1.834914	2	0.0772	2.514274	–	–	–
Hairdressing N = 32,811	5	0.0152	3	0.0125	0.44633	2	00039	1.271367	–	–	–
Telecommunications N = 4,720	5	0.1059	1	0.0684	2.438191	4	0.2576	8.389549	–	–	–
Early Years Care & Education N = 22,747	4	0.0176	3	0.025	0.890358	–			1	0.0235	1.847141
Health & Social Care N = 20,648	4	0.0195	1	0.0207	0.737303	1	0.0162	0.528601	2	0.0218	1.714195
Retailing N = 20,086	3	0.0136	1	0.0103	0.367664	2	0.0332	1.08286	–	–	–
Sports & Recreation N = 9,300	3	0.0323	1	0.0347	1.238997	1	0.0369	1.200605	1	0.0278	2.18808
Customer Service N = 29,063	3	0.0103				2	0.0223	0.727144	1	0.008453	0.664377
Glass N = 1766	2	0.1133	1	0.1721	6.13954	1	0.2475	8.062481			
All sectors	**91**	**.0246**	**55**	**0.028**		**33**	**0.0307**		**12**	**0.0127**	

Source: LSC WBL ILR 2003-2004. Note: All sector percentage death rate has been calculated across all learning frameworks reported in the ILR, not just across those reported in this table

Table 4.8: Learning frameworks shown ranked by total learner deaths per learning framework, overall learner death rate per learning framework, death rate for 16-18 year olds and death rate for 19-20 year olds

Total deaths per learning framework, 2003-04	Overall death rates (as percentage of all learners)	Death rates for 16-18 year olds (as percentage of 16-18 year olds in learning framework)	Death rates for 19-20 year olds (as percentage of all 19-20 year olds in learning framework)
Motor Industry	Glass	Glass	Telecommunications
Engineering Manufacture	Telecommunications	Telecommunications	Glass
Construction	Motor Industry	Motor Industry	Plumbing
Hospitality	Plumbing	Engineering Manufacture	Motor Industry
National Electrotechnical Industry	Engineering Manufacture	Plumbing	Engineering Manufacture
Plumbing	National Electrotechnical Industry	Hospitality	National Electrotechnical Industry
Hairdressing	Sports & Recreation	Construction	Sports & Recreation
Telecommunications	Construction	Sports & Recreation	Retailing
Early Years Care & Education	Health & Social Care	Early Years Care & Education	Customer Service
Health & Social Care	Hospitality	National Electrotechnical Industry	Hospitality
Retailing	Early Years Care & Education	Health & Social Care	Health & Social Care
Sports & Recreation	Hairdressing	Hairdressing	Construction
Customer Service	Retailing	Retailing	Hairdressing
Glass	Customer Service	Customer Service	Early Years Care & Education

Source: LSC WBL ILR 2003-2004

Small numbers should be treated with some caution, especially given that, at present, data are available for just the one year. Clearly it will be important to monitor these data in future years to determine if any trend emerges.

It should be noted that these deaths are seen across all the age groups, and there is only slight change in the relative positions of these different sectors when considering death frequencies across the age groups.

Table 4.8 shows the sectors ordered by total deaths, death rates per sector, death rates for 16 to 18 year olds and, finally, death rates for 19 to 20 year olds.

The ILR does not report either cause or location of death. As we have already noted, learners can die of a variety of causes and there is no grounds on the basis of the limited data reported within the ILR to *conclude* that these deaths occurred either at the learner's place of work, or as a consequence of their work or study. However, the very strong sectoral clustering suggests that these deaths are not entirely unconnected with occupation and sector. Analysis by binomial distribution supports the view that this pattern of distribution differs significantly from one that has come about by chance.

Work-based learners compared to the wider population

It should be noted that, although a hundred deaths is by no means an insignificant number, such figures need to be compared to those for young people in the population as a whole. The LSC can be reassured that these death rates are significantly lower than for the general population of youths in these age ranges. Below, we compare the data extracted LSC ILR for young people in work-based learning with figures published by the National Office for Statistics for the population as a whole. It should be noted that this is not an exact comparison, since the age groupings published by National Office for Statistics do not exactly match those used by the LSC. Also, we have had to draw on figures from 2001 for the UK as a whole, rather than just for England.

Nonetheless, given these caveats, it can be seen that the published figures cover broadly similar age ranges. The published statistics indicate that learners are significantly less likely to die than young people of a similar age in the general population. Table 4.9 shows this comparison.

One may expect learners as a group to have slightly better life expectancies than young people as a whole, since unfortunately the whole population will include some seriously ill individuals who will die at a young age. Nonetheless, the difference in death rates for learners and the general population of young people appears fairly substantial.

Table 4.9: Death rates for work-based learners compared with population rates

Work-based learners	**16-18**	**19-20**	**21-24**
Rate (deaths per 1,000 population in each age group)	0.28	0.31	0.13
England and Wales	**15-19**		**20-24**
Rates (deaths per 1,000 in each age group) 2001, all UK population†	0.5		0.7

*Sources: * LSC ILR, WBL, 2003 – 2004; † Table 3.14, http://www.statistics.gov.uk/STATBASE/Expodata/Spreadsheets/D7673.xls*

ILR database for FE

Similar analyses were conducted with the ILR for the FE sector. It is estimated that there are approximately 7,785,000 learners in this sector. It should be noted that it is difficult to conduct precisely the same analyses for FE as for WBL, as learners in the FE sector are grouped into subject groupings ('areas of learning') that do not map very closely onto either learning frameworks or onto occupational classifications.

Table 4.10 shows injury and death rates for the ten subject groupings for FE. It can be seen that the death rates are very low. For the three sectors for which there are similar groups reported in the WBL ILR, the rates for FE and WBL are shown compared in Table 4.11.

For the three sectors for which a comparison of death rates can be made between learners registered in FE and WBL, it can be seen that the death rates for learners registered in FE are many times lower than for comparable learner groups in WBL.

Summary of ILR analyses

We must emphasise that the numbers of deaths from both the WBL and FE ILR data sets are small. Furthermore, there is no information on cause of death, nor any information explicitly linking these young people's deaths to their work. While it is the case that the pattern of clustering into a minority of sectors in WBL may be entirely coincidental, there is at least the possibility that these deaths may be related in some way to sector of employment and learning.

The fact that such different rates are seen in FE in the three sectors for which it was possible to make some comparison suggests either that the young people's employment or training is involved in some way, or else suggests that FE is falling short of the reporting required of it by the LSC. Either way, these data would bear some further investigation by the LSC.

Table 4.10: Injury/illness and death rates amongst FE learners

Question L39 Destination (WBL)	Sciences (inc. maths and comp.)	Basic Education	Agriculture	Construction	Engineering (inc. manuf. technologies)	Business (inc. admin and mngmnt)	Hotel and Catering (inc. leisure and tourism)	Health and Community Care	Art and Design (inc. performing arts)	Humanities (inc. education and social studies)	Total
Injury/illness	138	32	0	7	5	32	7	22	21	90	517
Death	22	7	0	1	1	5	1	6	1	4	73
Total	520,818	120,259	19,016	50,809	47,770	161,187	88,256	239,990	83,400	377,688	2,493,110
Percentage death rate	.00422	.00582	–	.00196	.00209	.0031	.00113	.0025	.00119	.00105	.00292

Source: LSC FE ILR 2003-2004

Table 4.11: Comparison of percentage death rates between WBL and FE sectors

Sector	WBL	FE	WBL/FE
Construction	0.026	.00196	13.3
Engineering and manufacturing	0.0475	.00209	22.72
Hotel and Catering	0.0194	.00113	17.17

Source: LSC ILRs for WBL and FE

4.3 Conclusions and recommendations

Here we set out recommendations based on the analyses reported above.

4.3.1 Reporting by age

First, the data from the Labour Force Survey lend some support to the notion that young people registered on modern apprenticeships are more likely to be involved in an accident at work than are other young workers.

Clear comparison of LFS, LSC and HSE statistics is rendered difficult because, at present, many HSE annual reports on accidents and fatalities report accident and fatality rates for employees, self-employed and members of the public. They do not break the data down into those with trainee or apprenticeship status. Where age band is reported, these are usually for the age groups 16-34, 35-54 and 55+, making examination of the figures for young workers difficult. While there are some exceptions, the above appears to be the most common reporting practice.

We therefore suggest the LSC discusses with HSE the possibility of consistently including, within HSE reports, a further breakdown by apprenticeship/other worker and, if possible, by more fine-grained age groupings. Ideally the age groupings should be

4.3.2 Report rates not numbers

The LSC is starting to collate a data base of incidents and accidents (the Learner Incident Record). The Council has conducted some analyses of these data that show the main sources of incidents, in terms of providers, sectors, age groups, *etc.*. IES conducted some further analyses of this dataset, in particular comparing the figures against a base of numbers of learners registered in the WBL and FE sectors. These additional analyses indicated that the reporting rates are far more unbalanced (in terms of the reporting of incidents from FE compared to WBL) than were initially suspected by the LSC.

In addition, it is important to take base numbers of learners in each sector into account when considering numbers of incidents, deaths, *etc*. By using learner population figures it is possible to show that incident rates across sectors do not vary as much as might otherwise be suspected. The converse is also true for some sectors.

Therefore, we recommend that in any future reports from the LSC based on the learner incident record, the base numbers of learners, that is, number of learners in each age group and area of learning are used to contextualise the analyses and allow accurate comparison of rates between sectors, rather than raw numbers of incidents. This is important in order to gain a clearer view of the proportional frequencies of incidents in these groupings. We also recommend that a similar approach is taken when comparing incident rates across types of provider, region, etc. For similar reasons we suggest that the LSC makes efforts to ensure that learning framework (area of learning) is included in all reports of analyses in future.

4.3.3 Further investigation

Our analysis of the ILR for the work-based learning sector indicated that there were clusters of deaths involving learners in some sectors. These deaths may be unrelated to area of work or study, but the clustering suggests some further research would be worthwhile. IES was unable to make any further searches (*eg* of death certificates or coroners' reports) since the ILR we were working with was anonymised.

However, we suggest the LSC considers whether it would be worth some further investigation regarding the 18 deaths involving learners in the motor industry and 16 in engineering manufacture, to ascertain whether these were related to learning or occupational area. If they were related to work or learning in some way, then this would enable the LSC to identify the institutions that should have been responsible for reporting these fatalities. If found to be related to work or learning of course this would also provide additional evidence of under-reporting through the learner incident report system.

4.3.4 Improving data submitted to LSC

We have said throughout the report that caution needs to be exerted in interpreting many of the statistics. There are question marks over the accuracy of the Individual Learner Record. Nonetheless, the extent of some discrepancies between the WBL and FE ILR database suggest there are grounds for suspecting serious under-reporting in FE, as well as reinforcing the suspicion that the deaths involving work-based learners might not be entirely unrelated to their sector and occupation.

For three of the sectors for which high numbers of learner deaths were involved, it was possible to make a comparison between death rates reported by WBL and FE. The results showed that reporting rates for deaths involving learners across these three sectors were between 13 and 22 times higher in WBL than in FE. This is all the more extraordinary given that the FE data base includes much older learners than WBL (which has very few) and hence would be expected to have a higher incidence of 'natural' deaths.

We are not seeking to place any undue emphasis on the actual numbers of deaths, rather, we seek only to suggest that this comparison provides further support for the idea that, although there is generalised under-reporting of accidents, the majority of that under-reporting is attributable to non-reporting from the FE sector.

We therefore suggest that improving the reporting of incidents should become part of a wider, more general drive to improve reporting by institutions. We therefore suggest that the health and safety team consults more widely with colleagues within the LSC to consider how to ensure that funded organisations fully comply with reporting arrangements.

4.3.5 Link reporting mechanisms

One last suggestion follows on from the above point. Colleges are required to make an annual return on the ILR. We suggest the LSC considers whether to expand the reporting of details of accidents, illness and fatalities on this report. If completed on-line, it might be possible to set up an automatic link to the detailed set of incident reporting forms. While this would be less than ideal (meaning that some reports may come in up to a year late, with obvious consequences for follow-up, investigation, *etc.*) it would at least mean that a more comprehensive and therefore more revealing data set might be obtained in the longer term.

5. Survey of Providers

In early January a questionnaire survey of training providers and colleges was undertaken. The survey was anonymous and the aim was to gain information on extent of under-reporting of accidents and incidents and, where this had occurred, to explore the reasons for any non-reporting. In addition the survey also sought information on providers' beliefs regarding their obligations to report incidents to the LSC and other bodies, and examined the arrangements and channels for communication information on incidents and accidents.

Although the LSC is responsible for funding all post-16 education and training outside of higher education, it was decided that the emphasis for the survey would be on work-based learning, particularly apprenticeships and entry to employment (E2E).

5.1 Method

In this section we describe the means by which the survey sample was drawn up and the survey distributed.

5.1.1 Survey sample

A mail-out sample size of 500 training providers and colleges (hereafter referred to collectively as 'providers') was agreed with the LSC. A first step was to compile a mail-out contact list. This was achieved by working with the regional health and safety managers who requested health and safety co-ordinators in each of the local LSC offices in their region to forward contact details for providers in their locality. The emphasis was on those institutions providing work-based learning. For most of the institutions for which contact details were sent, the named contact provided was the health and safety manager.

Each questionnaire pack contained four questionnaires, with a cover letter to the central contact requesting that they complete one of the questionnaires and the additional three questionnaires be passed to other people working within the organisation. Since four questionnaires were mailed out to each provider, 2,000 questionnaires were distributed to providers in total. Details of the cover letter and instructions are given under 'Materials'.

5.1.2 Materials

Each pack sent out to a provider consisted of one central contact cover letter, questionnaire and pre-paid reply envelope plus three packs comprising a slightly different cover letter, the questionnaire and a pre-paid reply envelope.

Questionnaire

The questionnaire was designed for completion both by those in senior positions such as centre manager, health and safety manager or work-based learning co-ordinator, and also by tutors. The first section requested information on type of institution (college, training provider, group training association[1] or other) and the main role of the person responding. In the next section, respondents were asked about any responsibility they had in that role for reporting accidents and incidents. The questionnaire was printed in stapled booklet format on coloured paper. The questionnaire is appended at Appendix 3.

Cover letter

Two cover letters were drafted to be sent out with the questionnaire packs. The first letter was addressed to the main centre contact. It explained the purpose of the survey and, in addition, requested the main contact to further assist the survey by passing on the additional three enclosed questionnaire packs to colleagues. A letter was drafted to accompany the questionnaires passed on to colleagues, that explained the purpose of the survey.

The letters were co-badged with LSC and IES logos and were signed by Jill Joyce, National Health and Safety Advisor for the LSC. Both provider letters (central contact and other staff members) are shown in Appendix 4.

In addition, a reminder letter was drafted for mailing to all of the initial survey list three weeks after the initial mail-shot. This is also shown at Appendix 4.

[1] Group Training Associations (GTAs) were originally set up to help small and medium sized enterprises (SMEs) with their training needs and had strong links with the then Industry Training Boards. Initially GTAs typically involved small groups of member companies in the same industry and based in the same local area and were set up in response to difficulties in attracting and training young people. There are now between 150-170 GTAs in the UK, around half of which provide apprenticeship training in the engineering sector. The majority are limited liability companies, with around half of these also holding charitable status.

Procedure

Drawing up the mailing list

For the majority of the providers a central contact name was provided by the LSC officers. For some organisations however there was no contact name provided, and for these 'The Manager' was substituted in the name field prior to mail-merging. A few LSCs sent many contacts for one particular sector (for example, hairdressing) and where this was the case, some of these were randomly deleted to reduce sampling bias from one sector in one locality.

The mail-out

The questionnaire packs were mailed out in the week commencing 10 January 2005. Reminder letters were mailed out to all the original mailing list on the 27 January 2005. The reminder letter gave providers the option of contacting the researchers and requesting an electronic version of the questionnaire. Upon receipt of the reminder letter a large number of providers contacted the researchers to report they had not received the original mail-out, and the majority of these requested an electronic copy. Those who requested an electronic version were given the option of returning their questionnaire by email or by post.

5.2 Results

5.2.1 Response distribution profile

Four questionnaires were sent to each of the 500 provider institutions. In all, a total of 502 questionnaires were returned from 275 organisations, an institutional response rate of 55 per cent. Some 141 providers submitted single responses; 69 returned two responses; 38 returned three and 26 returned four questionnaires. One organisation sent in five questionnaires.

Table 5.1: Numbers of responses per responding organisation

Number of responses received per responding organisation	Frequency	Per cent
One	141	51.2
Two	69	25.1
Three	38	13.8
Four	26	9.5
Five	1	0.4
Total	**275**	**100**

Source: IES Survey of providers, 2005

Table 5.2: Numbers of responses from different types of provider organisation

Type of provider organisation	Number of organisations	Per cent	Number of responses	Per cent
College	55	20.0	108	21.5
Training Company	180	65.5	314	62.5
Group Training Association	14	5.1	30	5.9
Other	26	9.5	50	10.0
Total	275	100	502	100

Source: IES Survey of providers, 2005

Frequencies and percentage representation are shown in Table 5.1.

The majority of responses came from training companies, reflecting the skew towards work-based learning that was the main focus for the survey. This distribution is shown in Table 5.2.

Table 5.3 shows the distribution of the different types of respondent across the provider types. It should be noted that very few tutors responded from colleges. Mostly the questionnaires were completed by health and safety managers, managers and work-based learning co-ordinators.

It should be noted that some respondents did not complete all the questions. Therefore, in many cases, such as in Table 5.3, totals do not sum to the total number of respondents (502). In addition, where individuals occupied multiple roles (*eg* WBL co-ordinator and tutor) we have counted them once only, using their most senior role, in describing them within the respondent pool. This means that such an individual would have been counted only as a WBL co-ordinator in Table 5.3. However, in the reports of responses from tutors (made on a separate section of the questionnaire) such individuals' responses will have been included in the analyses. Therefore, the numbers of respondents reported in the sections dealing with tutor responses will have slightly higher numbers of responses than would be indicated on the basis of Table 5.3.

Table 5.3: Distribution of responses across roles and provider types

Respondent role	College	Training Company	Group Training Association	Other	Total
H & S Manager	33	89	9	11	142
WBL Co-ordinator	30	55	4	9	98
Manager	31	99	10	15	155
Tutor	7	44	2	4	57
Other	6	25	5	5	41
Total	107	312	30	44	493

Source: IES Survey of providers, 2005

5.2.2 Responsibility for reporting accidents and incidents

Reporting to the LSC, HSE and LA

Respondents were asked if they had responsibility for reporting accidents or incidents that occurred on training provider premises to the LSC, the HSE or to the local authority (LA). Responsibility for reporting to these bodies lay mostly with the health and safety manager, although the majority of managers and work-based learning co-ordinators also reported that they held this responsibility too. The proportions responsible for reporting incidents to the LSC, HSE and LA are shown in Table 5.4.

The majority (over 90 per cent) of health and safety managers said that responsibility for reporting incidents and accidents to the LSC and HSE was part of their role. Just over 60 per cent of managers and work-based learning co-ordinators were responsible for reporting incidents directly to the LSC. Just over one-third (37.5 per cent) of managers and just over one-quarter (26.8 per cent) of work-based learning co-ordinators said they had responsibility for reporting incidents directly to the HSE. A smaller proportion of health and safety managers said they had responsibility for reporting incidents to the local authority, just under three-quarters (73 per cent). Twenty-eight per cent of managers and just 17 per cent of work-based learning co-ordinators said they had responsibility for reporting to the local authority.

There was little variation in the proportions of respondents from the various types of training provider (college, WBL, GTA, *etc.*) who had responsibility for reporting to these external bodies. For reporting to the LSC between 62 and 74 per cent of respondents across the provider types reported having this responsibility,

Table 5.4: Responsibility for reporting to LSC, HSE or LA

	Health and Safety Manager	Manager	Work-based training co-ordinator	Tutor
Responsible for reporting incidents to LSC	135	95	61	10
Per cent	95.1	61.3	64.2	17.9
Base	*142*	*155*	*95*	*56*
Responsible for reporting incidents to HSE	120	48	19	6
Per cent	93.0	37.5	26.8	11.5
Base	*129*	*128*	*71*	*52*
Responsible for reporting incidents to Local Authority	81	32	11	6
Per cent	73.0	28.3	16.9	12.0
Base	*111*	*113*	*65*	*50*

Source: IES Survey of providers, 2005

Table 5.5: Distribution of responses across roles and provider types

	Incidents reported to:				
By:	**Department secretary**	**Course manager**	**Department manager**	**H&S manager**	**Other**
H & S Manager	1	1	5	4	2
WBL Co-ordinator	1	2	13	40	4
Manager	0	1	6	61	10
Tutor	1	3	14	34	5
Other	1	7	9	11	4
Total	*4*	*14*	*47*	*150*	*25*
Base	219	219	220	217	219

Source: IES Survey of providers, 2005

while for the HSE the figures were between 43 and 59 per cent. However, for reporting to the local authority, whereas over 40 per cent of respondents in training companies, GTAs and other types of non-college-based provider said they had responsibility for reporting incidents to the local authority, just 19.2 per cent of colleges said they did this. This may reflect the different nature of colleges and non-college-based trainers and the fact that many non-college-based trainers may be offering services to the public, such as hairdressing or catering. While educational establishments are required to report incidents to the HSE, organisations such as riding stables, hairdressers and caterers are required to report incidents to the local authority (HSE/HELA, 2005).

Internal reporting

Those who did not have responsibility for reporting to the LSC, HSE or Local Authority were asked if they were required to report any incidents involving learners that occurred on provider premises to another person within their organisation. The main people to whom these respondents said they reported accidents are shown in Table 5.5.

Table 5.6: How incidents are reported internally

	Incidents reported via:				
Respondent role:	**Accident report book**	**Accident report form**	**Telephone call**	**email**	**Other**
H & S Manager	23	32	21	17	5
WBL Co-ordinator	19	41	21	22	10
Manager	45	73	46	34	14
Tutor	29	28	20	7	17
Other	10	15	11	10	6
Total	*126*	*189*	*119*	*90*	*52*

Source: IES Survey of providers, 2005

The majority of incidents are reported to the health and safety manager. The next most frequently-reported route for reporting incidents was via the departmental manager.

Other individuals to whom incidents would be reported included the principal, the contracts, placement or quality manager, and the training manager.

Those who reported incidents internally were asked how incidents were reported. Responses are shown in Table 5.6.

The most frequently-reported means by which incidents are reported is via an accident report form, an accident reporting book or through a telephone call to the relevant individual. Other reporting methods included verbally reporting the incident face-to-face (32 reports), reporting incidents at discussions or in minutes (six reports), and, in three cases, via a website or intranet.

There were few differences in the proportions of respondents reporting use of these various means to report incidents across the different training provider categories.

5.3 RIDDOR-reportable incidents on training provider premises

Managers, work-based learning co-ordinators and health and safety managers were asked about the number of RIDDOR-reportable incidents/accidents involving apprentices or E2E learners (*ie* the two main groups of young work-based learners) that had occurred on the training providers' premises in the past year. In the analysis shown in Table 5.7, only one response per organisation has been used. Where multiple responses were gained from institutions, the response from the health and safety manager or other senior person has been used. Where different respondents reported different numbers of RIDDOR reportable incidents (*eg* two managers reporting four and five incidents respectively) then just one response, the highest, has been entered

Table 5.7: Number of RIDDOR-reportable incidents occurring on provider premises in previous year

Respondent role	0	1	2	3	4	5	6	7	10	15	44	Total
H & S Manager	92	16	10	10	2	3	0	1	0	1	0	135
WBL Co-ordinator	37	7	2	1	0	0	0	0	0	0	0	47
Manager	46	13	7	3	1	1	1	0	1	0	1	74
Tutor	7	0	0	0	0	0	0	0	0	0	0	7
Other	5	3	1	1	1	0	0	1	0	0	0	12
Total	187	39	20	15	4	4	1	2	1	1	1	275
Percentage of all reports	68.0	14.2	7.2	5.4	1.5	1.5	0.04	0.07	0.04	0.04	0.04	100

Source: IES Survey of providers, 2005

Table 5.8: Number of RIDDOR-reportable incidents occurring on provider premises in previous year, displayed by provider type

Provider type	0	1	2	3	4	5	6	7	10	15	44	Total
College	32	13	8	6	3	3	0	0	0	1	0	66
Per cent	*48.5*	*19.7*	*12.1*	*9.1*	*0.5*	*0.5*	–	–	–	*0.2*	–	
Training company	128	16	8	8	1	1	1	2	1	0	0	166
Per cent	*77.1*	*9.6*	*4.8*	*4.8*	*0.6*	*0.6*	*0.6*	1.2	*0.6*	–	–	
Group training association	8	4	2	0	0	0	0	0	0	0	0	14
Per cent	*57.1*	*28.6*	*14.4*	–	–	–	–	–	–	–	–	
Other	19	5	2	1	1	0	0	0	0	0	1	29
Per cent	*65.5*	*17.2*	*6.8*	*0.7*	*0.7*						*0.7*	
Total	187	38	20	15	5	4	1	2	1	1	1	275

Note that totals are not the same as for Table 7 as some respondents did not indicate either the type of institution in which they were employed.

Source: IES Survey of providers, 2005

into the analysis. We have not summed across responses because it is not possible to determine whether the respondents are referring to the same, or different, incidents. The table therefore represents a conservative picture of the likely distribution of RIDDOR-reportable incidents.

Table 5.8 shows the same data, this time reported by type of institution.

A total of 88 institutions reported that there had been one or more RIDDOR-reportable incidents at their premises in the previous year. Of these, four said that these had not been reported to the LSC and a further 3 said they did not know. All other respondents reported that all the RIDDOR-reportable incidents had been reported to the LSC.

Some 62 respondents said that these incidents had been reported to the HSE. Four however said they had not and 12 said they did not know whether or not these incidents had been reported to the HSE.

Respondents who said they were aware that some incidents had not been reported to the LSC or HSE were asked to give their estimate of the approximate number of incidents that had not been reported. Only a few gave estimates. These are shown in Table 5.9.

Focusing first on incidents not reported to the LSC, the survey returns indicated that four organisations had failed to report a total of seven RIDDOR-reportable incidents. This amounts to 4.5 per cent of institutions who had reported at least one incident.

Table 5.9: Numbers of RIDDOR-reportable incidents that were not reported to LSC or HSE

Not reported to	One incident	Two incidents	Three incidents	Total
LSC	2	1	1	4
HSE	2	1	-	3

Source: IES Survey of providers, 2005

The data reported in Tables 5.7, 5.8 and 5.9 represent the responses of people in senior health and safety and management roles in colleges and training companies and as such represent their overview of the situation. However, because many (and probably the majority) of these individuals may not be in hands-on teaching positions, it is possible they may not be aware of all incidents that occur if incidents are not being reported on within the organisation. Because of this, tutors were also asked a similar set of questions.

Tutors were first asked if they had personally witnessed any incidents involving learners in their own training or assessment sessions at the training/college premises. Out of a total of 74 individuals who responded to this section of the questionnaire, ten (13.5 per cent) confirmed that they had witnessed incidents. Those who had witnessed incidents were asked to estimate how many they had seen. More people replied to this question than the previous (13), suggesting that around 15 per cent of tutors had in fact witnessed incidents. The numbers reported by tutors are shown in Table 5.10.

Summing across the frequencies, the 10 tutors appear to have witnessed around 77 incidents involving learners. Of these, however, just six (7.8 per cent of incidents observed) were viewed as being potentially RIDDOR-reportable, and these had been observed by just three respondents (4.1 per cent of the sample of tutors). Respondents were then asked whether all of these potentially RIDDOR-reportable incidents had been reported internally. All three respondents reported that they had not.

5.3.1 Why RIDDOR-reportable incidents fail to be reported

Survey respondents were asked their views of the reasons why

Table 5.10: Numbers of incidents witnessed by tutors

Number of incidents witnessed	1	2	4	5	6	11	15	20	Total number
Number of tutors reporting	2	4	1	1	2	1	1	1	13
Total number of incidents (no. of incidents x no. of reports)	2	8	4	5	12	11	15	20	77

Source: IES Survey of providers, 2005

Table 5.11: Why are RIDDOR-reportable incidents on training provider premises not reported to the LSC?

Reason	H&S manager	WBL co-ordinator	Manager	Tutor	Other	Total
Learner does not report incident to relevant person until some time after event, does not seem worth reporting at that point	22	20	22	18	10	92
Incidents may appear less serious at the time	16	11	23	16	7	73
Not sure what needs to be reported	3	7	4	7	3	22
Oversight/forgetfulness	3	3	10	5	1	22
Pressure of work	5	4	7	5	1	22
Tutor may not report until some time after event, does not seem worth reporting at that point	6	7	5	N/A	3	21
Too much paperwork	5	2	6	5	–	18
Not sure to whom incidents need to be reported	4	3	1	5	2	15
Not sure how to report incidents	3	3	3	3	1	13
Concerns about receiving a warning/fine	2	4	3	2	1	12
Other reasons	5	–	4	1	1	11
Person whose job it is to report incidents was away at the time	3	–	2	4	–	9
Incident is the learner's own fault	1	2	–	4	1	8
No-one has particular responsibility for reporting incidents	2	–	4	1	–	7
Fear of other consequences	–	1	1	2	1	5

Note: these are abbreviations of the listed reasons. For full phrasing, please refer to the questionnaire appended at Appendix 2.

Source: IES Survey of providers, 2005

RIDDOR-reportable incidents on provider and employer premises fail to be reported. In the following sections the views of tutors, managers and health and safety managers are compared for both settings (training and employment).

On college/training organisation premises

All respondents were asked their views for why RIDDOR-reportable incidents on college/training organisations premises fail to be reported to the LSC. The views of the different respondent groups are shown in Table 5.11.

Two reasons stand out from Table 5.11 as the main causes of non-reporting identified by all groups of staff: the incident may appear less serious at the time and appear not to need reporting; and the learner does not report the incident until some time after it has happened, by which time it may not seem worth reporting. Most of the suggested reasons were endorsed by a scattering of respondents. In general, all reasons were endorsed by similar numbers of respondents in each group, although a higher

proportion of tutors (44 per cent) than senior managers (around one-third) said that incidents appearing to be less serious at the time.

The other main reason for non-reporting were that that employers did not inform providers of incidents that occurred on employer premises (although this is not strictly relevant given that the questions were asked in the context of incidents occurring on provider premises and is taken up in the later section on reporting on employer premises).

Reporting routes to external bodies

Amongst those institutions that returned multiple survey forms from individuals with different roles within the organisation, it was evident that in many cases several individuals within the same organisation had, or believed they had, responsibility for reporting directly to the LSC. This may not in itself indicate a problem, since different departments of a college might each have a nominated person with responsibility for reporting incidents. However, unless reports are centrally collated it will be difficult to gain an overview at an institutional level, and, within an organisation, across the various departments. We continue with this point in the next section, which continues with the theme of reporting routes and errors.

Faulty internal reporting

There were several indications of the way in which reporting may be disrupted.

In one case, returns were received from a manager (who was not responsible for directly reporting incidents to the LSC) and from the health and safety manager within the same organisation (who did). While the manager said there had been one RIDDOR-reportable incident, and also said that this had been reported to the LSC, the health and safety manager reported there had been none (and presumably therefore had reported nothing to the LSC). While this is only one case, nonetheless it suggests that inadequate internal communication of incidents to those with responsibility for reporting may mean that incidents remain unreported to the appropriate authorities.

In another organisation, two individuals who both described themselves as managers also both reported having direct responsibility for external reporting. While one said s/he was responsible for reporting to the LSC, HSE and LA, the other said s/he was responsible for reporting to the LSC and LA only. While one had reported two RIDDOR-reportable incidents to the LSC the other had had none to report. It may well be the case that both individuals were correctly reporting the particular situation within their own department or unit. Even were this to be the

case, they clearly had different ideas regarding to which external bodies they should report. Although we have noted that different types of organisation are required to report either to the HSE or to the local authority, there are only a limited number of situations that require different parts of a site to report to different investigating bodies. Given the nature of the roles of the individuals who replied to the questionnaire this is unlikely to have been the case for these providers.

There were several examples of this type of situation in which multiple responses from a single organisation indicated that different individuals believed they had responsibility for reporting and indicated they would report to different external bodies. In one such set of responses, the manager of a training company said s/he would report incidents to the LSC, HSE and local authority; the training manager said s/he would report to the LSC and HSE; while the health and safety manager, rather worryingly, said s/he would report to the LSC only.

Where there are separate and multiple reporting responsibilities and routes through to the LSC this leads to the possibility there may be less than adequate central internal collation of incidents. This makes it difficult for organisations to gain an overview of their performance in this regard and also make it difficult benchmark internally, *ie* identify any departments, subjects or units in which there are relatively high incident rates.

Lastly, one pair of responses indicated further confusion over organisational policy regarding the reporting of incidents. While one respondent replied that they reported non-RIDDOR-reportable incidents to the LSC, the other replied they did not.

Overall these constitute just a small number of cases. However, they illustrate that there is:

- evidence of RIDDOR-reportable incidents not being reported
- confusion over organisational reporting policy within provider institutions
- confusion and lack of consistency regarding the external bodies to which incidents on provider premises should be reported, and
- evidence that poor internal communication is impeding reporting to external bodies.

On employer premises

Work-based learning tutors were asked a set of questions concerning incidents that occur while learners are on employers' premises. First, they were asked whose responsibility it is to report incidents involving learners on employers premises. Of the 59 tutors who responded to this question, 21 said it was the

learner's employer/manager; ten said it was the assessor/tutor or WBL co-ordinator or similar; and 28 said it was the health and safety officer/manager.

However, very few had witnessed any incidents while on employer premises in the last year: just two individuals reported doing so out of 72 who replied to this question. Both said they had witnessed just one incident. Asked whether incidents on employers premises were reported to the LSC, HSE or Local Authority respondents said they believed they had been reported or they did not know.

A total of 31 tutors gave their opinions regarding the reasons why some RIDDOR-reportable incidents involving learners on employers premises are not reported. One additional reason was added to the set of possible reasons that was presented at Table 5.11 for the question regarding the employment setting: uncertainty over whose responsibility it is to report the incident. Response frequencies are given in Table 5.12. The responses from tutors regarding incidents on provider premises (previously reported as the fourth column in Table 5.11) are replicated in

Table 5.12: Why are RIDDOR-reportable incidents on employer premises not reported?

	On employer premises		On training provider premises	
Reason	**No.**	**Per cent**	**No.**	**Per cent**
Base	*31*		*36*	
Learner does not report incident to relevant person until some time after event, does not seem worth reporting at that point	20	*64.5*	18	*50.0*
Not sure what needs to be reported	15	*48.4*	7	*19.4*
Supervisor/manager may not report until some time after event, does not seem worth reporting at that point	14	*45.2*	N/A	N/A
Incidents may appear less serious at the time	13	*41.9*	16	*44.4*
Not sure to whom incidents need to be reported	12	*38.7*	5	*13.8*
Uncertainty over whose responsibility it is to report	11	*35.5*	N/A	N/A
Not sure how to report incidents	11	*35.5*	3	*8.3*
Too much paperwork	10	*32.3*	5	*13.8*
Pressure of work	9	*29.0*	5	*13.8*
Oversight/forgetfulness	7	*22.6*	5	*13.8*
Incident is the learner's own fault	7	*22.6*	4	*11.1*
Concerns about receiving a warning/fine	7	*22.6*	2	*5.0*
Person whose job it is to report incidents was away at the time	5	*16.1*	4	*11.1*
No-one has particular responsibility for reporting incidents	4	*12.9*	1	*2.8*
Fear of other consequences	3	*9.7*	2	*5.0*

Note: these are abbreviations of the listed reasons. For full phrasing, please refer to the questionnaire appended at Appendix 3.

Source: IES Survey of providers, 2005

Table 5.12 to allow comparison of their replies regarding incidents that occur in the training and employment settings.

More reasons were identified by tutors for non-reporting on employer premises than for non-reporting on training provider premises. Three reasons were believed by between two-thirds and two-fifths of tutors to contribute to non-reporting. In keeping with their views concerning the reasons for non-reporting on provider premises, tutors believed that delays in the reporting of incidents by the learners themselves was a major reason for non reporting of incidents that occurred on employer premises. Two-thirds of them felt this to be a reason for non-reporting from employer premises compared with 50 per cent who thought this contributed to non-reporting on provider premises. The next most frequently-endorsed reason was uncertainty over what needs to be reported, with nearly half of responding tutors endorsing this (48.4 per cent), while 45.2 per cent believed that supervisors or managers failing to report an incident to them until some time after the event (by which time it may not seem reporting) was a reason for non-reporting of incidents occurring on employer premises.

Following on from these three leading perceived causes of non-reporting at work were three others which around a third of responding tutors felt were likely contributory reasons for non-reporting of incidents. One was uncertainly regarding to whom incidents should be reported (38.7 per cent); the next was uncertainty over whose responsibility it is to report the incident, (35.5 per cent) and too much paperwork was also felt to be a factor by just under one-third.

5.4 Communications between employers and trainers

In the previous section, tutors identified delays in being informed by supervisors or managers of learners as a major factor that leads to the non-reporting of incidents. In the final section of the questionnaire we sought further information on the nature of communications between employers and providers. The information gained tends to support the claims of tutors regarding the dilatoriness of employers in providing information to trainers regarding learner accidents or ill-health.

5.4.1 Contact and notification of absence

Providers were asked if they had a named contact at the learner's place of employment who acted as a main contact for any communications regarding learners. Just five reported they did not; two colleges and three training companies.

The majority, but not all, respondents said they expected a learner's employer to contact them if the learner was likely to be absent through ill-health or accident. Just under five per cent of colleges

Table 5.13: Do employers notify training providers of absence?

	No, never	Only if learner is absent for a significant length of time	Mostly they do not notify us	Mostly they do notify us	Yes, always
College	4	6	17	64	8
Training company	11	10	60	175	10
Group Training Association	1	1	6	18	1
Other	1	3	2	16	3
Total	*17*	*20*	*85*	*273*	*20*

Source: IES Survey of providers, 2005

did not expect to be contacted, along with 6.8 per cent of training companies and 13.3 per cent of group training associations. Those who reported that they did not expect to be contacted may have been responding on the basis of experience: over one-fifth of respondents (102) reported that employers never, or mostly did not, contact them when learners were likely to be absent through ill health or accident (see Table 5.13). A further 20 organisations reported only being contacted in the event of long-term absence.

Those who said that employers would report learner absence only if they were likely to be absent for a 'significant length of time' were asked at roughly what point the employer would contact them. Two respondents said this would happen after two or three days, while six said after seven or eight days. A further two said after ten or 14 days. Three providers reported that employers typically contacted them after three weeks' absence. There were individual accounts though of some employers not contacting training providers until, variously, 28, 42 and 60 days.

5.4.2 Provider response to learner absence

While it may be the case that some employers are lax in reporting learner absence, it might be expected that providers would keep note of any learner absences (particularly any protracted absence) and take action to find out the reason for absence. Therefore providers were asked what actions would be taken if a learner was absent from a teaching session at the college or training company. Only four respondents (two from colleges and two from training

Table 5.14: Provider actions in response to learner absence

	College	Training company	Group training association	Other	Total
No action	2	2	–	–	4
Learner would be contacted	65	228	18	25	336
Employer would be contacted	48	155	14	20	237
Other	6	17	6	4	33

Source: IES Survey of providers, 2005

Table 5.15: Responsibility for contacting absent learners

	College	Training Company	Group Training Association	Other	Total
Tutor/assessor	44	173	11	24	252
Course administrator	15	37	9	5	66
Course co-ordinator	13	34	2	5	54
Other	28	66	8	5	107

Source: IES Survey of providers, 2005

companies) said that they would take no action (Table 5.14).

Contacting the learner was the course of action most often cited by providers. They were asked who was the person who would be responsible for contacting the learner. Table 5.15 shows provider responses to this question.

Other individuals identified by respondents as having responsibility for contacting learners included monitoring, attendance or retention officers for which there were eight reports of this role having the responsibility for contacting absent learners. All but one of these were employed in colleges. In training companies, a central administrative office or the company manager was often the person who would contact the absent learner. Fourteen colleges and eight training companies said that the training or work-based learning co-ordinator would do this.

The very great majority of respondents (85 per cent) said that they would contact a learner after just one missed session. Just over seven per cent said they would make contact after two or three sessions had been missed, and just three said they would do so after a month. Nine organisations said that they contacted absent learners on the day of absence. Three of these were colleges, four were training companies, one was a group training association and one fell into the 'other' category.

Over 81 per cent of respondents said that this contact always happened. Just 6.5 per cent of respondents said this was not the case. Thirty-nine individuals (7.1 per cent) said they did not know if this was the case or not. The individuals who reported that they did not always contact absent learners gave estimates that this was the case for between one to 75 per cent of cases. Providers were asked their views on the main reasons for any failure to contact the learner. Their responses are shown in Table 5.16.

Table 5.16 shows that pressure of work and no answer from the learner contact number are the two main reasons cited by providers in both companies and colleges for failing to make contact with absent learners.

5.5 Other observations and comments

Providers were invited to make any other observations or comments regarding the reporting of accidents and incidents involving learners. Many of the comments made under this section reinforced the issues that emerged from the literature review and the interviews with regional managers as well as serving to illustrate the patterns of response that had emerged from the more quantitative sections of the questionnaire.

Responsibility for health and safety and reporting

Some providers were confused and, it is probably fair to say, irritated, by the reporting responsibilities of providers relating to learners in the workplace.

> *'I deal solely with employed status construction trades apprentices therefore health and safety of the apprentice at work is the responsibility of the apprentice's employer. However it appears that some responsibility rests with us as the training provider but how can I be responsible for the health and safety of apprentices when they move from site to site on a daily basis. Despite several attempts I have yet to receive any answer to my questions to the LSC or HSE as to how I can monitor an apprentice's health and safety and why I should be held to account when I have no control over the health and safety on site.'*

> *'For employed learners, the responsibility for their health and safety at the employer's premises must be with the employer. There is an increasing and disturbing shift towards putting the onus on the training provider to advise and risk assess the employer on health and safety.'*

> *'I feel that more training and national advertising should be carried out regarding the management of learner health and safety. More controls should be in place for employers and not left for providers to deal with HSE matters.'*

Table 5.16: Reasons for failing to contact absent learners

	No policy on contacting absent learners	Pressure of work	No telephone contact details given for learner	No answer from learner contact number	Other
College	5	7	1	10	3
Training company	3	16	1	18	8
Group Training Association	2	2	1	3	1
Other	1	1	0	1	1
Total	11	26	3	32	13

Source: IES Survey of providers, 2005

The LSC requires providers to assess the safety of the workplace to ensure that the learner is in a healthy and safe environment. Failure by the provider to fully appraise the safety of the work setting was one contributory factor identified by the judge in the recent Anchor Garage case which received national coverage in the press while this research was ongoing[1]. Aside from this, providers felt there was need for more guidance regarding responsibility for reporting accidents that occur on employer premises:

> *'I feel there may be some anomalies concerning the severity of any accidents and [confusion regarding] whether they should be reported or not on behalf of employers.'*

Lack of understanding of responsibilities by employers

Many providers felt that employers did not understand their responsibilities, either in terms of health and safety in general or in terms of reporting. There was a suspicion therefore that many incidents were not being reported, despite systems being in place and/or communication between employer and provider being generally good. This would lead to the LSC not hearing of some incidents. Some, but by no means all, of the comments received in this vein are reported below:

> *'General lack of knowledge in SMEs of health and safety. As a provider we do support and advise where we can. More training required on reporting "near misses", [this] could be encouraged.'*
>
> *'Work providers are always asked to report accidents, both by employer liaison visits and regular newsletters. Very rarely do we receive any notification.'*
>
> *'Managers in the workplace are not sure what RIDDOR is.'*
>
> *'I find one of the main reasons that accidents in the workplace are not reported [is that] small employers (less than ten employees) … are not fully aware of their responsibilities under RIDDOR. In some cases these employers regard health and safety as only applying to larger companies.'*
>
> *'Employers do not know their responsibilities despite us giving them information. A really high-profile advertising campaign needs to happen to spell out employer's responsibilities for health and safety. We visit new employers who have no idea of their responsibilities – no accident book, no first aid, no emergency evacuation signs* etc.*'*
>
> *'As a general rule, employers haven't got the health and safety knowledge they need and aren't visited by HSE or local officials to*

---

[1] See, for example:

http://www.aoc.co.uk/aoc/Members/health_safety/health_safety_06_05

http://www.workplacelaw.net/display.php?resource_id=5552

http://www.theargus.co.uk/the_argus/archive/2005/03/12/NEWS30ZM.html

http://www.safetynews.co.uk/we200305/Manger%20receives%20custodial%20sentence%20for%20manslaugter%20of%20employee.htm

check on this. This lack of knowledge means that learners aren't given the correct training or advice when it comes to the procedure for reporting accidents.'

'Employers in small business often fail to report accidents/incidents to us. This is usually down to workload and lack of importance placed on reporting.'

Majority of employers when dealing with accidents forget to inform the 'training provider or college even though they have reported through their own chain of command/RIDDOR/accident book.'

'Non-RIDDOR reportable incidents are not reported to the training provider in many cases. Employers are often reluctant to do this as they fear repercussions on their business.'

'Contracted employers are informed of RIDDOR but do not always recognise accident or report to us.'

'Employers do not notify us or log the incident.'

In addition to these general issues to do with employers not understanding or not fulfilling their responsibilities with regard to reporting, there can be difficulties for providers whose learners work for organisations carrying out sub-contracted work. This can mean that the apprentice will be constantly moving around various work sites. This brings additional problems for the provider in attempting to monitor health and safety:

'Small employers contracted to diverse sites are difficult to monitor and evaluate consistently.'

Learners

Where employers do not report incidents, it would be hoped that providers would obtain this information from the learner. Many of the providers indicated that they would only hear about incidents when they next visited the learner and conducted a review. Many of these comments echo issues that had emerged from the literature review.

'We have to rely on the candidates reporting the accident as soon as it happens, this sometimes does not happen and does not become apparent until the next review. [Care] home managers seldom think about informing us.'

'Employed learners never report accidents to the training company until they have their review when they tell us, despite being told to tell us ASAP at induction.'

'Work-based learners with SMEs tend not to report accidents and is only on visits that it comes to light. This is often too late to investigate. Few SMEs report accidents to HSE.'

'We had one case of a learner who broke his arm whilst unloading a truck. In this case neither the employer nor learner notified us until some five months after the event. We still followed LSC procedures and were commended by the LSC in question about our professional handling of the matter. Recently we have designed a sticker to be adhered to learner employer's accident books that reminds employers to

notify us should any of their staff on a WBL programme with us is involved in an accident or incident.'

'Learners don't report minor incidents because they don't see the importance.'

One response in particular served to illustrate the points made in the literature review concerning learners feeling pressurised to undertake work without taking proper account of health and safety issues, and, where an incident occurs, feeling they should carry on without reporting it for fear of embarrassment or fear of consequences:

'Learners need help to become assertive enough to refuse to do a task for an employer if they feel that it is unsafe – they often come under a lot of pressure to do the jobs other workers do not want, without a safe system of work. They also need to be encouraged to report accidents as they can carry on for a while, limping, and only when asked why they are limping does the story come out. This is usually due to misplaced bravado, not wanting to look soft, wanting to prove they can do something and not let anyone know they have either done something that they are not supposed to do or have not worn PPE etc.*'*

College systems/staff

Some providers felt that staff did not understand reporting requirements or indeed what might be viewed as a minor incident. Others pointed to problems with their own internal reporting system that meant information might be lost:

'Poor understanding of RIDDOR requirements by staff (hence I do not get informed and no feedback).'

'Our organisation requires us to send details of accidents on an internal accident form. They then in time complete RIDDOR form. Since the base is in NE England and HO in London this logistic excess seems to get in the way of reporting incidents.'

'How minor are accidents and incidents that need to be reported?'

LSC systems and support

Several providers took the opportunity to comment on the LSCs own reporting procedures and requirements. In general, these were fairly evenly split between those who had encountered difficulties and those who were happy with the system and felt it had improved in recent years:

'LSC forms are easy to complete and are very comprehensive in coverage.'

'I can understand why some people are reluctant to report accidents/incidents as the amount of paperwork generated is excessive.'

'The paper work has slimmed down over the years but some times you do end up repeating yourself if the employer does not complete the F2508.'

'LIMS process is easy to follow in principle. If any doubt occurs regarding accidents to be reported I contact the LSC for advice, to ensure I do not fail to report an accident. '

'The session delivered on LIM was very beneficial and explained in non-jargon terms the reporting procedures. These should be reinforced to assessors at least annually to ensure complete understanding.'

Some pointed to areas where further clarification would be beneficial:

'On the introduction of the LSC, no information was available regarding accident reporting. On one occasion when we reported an accident there was no follow-up from the LSC. Only recently has this become an issue again for the LSC although their safe learner website I find confusing and not particularly user friendly.'

'Clearer information and explanation for completing LSC accident investigation form would help.'

'Some feedback from the LSC would be useful.'

Some however felt there was duplication of effort in the reporting system that was viewed as unnecessary bureaucracy: While providers understood the need for reporting, some were frustrated by the need to report to multiple external bodies. They felt there was scope for reporting to be streamlined:

'Often there are too many authorities to report to. It should be simpler to report to main funding body who will then pass on the information to relevant authorities ie HSE, local authorities etc.*'*

'It would be useful for the LIR to contain information from the F2508 so that a duplicate F2508/copy of the F2508 has to be submitted, as a copy of the F2508 cannot be submitted electronically, usually.'

'Two reporting systems, one to HSE and two, to LSC seems bureaucratic. 2. AIMS package real software problems. 3. When to report and when not to report is confusing due to many ifs and buts. 4. Constant debate around network of H & S Managers and it is because RIDDOR is confusing! If the people who know are confused then how will this affect the rest of the organisation around reporting?'

Some providers made suggestions for further training, information and clarification that would be appreciated:

'One-half day course on "how" to report accidents and to "whom"; what paperwork needs to be completed would be ideal session. Each provider should have a nominated H&S Advisor to refer to.'

'We would appreciate more practical information on types of injuries which can occur at work and which ones should be reported. Also more widespread publicity about what RIDDOR does, why it is important to report incidents and the benefit this offers to society as a whole.'

'We would appreciate more practical information on types of injuries which can occur at work and which ones should be reported. Also more widespread publicity about RIDDOR, why it is important to report incidents and the benefit this offers to society as a whole.'

In some cases, providers made suggestions for facilities that in fact already exist (*eg* the option of emailing in reporting forms) which suggest, as the second comment here indicates, that the LSC still has a considerable way to go in making providers aware of the available systems and options:

> *'Forms should be available on computer – electronic copy to speed up the process of reporting.'*
>
> *'Systems need to be more well known.'*

Bureaucracy

Some felt that the current regulations could be reviewed. In keeping with the views of the LSC, providers felt there was a need for clarification from the HSE. In addition they wanted to see the general volume of paperwork reduced:

> *'The "three day" rule involves us in a huge amount of work for often trivial accidents. This does have the effect of devaluing the exercise although I understand how important it is to prevent more serious occurrences. Also employers don't like having to go through our bureaucratic processes when they have already done an HSE F2508.'*
>
> *'Learners are treated as members of the public as far as RIDDOR. If we send them to hospital purely as a precaution this means that we should report it under RIDDOR, even if the hospital discharges them almost immediately. The HSE are not interested in these types of incidents being reported and I can see why. I would suggest that as far as the RIDDOR regulations only are concerned learners are classed as employees, which would remove this burden.'*
>
> *'Reduce the paperwork.'*

Less priority for health and safety and less local contact?

While one respondent had referred to the existence of a good relationship between themselves and the LSC's regional health and safety manager, one said the opposite.

> *'I have had an extremely good working relationship with the local [LSC] for the past 15 years, this encouraged the reporting of accidents and incidents and proved very successful. Now however, we do not have that "local" contact and cannot put a face to a name when reporting. I will when necessary report such incidents but without the same enthusiasm I once had. For a system to work successfully I believe closer contact is needed by all parties.'*

Unfortunately it is not possible to ascertain whether their response came from one of the areas in which RMs suspected that the health and safety co-ordinators were not visiting providers.

5.6 Summary

The outcomes of the survey are discussed in full in chapter 7. However, it is worth briefly noting here that the quantitative

outcomes of the provider survey and the provider's comments served as illustrations of the outcomes of the literature review and interviews. There was evidence that observations of incidents were not communicated internally and those who had responsibility for reporting to external bodies were not aware of all incidents that had occurred. The major concern expressed by providers, in keeping with the findings of the literature review, was that they were not informed of incidents by employers or learners. In the next chapter we report the findings of the parallel survey of employers.

6. Survey of Employers

In parallel with the questionnaire survey of training providers a postal survey was conducted of employers who employed, or offered work placements, to learners. The emphasis therefore, was primarily on employers who employed apprentices and offered entry to employment (E2E) placements. As with the provider survey, the employer survey was anonymous and the aim was to gain information from the employer's perspective on the extent of any under-reporting of accidents and incidents and, where this had occurred, to explore the reasons for any non-reporting.

In addition the survey also sought information on employers' beliefs regarding their obligations to report incidents, their health and safety policies and arrangements for the reporting of accidents at work, and examined the arrangements and channels for communicating information between employer and provider on incidents and accidents.

6.1 Method

In this section we outline the way in which the survey sample was generated, the development of the survey questionnaire and the mail-out procedure.

6.1.1 Survey sample

A mail-out sample size of 1,000 employers was agreed with the LSC. A first step was to compile a survey sample mail-out list. This was achieved by working with the LSC regional health and safety managers who asked local LSC health and safety co-ordinators in their region to request contact details from providers for a sample of employers who offered apprenticeships or E2E training. For most of the employer organisations for which contact details were obtained the named contact was a senior manager.

6.1.2 Materials

Each employer was sent a cover letter, questionnaire and pre-paid reply envelope.

Questionnaire

The questionnaire was designed for completion by the central contact identified by the provider. Typically this was someone in a senior position such as managing director, HR manager, training manager, line manager or similar. The first section requested information on the organisation, its training arrangements and the main role of the person responding. In the next section, respondents were asked about the learners they currently employed or had on placement, and the training arrangements for apprentices. This was followed by sections that asked about any accidents or dangerous occurrences that had occurred to their employees while on training provider and/or employer premise and the notification procedures following any incident. The final section of the questionnaire requested information on health and safety policies and the reporting of incidents at work. The questionnaire was printed in stapled booklet format on coloured paper. The questionnaire is appended at Appendix 3.

Cover letter

A cover letter was drafted to be sent out with the questionnaire packs. The letter was co-badged with LSC and IES logos and explained the purpose of the survey. As with the provider letters, the cover letter was signed by Jill Joyce, National Health and Safety Advisor for the LSC. The letter is shown in Appendix 4.

In addition, a reminder letter was drafted for mailing to all of the initial survey list three weeks after the initial mail-shot. This is also shown at Appendix 4.

6.1.3 Procedure

As with the provider survey, the questionnaire packs were mailed out in the week commencing 10 January 2005. Reminder letters were mailed out to all the original mailing list on the 27 January 2005. The reminder letter gave employers the option of contacting the researchers and requesting an electronic version of the questionnaire. In keeping with the response to the reminder letter to providers, receipt of the reminder letter prompted a large number of employers to contact the researchers to report they had not received the original mailing, and many subsequently requested an electronic copy. Those who requested an electronic version were given the option of returning their questionnaire by email or by post.

6.2 Results

6.2.1 Response distribution profile

In all, a total of 186 questionnaires were returned. from the mail-out to 1,000 organisations, a response rate of 18.6 per cent. However, three gave no information on size of their organisation which means their data is omitted from several of the reports that follow. In general, a good distribution across sectors and size of organisation was obtained, although only small numbers of responses were received from the recreation and travel, finance and agriculture sectors. Frequencies and percentage representation by sector and size of organisation are shown in Table 6.1.

The sectors from which the largest proportions of responses came were construction, health care, engineering and manufacturing, that are all sectors in which there is widespread emphasis on work-based learning that was the main focus for the survey.

Respondent role

Individuals who completed the questionnaire held a variety of roles. Table 6.2 shows the main role or job title of respondents. Over 40 per cent of questionnaire respondents indicated a job title other than HR manager, personnel manager, MD, *etc*. In the main these tended to be jobs such as contracts manager, office manager, operations manager, training co-ordinator, *etc*.

Of these respondents, a majority (104 or 55.9 per cent) were involved in directly supervising apprentices or E2E learners.

Table 6.1: Numbers and types of responding organisation

	Sector												
Size of organisation	**Admin/ prof**	**Agriculture**	**Construction**	**Customer service**	**Engineering**	**Finance**	**Health & beauty**	**Health care & public service**	**Hospitality**	**Manufacturing**	**Recreation & travel**	**Transportation**	**Total**
Up to 50 employees	6	5	22	6	7	1	11	20	5	8	2	1	96
51-250	2	0	10	1	6	0	2	5	2	7	0	3	39
251-500	2	0	2	0	6	0	1	1	0	1	1	0	15
More than 500	2	0	4	2	8	1	0	9	0	4	0	2	33
Total	*12*	*5*	*38*	*9*	*27*	*2*	*14*	*35*	*7*	*20*	*3*	*6*	*183*
Sector as percentage of all reports	6.6	2.7	20.8	4.9	14.8	1.1	7.7	19.1	3.8	10.9	1.6	3.3	100

Source: IES survey of employers, 2005

Table 6.2: Distribution of responses across roles and organisational size

Completed by:	HR manager	Personnel manager	Training manager	MD	Line manager	Supervisor	Other	Total
organisation size								
Up to 50 employees	5	5	1	22	9	4	50	96
51 – 250	6	2	5	4	6	4	12	39
251 – 500	2	0	3	0	2	1	7	15
More than 500	3	0	14	0	1	4	11	33
Total	*16*	*7*	*23*	*26*	*18*	*13*	*80*	*183*
Per cent	8.7	3.8	12.6	14.2	9.8	7.1	43.7	100

Source: IES survey of employers, 2005

Learners employed or on placement

The organisations that responded currently employed between one and 3,000 apprentices. All responding organisations employed at least one apprentice. Fewer organisations offered placements to E2E learners, although this is perhaps not surprising given that this is not such an extensive or well-established programme as apprenticeship. Table 6.3 shows the numbers of organisations that reported employing or offering E2E placements and the range of numbers of places offered.

Employers reported that the majority of their apprentices or learners on placement were registered with a college of further education (93, equivalent to 50 per cent of responses to this question). Nearly 20 per cent of employers reported that their learners were registered with a private training provider, and 8.1 per cent reported their learners were registered either with a group training association or that they trained their learners in-house. Other responses largely indicated the use of either chambers of commerce or joint training arrangements with, for example, a college together with a group training provider.

The majority, but not all (80.1 per cent), had a named contact at the training provider organisation. For most of these (122, 83.6 per cent of those that had a named contact), the named contact person was the learner's tutor or assessor. While one-quarter reported that they had been in contact with this person just a few times in the past year (two to four times), a further ten per cent reported having been in touch at roughly monthly intervals. The main reason cited by employers for this contact was to monitor and discuss progress.

6.2.2 Accidents involving apprentices while at the training provider premises

Out of the total number of 186 replies to the survey, ten reported that an apprentice had had an accident while at the training

Table 6.3: Range of numbers of apprentices and E2E learners at responding organisations

Sector	Admin. /prof.	Agri-culture	Con-struction	Customer service	Engineer -ing.	Finance	Health & beauty	Health care & public service	Hospitality	Manuf.	Recreation & travel	Transpor–tation
Apprentices												
Range of no. of apprentices in orgn.	1-250	1–4	1-32	1-250	1–3,000	1	1-22	1-225	1-250	1-81	1-3	3-30
No. of employers employing apprentices in this sector	26	5	35	12	41	1	12	23	7	15	4	3
E2E												
Range of no. of E2E placements in orgn.	1-3	1-2	1-2	1	1-9	–	3	2-3	1-12	4	–	1
No. of employers offering E2E placements in this sector	4	2	2	1	5	–	1	3	2	1	1	1
Sector as percentage of all reports	6.6	2.7	20.8	4.9	14.8	1.1	7.7	19.1	3.8	10.9	1.6	3.3

Source: IES survey of employers, 2005

Table 6.4: Actions taken and responsibility for taking action if apprentice has an accident

	What would happen if an apprentice has an accident at your premises that meant …		
	… they could not attend their next scheduled training session at the training provider's premises?	**… they could not see their tutor/ assessor on their next scheduled visit to your site?**	**… the apprentice was likely to be absent for some time so that they could not attend training/see their tutor/assessor for several weeks**
Action taken			
No action	2	2	–
Per cent	1.1	0.5	–
I/their supervisor would expect the apprentice to contact the training provider to let them know	52	30	29
Per cent	28.0	16.1	15.6
I/their supervisor would contact the training provider	104	124	123
Per cent	55.9	66.7	66.1
I would expect the other apprentices to inform tutor s/he was absent	1	3	3
Per cent	0.5	1.6	1.6
I would expect the apprentice to explain what had happened next time s/he saw their tutor	–	3	4
Per cent	–	1.6	2.2
Multiple response/other	4	3	4
Per cent	2.2	1.6	2.2
Base	*163*	*161*	*162*

provider premises in the past. Four incidents had taken place at FE colleges, three at group training associations, and two at private training companies. It should be noted that, although the majority of apprentices are registered with work-based learning providers, the largest number of incidents was reported at FE colleges followed by group training associations.

Five respondents indicated following the accident that the training provider had contacted the employer to let them know what had happened. A further three reported that the apprentice themselves had told the employer what had happened. The remaining two indicated that the injury had been minor. Respondents were asked whether, as far as the employer knew, anybody else was contacted by the training provider. One reported that the HSE had been contacted and two reported that the apprentice's family had been contacted. Another said that the apprentice's GP had been contacted. None mentioned that the incident had been reported to the LSC.

6.2.3 Accidents involving apprentices while at the employer's premises

Employers were asked three questions relating to what would happen if an apprentice had an accident on their premises that meant they would miss one or more training or assessment sessions. Table 6.4 shows their responses to these questions. The majority, but not all, employers indicated that they would contact or inform the provider. Many however expected the apprentice themselves to inform the provider of the situation. Some 15.6 per cent of employers expected the apprentice to inform the provider, even where their accident was likely to lead to long-term absence. One provider said (in response to the question regarding accident leading to absence for one session) that they would expect the provider to contact them as to why the learner was absent. A few respondents –- around two or three responses for each of these questions –- indicated that they would both contact the provider themselves and expect the apprentice to notify the provider, or would notify themselves but also expect the other apprentices to let the provider know about the situation.

The set of scenarios presented in these questions proposed a gradually worsening situation. In the first question the suggested implication was an inability to attend one training session at the college/training provider. Given that attendance at college is usually, although not always, on a weekly basis, this implies a time lapse of a week at most. In the second question, the situation is one in which a tutor/assessor visiting the organisation is unable to see the learner. Given that the LSC requires tutor visits to be at least every 12 weeks, this implies that the absence may well be for longer than a week. In the third of this set of questions the implication is that there is long-term absence arising from an accident. In fact, each of these situations potentially would be RIDDOR-reportable, given that each implies absence of a week or more (*ie* more than the three days absence or change of activity that should prompt a report under RIDDOR

Table 6.5: Actions following discontinuation of an apprenticeship

	Who usually has responsibility for contacting?			
	HR manager, personnel manager, training manager, supervisor etc.	No nominated personnel	The apprentice	To
Organisation contacted				
The training provider	143	3	14	16
The LSC	8	–	1	9
The HSE	63	2	2	6

Source: IES survey of employers, 2005

requirements). Despite this, under the 'other' response option, just one employer commented at this point that they would contact the HSE.

Following this set of questions, respondents were asked whether, in the event of an accident that led to apprentice not being able to continue with their apprenticeship for some time, their organisation would contact anyone. The response options were the training provider, the LSC the HSE and 'other'. responses are shown in Table 6.5.

The majority of respondents (160) said they would contact the training provider. Technically, the only responsibility they would have in the context of the discontinued apprenticeship relates to the courtesy of informing the provider. The provider should then inform the LSC. While the majority of employers said that they would inform the training provider, 14 expected the apprentice to do this. Given that the scenario was one of long-term absence, which might imply some difficulty for the injured individual in making contact with external organisations, this seems somewhat cavalier.

The answers in relation to the HSE are difficult to interpret. Technically, in the specific context of a discontinued apprenticeship, there is no need to inform the HSE of this fact. However, presumably respondents who said they would contact the HSE are responding to the presumption of this being a serious accident at work, which would require reporting under RIDDOR. Therefore it is encouraging that 67 employers said that they would contact the HSE. However, in response to a question regarding whose responsibility it would be to report the incident to the HSE, two respondents said they believed it would be the responsibility of *the apprentice* to notify the HSE.

Taken together these responses suggest there is some general confusion about the reporting requirements following an accident involving an apprentice. Amongst the 'other' responses obtained in response to this question were the comments that the discontinuation of the apprenticeship would be reported to 'the body that governs the NVQ system'. Again, this seems to indicate some confusion over the exact nature of employers' reporting responsibilities.

6.2.4 Health and safety policies and the reporting of accidents at work

The above indicates some confusion regarding the requirements for reporting incidents at work that subsequently would lead to apprentices missing training sessions or interrupting an apprenticeship. The next section asked specifically about health and safety policies and the reporting of accidents at work.

Health and safety policies

The great majority of respondents (182) reported that their organisation did have a health and safety policy. Just three said they did not. It is a legal requirement for organisations employing more than five people to have a health and safety policy. The three organisations that did not have health and safety policies had indicated that they had up to 50 employees, so it is not possible to tell whether they had more than five employees, although this would seem likely given that they were sufficiently large to have taken on apprentices. Two of the three were construction companies, one was in engineering.

The areas covered by organisations' health and safety policies in respondent organisations are shown in Table 6.6.

Accidents, injuries, reportable diseases, incidents (slips and trips) and RIDDOR-reportable injuries were covered by the majority of policies. Illness was the topic that was least likely to be covered, but even for this some 61.8 per cent of respondents indicated it was included. Of the 182 organisations that had a health and safety policy, 179 (98.4 per cent) said that it contained a section covering incident reporting. Fewer though, 85.2 per cent, said there was a section dealing with RIDDOR-reportable incidents.

In addition, 180 respondents (97.8 per cent of all respondents) said that supervisors, managers, apprentices and other learners were made aware of the requirements for the reporting of accidents, incidents and illness. Two respondents however said this did not happen, and two did not know, which implies either that it does not or that the policy is not very well communicated to employees.

Respondents were asked how the requirements for accident reporting were brought to the attention of managers, supervisors and

Table 6.6: Health and safety policy content and coverage

	Incident reporting	Illness	Reportable diseases	Injuries	Incidents (slips and trips)	Dangerous occurrences	Accidents	RIDD report injur
Coverage	179	112	130	172	159	156	176	15
Per cent (Base = 182)	98.4	51.5	71.4	94.5	87.4	85.7	96.7	85.

Source: IES survey of employers, 2005

apprentices. Many respondents indicated they used a mixture of methods. The most frequently-cited means was requiring supervisors to tell learners about the policy. More than half of respondents said that the HR manager would include this in a briefing on health and safety for new employees. However, clearly there is leeway for this either not to happen, or for apprentices to forget. Therefore, many respondents (57 per cent) said that apprentices and other new employees were required to sign a form to say they had read and understood the policy.

Twenty respondents indicated other ways in which individuals were made aware of reporting requirements. A variety of different approaches were described, which included one organisation that included two copies of accident report forms being provided with the induction pack; another organisation in which 12 week reviews also covered health and safety; and health and safety being included in induction as individuals moved into each new area of work. One respondent indicated that, in addition to reporting accidents, employees were asked to report 'near misses' as well.

Use of data on accidents

Although the great majority of respondents reported having a health and safety policy that included incident reporting, fewer (59.1 per cent) could identify ways in which the information recorded was used. Uses are shown in Table 6.7.

In addition to asking about the use of data from incident reports, respondents were asked whether anything happened following report of an incident. Out of the 176 individuals that responded to this question, 161 (91.0 per cent) indicated that some action would follow the reporting of an incident. Table 6.8 indicates the main actions that

Table 6.7: Use of incident data

Report to Board meetings
Prevention/trying to ensure same thing does not happen again
Analysed at Health and Safety meeting
Benchmarking exercise
Risk assessment
When submitting pre-qualification questionnaires for tender submissions.
COSHH assessments.
Inform LEA
To produce Key Performance Indicators for review.
Investigation of each one.
Comparisons are made with local authority rate and UK all industries accident rate.
To determine future changes in Standard Operating Procedures.
Workplace improvements

Source: IES survey of employers, 2005

Table 6.8: Actions that follow report of an incident

Action	Frequency	%
Procedures are reviewed	146	90.1
Risk assessment is reviewed	143	88.3
Accident site inspected	132	81.5
Incident victim is interviewed	119	73.5
Colleagues who witnessed incident are interviewed	114	70.4
Training is reviewed	112	69.1
Incident victim's supervisor is interviewed	100	61.7
Other	10	6.2
Base	186	

Source: IES survey of providers, 2005

respondents said would typically follow an incident report.

Amongst the twenty reports received of other actions taken, two referred to accident investigation, one reported that photographic evidence was collected, one reported that a memo would be sent to all staff and another said that the incident would be discussed at the Safety Committee.

6.3 RIDDOR-reportable incidents on employer premises

Employer representatives were asked about the number of RIDDOR-reportable incidents/accidents that had taken place within the past three years, and how many had involved apprentices or E2E learners. Twenty-six respondents did not answer this question; of the 160 who did complete this question, 72 had had a RIDDOR-reportable incident in the last three years. One-third had had only one or two, but two organisations reported 105 and 107 incidents over the past three years. These two organisations were in the health and care/public service and manufacturing sectors.

Of those respondents that said there had been one or more RIDDOR-reportable incidents, eight (11 per cent) said that one or more of these incidents had not been reported. The left-hand column of Table 6.9 shows the number of RIDDOR-reportable accidents that had been reported; the numbers in the columns that follow that are the numbers that organisations say they did not report.

Table 6.9 shows that one organisation had had one RIDDOR-reportable incident but not reported it; two had not reported one incident, and two had not reported two incidents. A further three organisations had had five, six and nine incidents they had not reported in the same period of time.

Respondents were asked if any of these incidents involved apprentices or other learners. In both of the organisations that had had two unreported incidents, both incidents had involved apprentices. In the organisation that had not reported nine incidents, one had involved an apprentice.

Very few respondents indicated any view regarding why incidents failed to be reported. One person indicated it was because people were unsure what needed to be reported or how or to whom to report incidents. Two individuals believed that non-reporting arose because incidents appeared less serious and to not need reporting at the time. One person said there was too much paperwork involved.

Although few respondents had a view on why incidents were not reported, more (although not many) had a view of the types of incident that tended not to be reported. A total of 22 people thought there were particular types of incident that, even though they should in principle be reported, tended not to be. Most of the replies given to this question (11 respondents) referred to minor injuries in one form or another. Another two referred to near misses not being reported. Apart from these, replies included references to apprentice road traffic accidents on the way to college and absences of more than three days where the employer does not believe this to be genuinely work-related. One person said that the basis for calculation of the three days rule was not well understood in some companies.

6.4 Other observations and comments

At the end of the questionnaire employers were invited to make any other comments or observations regarding the reporting of accidents

Table 6.9: Numbers of incidents not reported

	Numbers not reported					
RIDDOR-reportable accidents reported in last 3 years	**1**	**2**	**5**	**6**	**9**	**Total**
0	–	1	–	–	–	1
1	2	–	–	–	–	2
2	–	2	–	–	–	2
5	–	–	1	–	–	1
6	–	–	–	1	–	1
9	–	–	–	–	1	1
Total	*2*	*3*	*1*	*1*	*1*	*8*

Source: IES survey of employers, 2005

and incidents. Fewer made any comments here, and many of those that did write something here spoke of their robust health and safety procedures, in part confirming the researchers' suspicions that it was largely the better employers –- those who were confident of their health and safety record –- that had replied to the survey. A few others though made comments that mirrored concerns that had also been raised by providers. These are outlined below.

SMEs

Providers had voiced concerns regarding the relative lack of expertise and knowledge of health and safety requirements amongst SMEs and one employer pointed to this issue too:

> *'At this company I am training manager and health and safety manager – and work as part of the HR team – hence am in control of the whole process of accidents, injury and reporting. However, in very small/one person companies I am sure there is poor understanding of the requirements to report injuries and they do not want to be seen as a "risk" hence may not report. In such cases trainers must be instructed to also report any injuries and ill health and be protected from possible repercussions from the work place providers.'*

In addition, one small businesses felt it was difficult and expensive to put health and safety provisions in place, although was clearly appreciative of their apprentices:

> *'It's just really expensive getting up together with health and safety for small business, which leads to a reluctance to report and reshape the business. My apprentices are very good!'*

Clarity and guidance on reporting requirements

Regional Managers and providers had alluded to the fact that there is some degree of doubt regarding what needs to be reported. One employer confirmed this by suggesting that further guidance on severity of incidents would be helpful:

> *'Would like to have clarity on exactly how minor an accident or occurrence needs to be before it does not need reporting. Also how [bad] this would need to be to involve RIDDOR and HSE.'*

Communicating with providers

Colleges and training providers had expressed some doubts regarding health and safety at employer premises. However, in turn, employers pointed to some examples of poor practice amongst providers. One reported that they were sent day release students for whom they had no contact details in event of an incident; another reported receiving an unreasonable reaction from their training provider when they reported that one of their apprentices had had an accident and this had led them to reconsider what their own actions would be in the event of a similar situation in the future:

'Despite hefty risk assessments, where the apprenticeship is involved in a training course with animals, the risk will always be there. I would like to see a sheet provided by the course provider outlining the students who are on day release, their emergency contact numbers, name of their doctor etc. For our employed staff we do a pre-employment health/data form. Some of these day release students are allocated to [us] and if they were to faint/collapse on the first day we do not have any information at hand.'

'One of my apprenticeships had a serious accident outside of work, which resulted in her being on crutches. Her training provider suspended her as she could not attend (in their opinion) safely –- [I felt] that this was unfair. She was still "working" for me and able to complete units and assignments for her assessor and I feel they discriminated against her (if she was disabled surely she would still be able to attend). I am not 100 per cent sure I would be so quick to notify the training provider of a similar incident.'

Despite some employers not considering whether the LSC should be informed, some were aware of the importance of the relationship with the LSC and told of having systems in place for ensuring all parties were aware of any incidents involving learners:

'Any reports sent to the HSE are copied and sent to the NVQ Centre administration office. It is sent to the LSC contract manager for checking against any funded learners. These could be apprentices or over 25 learners. If any funded learners are identified, an LSC report will then be completed and sent to the LSC as required in our contract.'

There were other examples of good practice arising from the employer survey. These will be presented and discussed, along with good practice examples from the providers, in the final chapter of this report.

6.5 Summary

The employer survey confirmed many of the issues raised by providers and regional managers. These included the reasons for the non-reporting of incidents and indicated that not all employers have a clear idea of their reporting responsibilities. Some (albeit a small number) appear to believe it is employees' responsibility to report incidents to the HSE.

The employers also identified communication problems between providers and employers and in addition identified some faults in provider actions regarding health and safety also.

The findings of this survey and the survey of providers are discussed, together with the outcomes of the RM interviews and the background evidence from the literature review, in chapter 7.

7. Themes Emerging From the Different Components of the Research

In this chapter we draw together the evidence emerging from the different strands of research. At places the points made are illustrated by extracts from interviews with learners and providers. Before moving on to consider the overall points to emerge from the research we will briefly outline some further aspects of methodology. First we describe attempts to recruit learners to the focus groups. Then we indicate the source of other quotes that are used as illustrations in the discussion.

7.1 Arranging focus groups

With regard to learners, the intention had been to run focus groups with learners in two regions of the country and to this end several attempts were made to organise focus group meetings in large towns. Large towns were chosen since this potentially allowed learners to be invited from several provider organisations in close proximity. In each case a large college was chosen as the venue to host the meetings and the research team worked with the college health and safety manager to recruit learners. Despite strenuous efforts on the part of the health and safety managers it proved impossible to recruit learners to take part in the focus groups. This was the case despite offering refreshments and a £10 reward for participation and using a wide variety of recruitment methods: in one college the health and safety manager put up 30 posters at three college sites (the poster is illustrated at Appendix 5); at another college the health and safety manager put an advertisement for the focus groups in the college newsletter and a notice on the college intranet; in another region, the health and safety manager sent a letter from the research team to learners (the letter is appended at Appendix 5).

In contrast to these efforts, though, was the experience of trying to recruit learners in a fourth FE college. Here, we were keen to try contacting students by email. While the health and safety manager was keen to assist, he was unable to email students himself. He had spoken to several colleagues, including the director of student services, with regard to forwarding our email to learners but he reported that none were prepared to forward the email on to the students. He said, '*They just can't be bothered*'. He was very keen to

help but did not hold out much hope that he could persuade anyone to assist with this. In the end we abandoned the attempt to contact learners in that college.

As a result of the posters *etc.* at the other three colleges three learners contacted us. Two had seen the posters and a further young person had been told of the invitation by one of the original contacts. These were interviewed (one face-to-face, two by telephone) during February 2005. They received a £10 token for taking part in the interview.

Extracts from their interviews are used to illustrate the various points to emerge from the research.

7.2 Other interviews

During the course of the research, as part of other ongoing work, the team had occasion to speak to members of a sector skills council and college tutors. The opportunity was taken to conduct short interviews relating to learner health and safety. Extracts from these are also used to illustrate the points that emerged from the research programme.

7.3 The emerging picture

Here we identify the points that emerged across the different components of the programme of research. The issues raised are illustrated where appropriate with excerpts from the interviews.

7.3.1 Organisational culture and supervision

The literature review indicated that organisational culture was a factor influencing reporting. In particular, the type of 'macho' culture found in construction and other strongly masculine environments was an issue. This was also supported by regional managers, one of whom reported:

> *'There is a "laddish culture" in some occupations/sites where men predominate and the message given to these young people by colleagues is "Don't make a fuss, don't be a wimp". I have seen people with broken fingers and open arteries who seemed to think (or their colleagues seemed to think) that they shouldn't make a fuss.'*

The interviews with learners also confirmed that this factor discouraged individuals from complaining or reporting an incident:

> *A pallet was dropped on my foot by a forklift truck … The supervisor just told us to get on with the work and that was it.'* Learner

A lack of adequate supervision for learners in the workplace was also raised as a concern in the interviews with regional managers. Shop floor supervisors may be inadequately prepared for supervising young people. RMs said that this problem had been recognised for

years yet still persisted. The following extract from an interview with a young learner shows how inadequate supervision can encourage learners to continue with dangerous practices:

> Learner: *'We open packs at work with Stanley knives, … we're not really allowed to use them, but because it makes work a lot easier we bring them in …'*
>
> Researcher: *'So, are you being supervised when you are unpacking boxes?'*
>
> Learner*: 'Yes, I am supervised all the time'*
>
> Researcher: *'And you said that you cut yourself quite often using the knife, were you being supervised then?'*
>
> Learner*: 'Yes'*
>
> Researcher*: 'And did the supervisor say anything about the fact that you were using a knife?'*
>
> Learner*: 'No, because he used one himself.'*

In addition to organisational culture, the introduction of workplace incentives to reduce accident reporting was identified as a factor in the literature review. There was worrying news from the USA that suggested that external financial incentives (in the form of reduced insurance premiums) for reduced levels of accident reporting were leading companies to offer bonuses for not reporting accidents, rather than the intended consequence of improved health and safety management[1].

7.3.2 Individual attitudes

The literature review identified four main attitudes that can affect reporting: young people think that incidents and accidents are 'just part of the job'; they worry that they may be labelled an 'unsafe worker' if they report an accident, or be humiliated; they are too busy to report the incident; or they think the incident is not serious.

Our research provided support in the main for just two of these: incidents are seen as 'just part of the job' and learners do not think incidents are sufficiently serious to warrant reporting:

> Learner*: 'I burnt myself taking a roasting pan out of the oven. Also, I cut myself taking a knife out of my knife case.'*

[1] In contrast to this, a discussion site for college health and safety managers received a message shortly after conclusion of this research `reporting that one` college had changed its system of payments to trained volunteer first aiders. Instead of paying an honorarium, the college had started a system of paying 'per event'. There is a rota and the on-call first aider is contacted by radio. Any claim for payment has to be backed up by an accident/incident form. Initial indications are that more incident report forms are now being received.

Researcher*: 'Did you tell [your tutor] what had happened?'*

Learner*: 'No, it didn't seem important.'*

In addition, there is evidence that supervisors do not make sufficient effort to ensure that learners follow health and safety reporting requirements, as the following extract from an interview indicates:

Researcher*: 'And when you started work there, did anyone tell anything about what should happen if you had an accident?'*

Learner: *'Yes, they showed me where the accident book was, and told me who should fill it in.'*

Researcher*: 'Who should be responsible for filling it in?'*

Learner: *'Supervisors, or whoever is on duty that shift.'*

Researcher*: 'And what has typically happened when you have had one of these accidents?'*

Learner: *'I haven't said anything about it, as I didn't think it was important.'*

Researcher*: 'Was your supervisor aware that you had cut yourself?'*

Learner: *'Yes, he asked if I wanted to report it but I said no.'*

Very many of the providers said in their responses that learners did not tell them about incidents and so the provider was unlikely to hear about this until their next learner review, which could be some weeks or months even after the event.

7.3.3 Administration and communicating

An HSE report reviewed in the initial stages of the research revealed that the HSE had found that an absence of suitable systems to follow up injuries that could become reportable hindered reporting. This was confirmed in the survey of providers. Asked why accidents on provider premises might go unreported, around one-third of managers, health and safety managers *etc.* and 44 per cent of tutors said it was because the incident appeared less serious at the time than it turned out to be. Some 40 per cent of tutors also felt this to be a reason for non-reporting on employer premises too. A provider commented:

'Small accidents (a banged thumb/cut finger) can end up as a reporting incident/accident and result in a week or ten days" absence."'

The HSE report also found that managers interpreted RIDDOR requirements differently or misunderstood what was required of them, and this could lead to under-reporting. The survey of providers provided examples of organisations in which different managers said they had responsibility for reporting but gave contradictory replies regarding the institutions to which incidents would be reported. In

one such situation, one respondent (the manager) said s/he was responsible for reporting to the LSC, HSE and LA; the training manager said s/he would report to the LSC and HSE; while the health and safety manager said that s/he would report incidents to the LSC only. In another pair of returns to the provider survey, one person said they had responsibility for reporting to the LSC, while the second respondent said they did not; the one with reporting responsibility said there had been no RIDDOR-reportable incidents that year, the person without reporting responsibility said there had been one.

The sector skills council representative also provided evidence that regulations are interpreted differently. At present, RIDDOR requires incidents that lead to learners going to hospital to be reported to them, no matter how trivial the incident. The sector skills council interviewee was aware of one college where:

> *'..the H&S person says they do not have to report if the student walks themselves to hospital, only if they are taken by a member of staff.'*

A situation is left open to interpretation where there is a lack of clear guidance. Several providers commented on there being a need for clearer guidance and guidelines.

> *'Poor communication of reporting requirements and lack of clear guidelines.'*

> *'Clearer information and explanation for completing LSC accident investigation form would help.'*

> *'Constant debate around network of H&S managers because RIDDOR is so confusing! If the people who know are confused then how will this affect the rest of the organisation around reporting?'*

> *'We should appreciate more practical information on the types of injuries which can occur at work and which ones should be reported.'*

In addition, there were similar calls from employers:

> *'Would like to have clarity on exactly how minor an incident needs to be before it does not need reporting.'*

Quite aside from confusion over what should be reported and which individuals within organisations are responsible for doing so, there is evidence that observed incidents simply are not reported by those who observe them. Several tutors said they had observed incidents that they believed to be RIDDOR-reportable that they did not report.

The HSE report also identified inadequate internal communication and lack of investigation could lead to under-reporting. In the IES survey 100 providers said that their internal accident reporting system included reporting by telephone. There is unlikely to be any way of checking in such a situation whether the incident has been formally recorded by the institution or reported to the LSC and other bodies. In an interview with a tutor in which reporting actions following a hypothetical accident in a classroom were discussed, the

failure to 'close the loop' in terms of internal reporting was made clear:

> Tutor: *'I would report the incident at the end of the class, in the accident book at reception.'*
>
> Researcher: *'And would that be reported to the LSC?'*
>
> Tutor: *'I don't know.'*
>
> Researcher: *'Do you know what happens to the entries in the accident book? Are any reports compiled?'*
>
> Tutor: *'I don't know.'*
>
> Researcher: *…'but it would be somebody else's job to report any incidents to the LSC?'*
>
> Tutor: *'Yes, I suppose so.'*
>
> Researcher: *'And you would not know whether they had done so or not?'*
>
> Tutor: *'No.'*

This point was also reinforced in the employer survey. A supervisor of apprentices, asked whether data on reported incidents were used in any way, said:

> *'No idea, we pass on the information to our health and safety office.'*

Clearly in this case there was no information circulated to staff about health and safety issues, nor any feedback regarding reporting. In the interviews with regional managers one had emphasised the need for some form of 'feedback loop' so that accident statistics are not just recorded, but acted upon to improve practice. A further point arises, that in the absence of any form of feedback to staff, tutors are unable to know what happens to any incidents that they report. Were organisations to circulate updates on accidents, individuals would be able to check that any incidents reported verbally, such as through telephone calls, had been logged centrally.

In general, then, the research supported many of the factors suggested by the HSE as contributing to under-reporting.

7.3.4 Employers' understanding of health and safety requirements

As well as learners not reporting incidents to providers, many of the providers said they were not informed of incidents by employers. This can be a problem, especially if providers are required by the LSC to investigate what happened and quality assure the employment premises as a safe place for the learner:

'Employers still do not tell us immediately but we still have an obligation to investigate. We may not hear for ten days or more and still we have to try to investigate what happened.' Interview with tutor

Although this interviewee was not happy at having to follow-up incidents some days after the event, many providers spoke of much longer gaps before they were made aware of the situation.

'Work providers are always asked to report accidents, both by employer liaison visits and regular newsletter. Very rarely do we receive any notification.'

'The majority of employers when dealing with accidents forget to inform the training provider or college even though they have reported through their own chain of command/RIDDOR/accident book.'

'Employers in small businesses often fail to report accidents/incidents to us. This is usually down to workload and a lack of importance placed on reporting.'

This may be compounded by learners forgetting or being unwilling to report.

The survey of employers suggested that a group of employers – around 11 per cent of those reporting RIDDOR-reportable incidents –- had not reported at least some of these incidents. Some appeared not have reported any, although it is possible they simply did not understand the questions being asked in this part of the form. Were these to be accurate reports, then the data suggest that in eight of the 186 organisations that replied, anything up to 28 potentially RIDDOR-reportable injuries were not reported.

A further point of concern was that some organisations (albeit only a few) thought it was the apprentice's responsibility to report an accident to the HSE.

7.3.5 Reporting procedures and bureaucracy

The literature review identified onerous and time-consuming reporting procedures as a barrier to reporting. There was a range of opinion from providers regarding whether the LSC reporting system was user-friendly or not. While some did comment on how the system had improved over time, others commented on the repetitive nature of the reporting and the duplication of information across forms for the HSE and LSC. Although we have been informed by the central health and safety team that the LSC will accept HSE Form 2508, even some RMs were unaware of this, and providers and a sector skills council also appeared not to know this:

'I don't like the new forms, the LIRF. We have had four different forms, they are not difficult to fill in but they never seem to be the most user-friendly. It asks when did last ensure they were in a safe environment. The answer is always going to be "at review". And then the subsequent questions just more-or-less duplicate this. Answer is always "at review". And who is going to say "no [I didn't assure …]"? If the LSC used the F2508 reporting

form [this] would be better, although it doesn't give information on why that happened or how you would prevent it happening again'. Sector Skills Council representative

It would appear that many organisations would prefer an approach in which the HSE form was the main reporting form, supplemented by an additional form from the LSC that followed up on why the incident happened and what had been done to prevent it happening again. At the least, the LSC could publicise the fact that they accept F2508 more widely.

A related issue is that of spurious reporting, which RMs and providers alluded to as an issue. This in turn is related to the perceived level of bureaucracy and administrative effort may then be seen as unnecessary:

'The "three day" rule involves us in a huge amount of work for often trivial accidents. This has the effect of devaluing the exercise although I understand how important it is to prevent more serious occurrences.'

7.4 Summary

The research confirmed many of the points identified in earlier research in this area. In chapter 8 we move on to discuss the findings, consider some examples of good practice reported during the research, and consider the main actions that need to be taken based on the findings.

8. Conclusions and Recommendations

In this section we summarise the main findings of the work; identify examples of good practice; and set out recommendations based on the information gathered.

8.1 Main findings

While the research was wide-ranging in nature, in the end the main reasons for under-reporting amounted to just a limited number of issues:

- Learner non-reporting (both within their employing organisation and to their tutor), mainly because they do not view this as important.
- Employers not reporting incidents to providers.
- Evidence of disruption in internal reporting systems, which may not be detected because there is also no feedback loop.
- Confusion over reporting requirements and responsibilities.
- Multiple reporting routes from providers to the LSC and other bodies, possibly with no central co-ordination.

In addition, although bureaucracy did not show up in the responses as an issue of concern to a majority of respondents, nonetheless a small group of individuals did comment on the need to make reporting more user friendly and improve the LSC forms. In addition, this finding also suggested there may be a need for more publicity to make providers aware of the ways in which reporting may be accomplished.

These are the main findings in terms of factors contributing to under-reporting.

8.2 Examples of good practice and recommendations

It is often the case that surveys of this nature tend to attract responses only from the better employers and providers. This does mean that they are often rich sources of examples of good practice. In this section we note some of the examples of practice from providers and employers.

8.2.1 From providers

Raising awareness in learners and encouraging them to report incidents

Here, a range of providers describe actions their organisation has taken to get across the message to learners and employers about the need to take health and safety seriously and report any incidents that occur.

> *'We deliver health and safety very rigorously, and give the learners health and safety refresher sessions every six months regardless of who or which vocational area they work in. We monitor placements and learners every ten weeks at placement and record findings to constantly monitor employers and learners alike.'*

> *'Procedures and training [are] evaluated regularly. Each accident is internally investigated and the learner's awareness is evaluated to determine whether sufficient/specific training is evident. Learner support/training includes: generic health and safety at induction, occupationally specific training (prior to placement start), C.I.E.H. in-centre training certificate (before placement), placement induction (documents returned/collected within seven days), ongoing placement and NVQ specific training and assessment.'*

> *'At [our training company] both staff and learners are given information at induction on the importance of reporting accidents and near misses. I also deliver an induction unit (one full day) with learners in the construction department. This involves a simulation of reporting accidents/near misses etc. and stresses the importance of this as it highlights trends and, more importantly, [the] resources and training required to prevent these trends from continuing. Staff should also periodically carry out this exercise.'*

> *'The learners are all given a [copy of the] policy regarding incident/accident reporting which is discussed as a group plus at one to one interviews as a reminder to the learner.'*

This last approach (group discussion) may be of particular benefit in helping to make young learners realise they are not 'out of step' in thinking they should report incidents.

Monitoring safety and incident reporting in employing/placement organisations

In this section providers speak of the steps they take to ensure they are able to monitor health and safety of learners in their employing or placement organisations:

> *'Our company has just instigated procedures for assessors to report back to our H & S officer if we observe any health and safety problems in the workplace. Previously, we mentioned it to the line manager/mentor of the learner for them to action.'*

> *'Sometimes it is a bit "hit and miss" whether employers contact us, but we have recently tightened our policy on non-attendance and therefore incidents are likely to come to light sooner!'*

'Our company ensures all employer/placement providers have current insurance cover for learners working on their sites.'

'We have designed a sticker to be adhered to learner employer's accident books that reminds employers to notify us should any of their staff on a WBL programme with us is involved in an accident or incident.'

'We are putting together an employer pack to reiterate the employers responsibilities.'

'Many placements have no idea of accident reporting, if we identify this [as a potential problem] we increase the frequency of monitoring visits.'

Some of these are quite simple ideas, but are likely to improve both the safety of learners in the employing/placement organisations and the level of reporting.

Reporting lines, follow-up and feedback loops

In the discussion we noted the need to ensure there is feedback to all individuals involved in reporting incidents. In these extracts from provider questionnaires we identify some good examples of the ways in which provider organisations have ensured that information is fed back to staff and learners.

'All managers contact me if they think an accident is reportable and I inform them if we need to report it to LSC and EHO.'

'Our particular policy is, following the reporting of all accidents, however minor, I sit down with each individual with his instructor to carry out a safety awareness interview to determine the reasons and then learn [from this]. This is then filed along with the accident form in a safe. The accident stats are then shared with all staff and trainees.'

'All accidents however minor are investigated and recorded. A monthly report on health and safety is circulated to directors.'

Monitoring learner injuries/absence

Several providers gave accounts of their review and recording procedures for taking note of incidents involving learners. Some of their approaches are described below:

'We formally visit apprentices at least nine times per year and make a point of asking them about absence or accidents or injuries. This is also recorded.'

'We review trainees every six to eight weeks and complete a review form which asks about accidents/non-attendance etc. If the trainee has been ill they fill in a sickness reporting form or give us a copy of doctors note (as appropriate). If there is an accident, we ask for a photocopy of the accident book and telephone LSC to notify. As appropriate, accident reports are also completed and sent to LSC.'

'Every employer is aware that all absences and accidents need reporting for E2E learners to us. Our administrator telephones each week to check on attendance and progress regardless of whether they have been absent.'

These are examples of quite simple but sensible and effective actions that providers have taken to raise awareness and improve reporting practice. Next we go on to consider some examples from employers.

8.2.2 From employers

The following extracts from employers show how apprentices can be involved in health and safety at work and give illustrations of how employers have used health and safety data to improve practice. They also give examples of how reporting can be streamlined.

> *'All accidents and incidents involving all are reported, plus near miss issues for the purpose of prevention. Apprentices are invited to attend health and safety meetings and are encouraged to contribute to the deliberations.'*

> *'[Our] learners are all given information about RIDDOR on induction and this is reinforced during early training visits. Site managers and mentors are aware of the policy for reporting accidents and injuries and each site has monthly H&S meetings.'*

> *'We collect data on a spreadsheet to highlight areas of concern.'*

> *'We collect incident data as a basis or discussion/review of policies and consideration of whether changes/actions are required.'*

> *'We have a safety office who monitors all accident reports and its risk assessments so they would be the first point of call for all reporting processes.'*

> *'Any reports sent to the HSE are copied and sent to the NVQ Centre administration office. it is sent to the LSC contract manager for checking against any funded learners. If any funded learners are identified, an LSC report will then be completed and sent to the LSC as required in our contract.'*

The employers identified a range of actions, that, if more widely adopted, would improve health and safety and reporting practice.

8.2.3 Recommendations

We made recommendations specific to the LSC in chapter 3 and so will not repeat those here. In this section we focus primarily on ways to improve reporting from providers, and to a more limited extent, employers.

1. One factor identified as leading to under-reporting was that incidents that initially appeared trivial could subsequently become more serious. Ideally, providers should be able to demonstrate they have a follow-up procedure in their reporting arrangements that specifies the procedure to follow in this situation.
2. One of the concerns that was identified during the course of the research was whether incidents reported by tutors were

subsequently acted upon by health and safety managers. There were concerns that information could be lost in the internal reporting system. One suggestion made by a provider was for feedback should be provided to all involved in incident on reporting actions; furthermore, this respondent also circulated regular statistical updates to staff and trainees. We would suggest that more organisations take steps to build feedback loops into their reporting procedures.

3. Raising awareness in learners and encouraging them to report is a key issue. Young people may feel intimidated by colleagues into thinking they should not report incidents. The use of group discussion techniques as suggested by one provider may be a particularly useful way to start to challenge this culture and enable young people to understand they are not the only learner in this situation and it is right to report incidents.

4. Many providers confirmed that they did question learners about illness and accidents when they visit them and review progress. Given the concerns of some LSC representatives regarding the adequacy or otherwise of tutor questioning of learners, the suggestion of one provider, that had instituted a review form that included a record of sickness, absence and/or illnesses, would appear to be a useful innovation. It might be feasible for learners to keep their own copy of this (perhaps as part of their evidence portfolio) so they enter any incidents in it as they happen; these could then be copied into the provider copy when they next visited. If the provider subsequently found any serious issues had not been reported to the company, they could then ensure this was done.

5. The research team is aware that the LSC is trying to pursue 'light touch' monitoring and policy dictates that they no longer 'police' health and safety. Nonetheless it needs to be remembered that many people like clear guidance which may border on prescriptive. Many of the respondents alluded to the complexity and confusion in trying to get to grips with RIDDOR requirements. Several asked specifically for clear guidance on what needed reporting (and what did not). While it is not possible to list all conceivable accidents, it would probably be possible to give examples of minor and major incidents and what is the appropriate action. Were it possible for the LSC to produce such guidance, it should be noted that most likely this would need frequent re-issue, perhaps every year, because people do move on and quite aside from that, simply forget.

6. One of the most frequently cited reasons for non-reporting was that providers only found out after some time. It would be of value for the LSC to publicise the fact that providers are encouraged to send in reports of incidents even if it is some time after the event and some details are lacking because of this. The LSC may wish to consider emphasising that no penalties at present are attached to late reporting.

7. The LSC has sought guidance from HSE regarding the reporting of minor incidents that nonetheless result in a trip to hospital. There was irritation from several quarters with this situation. Such events are RIDDOR-reportable to HSE. We suggest the LSC considers whether it could consult with providers on this issue, develop a set of guidelines regarding what is appropriate to report or not, and forward these to the HSE to approve, rather than wait for the HSE to decide a response to their query. We note that some minor incidents referred to hospital may become serious, such as an allergic reaction to a wasp sting. However, such situations would be covered by normal reporting requirements and/or would be picked up if the type of reporting situation we have suggested in point 1 above.
8. We are aware that the LSC has made much effort to publicise and to offer training in the Learner Incident Record procedure. We are also aware from discussions with the central health and safety team at the LSC that there is provision for the LSC to accept HSE F2508 as part of the reporting procedure. Nonetheless, many respondents were not aware of currently existing options, suggesting for example that it should be possible to email in the forms, when this is in fact the case. We cannot emphasise sufficiently the need for publicity and still more publicity. It would also be worthwhile conducting a survey of provider training needs regarding LIR and the reporting system. We emphasise the fact that this should be a survey of provider-identified needs to ensure training is targeted on the issues that provider remain confused about.

Other issues affect reporting but there is less that LSC can do. Culture of some masculine areas of work are likely to remain a problem for some time. Issues such as the fact that some employers think that apprentices are themselves responsible for reporting incidents to RIDDOR is of concern, but completely outside LSC remit. Many providers are seeking to educate employers but there is a limit to extent of their influence. By taking action to spread good practice and develop awareness in learners themselves it is hoped that good practice will gradually spread more widely into employing organisations.

Appendix 1: List of Journals Searched for Source Materials for Literature Review

- Journal of Occupational & Environmental Medicine
- Journal of Occupational Accidents
- Occupational Health Review
- Occupational Health (Brighton University has online access but IES doesn't)
- Health Risk and Society
- Occupational Safety & Health (accessed through Brighton Library)
- Health & Safety at Work (accessed through Brighton Library)
- International Journal of Behavioural Safety (searched but yielded nothing)
- Safety Science (access through Ingenta.com)
- Journal of Safety Research (access through Ingenta.com)
- Journal of Organisational Behaviour (access through PyschInfo)
- Scandinavian Journal of Work, Environment & Health (access through PyschInfo)
- Policy & Practice in Health & Safety (access through Ingenta.com)
- IRS Employment Review
- Occupational Health [at work]
- Managing Safety and Health [at work]

Appendix 2: Discussion Guide for Interviews with Providers

The Institute for Employment Studies is currently investigating the under-reporting of accidents and incidents involving learners on behalf of the national LSC. As part of this work we are interviewing regional health and safety managers to gather their views on how the LSCs accident reporting system is operating and any lessons that could be learnt on the basis of your experience of the system so far.

The intention is to try to find ways in which the reporting of accidents and incidents could be improved and to share any lessons coming out from the various regions. However, we do not plan to identify the regions in our report and every attempt will be made to render any comments used in the report unidentifiable.

1. How does the reporting system work in your region?

   How are the reporting arrangements organised?

   How many local LSCs report to you (the co-ordinator)?

   (If not clear from previous two questions use some/all of these follow-up questions) What are the reporting steps that must be followed/what is the structure of the reporting network/how are incidents and accidents reported through to you?

   Do you have any regular meetings between all H&S officers and yourself?

   If yes, what sorts of things are discussed at these meetings? *(In other words, what do the processes of 'reporting' and 'co-ordination' actually consist of in this region).*

   If no, how does the reporting network actually operate?

2. Do **you personally** go out to providers to talk to them about health and safety issues or seek assurance from them on H&S issues?

   If no, go to Question 3

   If yes, What does this process consist of? *ie try to find out if it is largely 'seeking assurance' or 'talking to' – or both*

How do you decide which providers to visit? (is it on random selection basis?. Is it only to providers about which you have concerns? Do you target only those areas in which you know there are greater risks of accidents occurring?).

How do you feel this selection/decision/visiting process works?

In your view, could any changes be made to improve it at all? If so, what changes could be made to improve the system? *(check for their views on desirable changes to both the selection/decision process and to the visit process).*

Go to Question 4

3. Do you think it would be desirable for regional co-ordinators to visit providers?

   If no, why is this? *(check for reasons such as sufficiency of information coming through from local officers, no problems as far as they can see in the current arrangements etc.)*

   If yes, why is this?

   What prevents regional co-ordinators visiting at present (is it because of: pressure of work, because it is not in co-ordinator role, they do not feel prepared to proactively seek assurances from providers as they have not had any training for this aspect of the role, other reason?).

   What would need to happen to get this working? Check for: Change in policy? Change in contract? Provision of training?

4. Do the local LSC H&S officers visit providers to talk to them about health and safety issues or seek assurance from them on health and safety issues?

   If yes, what does this process consist of?, what are the various ways in which the LLSCs organise these visits?. *Check for differences in how LLSCs in same co-ordinator's region organise visits differently; does it largely appear to be 'seeking assurance' or 'talking to'?*

   How do they decide which providers to visit? (does it vary by LLSC? is it on random selection basis? Is it only to providers about which they have concerns? Do they target only those areas in which they know there are greater risks of accidents occurring?).

   How do you feel this selection/decision/visiting process works?

   Do you feel the approach adopted by some LLSCs to this process is more successful than others? (NB 'successful' here means in terms of eliciting reports of problems regarding accidents/ incidents/health and safety).

And do you have a view on why some of the other local offices are less successful in finding out about problems with accident reporting or with H&S issues in general?. *(Check for descriptions of officers being proactive in seeking out information, having had training for this aspect of the role).*

If not clear from previous, Could you tell me what approaches tend to be more successful? *If it does not emerge in context of their answer, add,* 'and why is this?'

If no, why is this?. Check following: Is it because it is agreed that the role does not include visiting; they have been unable to conduct visits so far but plan to do so in future; have not had necessary training to equip them to do this? Other reasons?

If the local agreement is for local LSC H&S officers not to visit providers, ask for their view on this –- is this okay, or would they prefer to see local LSC H&S officers visiting providers?

What would need to happen to get this working? (Change in policy? Change in contract? Provision of training?).

5. Omit this question if already answered in reply to Questions 3 and 4. Modify this question to take into account whether the regional co-ordinator and/or local H&S officers visit organisations. Do you feel that you/the local H&S officers are adequately prepared to visit providers and investigate whether they are reporting all reportable incidents and accidents?

   Do you/they feel competent to make judgements about learner or management competence issues? If no, why is this? What might help? *(idea here is to get at factors that an LSC might incorporate into a training programme).*

   Has the introduction of the regional H&S management structure helped with this? If no, explore what might help and why.

6. Do you have any general 'feel' about whether there are significant amounts of under-reporting occurring?

   If yes, does this tend to be in particular sectors (*eg* construction, catering, *etc.*); in particular types of institution (colleges, private training providers, group training associations, *etc.*); with particular types of learner (E2E, apprentices); at particular locations (at the training provider site; at the employer's premises; outside the learning & employment settings).

7. Do you feel that there is sufficient guidance available to help providers manage the specific risks to young workers on placements? Is there sufficient guidance to help them manage the specific risks for young learners who have special needs?

8. Do you think there is sufficient guidance available to providers on reporting and investigating incidents?

9. Do you think that the learners themselves are made sufficiently aware of health and safety risks and the need to notify the appropriate person of any incidents?

10. Can you make any other suggestions for changes that might improve the reporting of accidents and incidents involving learners?

Thank and close.

Appendix 3: Questionnaires and Glossary of Terms for Providers and Employers

SURVEY OF TRAINING PROVIDERS WHO PROVIDE TRAINING TO APPRENTICES AND/OR E2E LEARNERS

ies

THIS SURVEY IS CONFIDENTIAL AND ANONYMOUS

This questionnaire is being sent out by the Institute for Employment Studies on behalf of the Learning and Skills Council. It is part of research that is being undertaken to try to improve the reporting of accidents involving apprentices and other learners, by looking at the barriers that stop people from reporting accidents and incidents.

We will very much appreciate your spending some time filling in the survey. To make it easy to complete, most of the questions require just a tick in response; only a few require a written reply.

The aim of the research is to explore the sorts of problems that are encountered by training providers (this includes colleges, training companies, group training associations, etc.) when learners are involved in incidents or accidents. We realise that some of the questions we ask are of a somewhat sensitive nature and can assure you that it is absolutely not the intention of the work to identify any individual organisation; nor is there any way in which your organisation can be identified.

Please answer the following questions as fully as you are able by ticking the boxes or writing in the spaces provided. Please return the completed questionnaire to IES in the reply-paid envelope provided. If you have any queries, please contact Linda Miller: telephone 01273 873441 or Peter Bates: telephone 01273 873681. Thank you for your co-operation.

1. In what type of organisation do you work? (*If you work in more than one organisation, please tick the organisation through which you received this questionnaire)*

a. College ☐ b. Training company ☐

c. Group Training Association ☐ d. Other ☐

(*Please describe*) .....

2. What is your role in the college/company *(Please tick any/all that apply)*

a. Health & Safety Manager ☐ b. Work-based training co-ordinator ☐

c. Manager ☐

d. Tutor ☐ (*Please specify subject*) .....

e. Other ☐ (*Please specify*) .....

Incident and accident reporting

3. In your role, are you responsible for reporting any accidents or incidents that occur on college/company premises and involve learners directly to: *(Please tick as appropriate)*

The LSC	yes ☐ 1	no ☐ 2
The HSE	yes ☐ 1	no ☐ 2
The Local Authority	yes ☐ 1	no ☐ 2

4. If you answered 'no' to Q3, are you responsible for reporting any accidents or incidents that involve learners and occur on college/training company premises to someone else within your college/training company? *(Please tick any/all that apply)*

If yes, to whom?

a. Departmental secretary ☐ b. Course manager ☐

c. Departmental manager ☐ d. College/company H&S manager ☐

e. Other ☐ (*Please describe*) .....

5. How is this done? *(Please tick any/all that apply)*

a. Via accident reporting book ☐ b. Accident reporting form ☐

c. Telephone call ☐ d. email ☐

e. Other ☐ (*Please describe*) .....

If you are a tutor/assessor, please go to Q9. If you are a manager, work-based learning co-ordinator or health and safety manager, please go to Q6

Managers, work-based learning co-ordinators and health and safety managers

6. Approximately how many RIDDOR-reportable accidents and/or incidents involving apprentices or E2E learners have occurred on your premises in the past year? *(Please enter number in box)*

☐

Have all of these RIDDOR-reportable incidents/accidents been reported to:

The Learning and Skills Council?	yes ☐ 1	no ☐ 2	don't know ☐ 3
The HSE?	yes ☐ 1	no ☐ 2	don't know ☐ 3
The Local Authority?	yes ☐ 1	no ☐ 2	don't know ☐ 3

If no, approximately how many incidents/accidents have not been reported? (Please enter number(s) in box)

To the LSC? ☐

To the HSE? ☐

To the Local Authority? ☐

7. What do you believe is/are the main reason(s) for not reporting RIDDOR-reportable incidents to the LSC? (*Please tick any/all that apply)*

a. We are not sure what needs to be reported ☐

b. We are not sure how to report incidents ☐

c. We are not sure to whom incidents need to be reported ☐

d. Incidents may not appear to need reporting at the time (appear less serious than they are) ☐

e. No-one has particular responsibility for reporting incidents ☐

f. Oversight/forgetfulness ☐

g. Pressure of work ☐

h. Too much paperwork involved, so we avoid reporting unless a major incident ☐

i. Tutors often do not report incidents to me/the relevant person until some time after they have happened, and it does not seem worth reporting at that point ☐

j. Learners often do not report incidents to me/the relevant person until some time after they have happened, and it does not seem worth reporting at that point ☐

k. The incident is the learner's own fault ☐

l. The person whose job it is to report accidents was away at the time ☐

m. Concerns about receiving a warning and/or fine ☐

n. Fear of other consequences (*Please specify)* ☐

o. Other (*Please briefly describe*) ..... ☐

8. Do you also report **non**-RIDDOR-reportable incidents/accidents to the Learning and Skills Council? *(Please tick one box only)*

yes ☐ 1 no ☐ 2 *Now please go to Q17*

Work-based learning tutors

9. Have you personally witnessed any accidents and/or incidents involving learners in your training/assessment sessions on your (college/training company) premises in the past three years? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If yes, approximately how many? (Please enter number in box)

☐

10. Approximately how many of these incidents/accidents do you believe were potentially RIDDOR-reportable? *(Please enter number in box)*

☐

11. Were all of these potentially RIDDOR-reportable incidents/accidents reported to the college/ training company manager/health and safety manager? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If no, approximately how many were not reported? (Please enter number in box)

☐

12. What do you believe is/are the main reason(s) for not reporting RIDDOR-reportable incidents to the LSC? *(Please tick any/all that apply)*

a. We are not sure what needs to be reported ☐
b. We are not sure how to report incidents ☐
c. We are not sure to whom incidents need to be reported ☐
d. Incidents may not appear to need reporting at the time (appear less serious than they are) ☐
e. No-one has particular responsibility for reporting incidents ☐
f. Oversight/forgetfulness ☐
g. Pressure of work ☐
h. Too much paperwork involved, so we avoid reporting unless a major incident ☐
i. Learners often do not report incidents until some time after they have happened, and it does not seem worth reporting to the LSC at that point ☐
j. The incident is the learner's own fault ☐
k. Concerns about the organisation receiving a statutory warning and/or fine ☐
l. Fear of other consequences (*Please specify)*..... ☐
m. Other (*Please briefly describe*) ..... ☐

13. Whose responsibility is it to report RIDDOR-reportable incidents/accidents involving apprentices or E2E learners on employer premises? *(Please enter job title)*

.....

14. Have you personally witnessed any RIDDOR-reportable accidents and/or incidents involving learners in any training/assessment sessions you have conducted on apprentices' employers' premises in the past three year? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If yes, approximately how many? (Please enter number in box)

☐

15. Were any of these incidents/accidents on employers' premises not reported *(Please tick one box only in each row)*

To the LSC?	Yes (not reported) ☐ 1	no (all were reported) ☐ 2	don't know ☐ 3
To the HSE?	Yes (not reported) ☐ 1	no (all were reported) ☐ 2	don't know ☐ 3
To the Local Authority?	Yes (not reported) ☐ 1	no (all were reported) ☐ 2	don't know ☐ 3

If yes, approximately how many were not reported? (Please enter numbers in boxes)

To the HSE? ☐ To the LSC? ☐ To the Local Authority ☐

16. In your opinion, what is/are the main reason(s) for some RIDDOR-reportable incidents/accidents involving learners on employers' premises not being reported? *(Please tick any/all that apply)*

a. Uncertainty over whose responsibility it is to report incident ☐
b. Uncertainty over what needs to be reported ☐
c. Uncertainty regarding how to report incidents ☐
d. Uncertainty regarding to whom incidents need to be reported ☐
e. Incident does not appear to need reporting at the time (appeared less serious than it was) ☐
f. No-one has particular responsibility for reporting incidents ☐
g. Oversight/forgetfulness ☐
h. Pressure of work ☐
i. Too much paperwork involved, so reporting is avoided unless a major incident ☐
j. Supervisors/managers do not report incidents to the relevant person until some time after they have happened, and they may not seem worth reporting at that point ☐
k. Apprentices do not report incidents to the relevant person until some time after they have happened, and they may not seem worth reporting at that point ☐
l. The incident is the apprentice's own fault ☐
m. The person whose job it is to report accidents is away at the time ☐
n. Concerns about receiving a statutory warning and/or a fine ☐
o. Fear of other consequences (*Please specify*) ..... ☐
p. Other (*Please briefly describe*) ..... ☐

Communication between employers and trainers

17. Do you have a named contact at the learner's place of employment who acts as a main contact for any communications/queries from the college/training company regarding their apprentices/other learners? (*Please tick one box only)*

☐ 1 ☐ 2

18. If a learner is likely to be absent through ill-health or accident, does your college/training company expect the apprentice's employer to notify you? (*Please tick one box only)*

☐ 1 ☐ 2

19. When apprentices are absent due to ill-health or accident, do their employers usually notify you? (*Please tick one box only)*

No, never ☐ 1
Mostly they do not ☐ 2
Mostly they do notify us ☐ 3
Yes, always ☐ 4
Only if they are absent for a significant length of time ☐ 5
Roughly, how long? .....

20. If a learner is absent from a taught session at the college/training company, what action would the college/training company take? (*Please tick one box only)*

No action ☐ 1
The learner would be contacted to find out why they were absent ☐ 2
The employer would be contacted to find out why the learner was absent ☐ 3
Other (*Please describe*) ..... ☐ 4

21. If the college/training company usually contacts the learner or employer, who would **usually** contact them? (*Please tick one box only)*

The learner's tutor/assessor	☐ 1	Course administrator	☐ 2
Course co-ordinator	☐ 3	Other	☐ 4

(*Please specify*) .....

22. At approximately what point would this normally happen? (*Please tick one box only)*

After one missed session	☐ 1	After 2-3 weeks/sessions	☐ 2
After a month	☐ 3	At the end of term/semester	☐ 4
Other	☐ 5	*(Please specify)*	

23. Does this contact always happen? (*Please tick one box only)*

yes ☐ 1 no ☐ 2 don't know ☐ 3

If no, for approximately what proportion of absences do you fail to contact either the learner or employer? (Please enter number in box)

☐

23. What is/are the main reason(s) why your college/training company fails to contact the learner or employer? *(Please tick any/all that apply)*

a. No policy on this	☐ 1	b. Pressure of work	☐ 2
c. No telephone contact details given by learner	☐ 3	d. No answer from contact number for learner	☐ 4
e. Other	☐ 5	*(Please specify)*	

25. Do you have any other observations or comments you would like to make regarding the reporting of accidents and incidents involving learners?

.....

.....

.....

.....

.....

.....

.....

Thank you for completing this questionnaire.
Now please place this questionnaire in the reply-paid envelope and return it to Dr Linda Miller at The Institute for Employment Studies, Mantell Building, University of Sussex, Falmer, Brighton, BN1 9RF

SURVEY OF EMPLOYERS WHO EMPLOY APPRENTICES AND/OR OFFER WORK PLACEMENTS TO YOUNG LEARNERS

ies

THIS SURVEY IS CONFIDENTIAL AND ANONYMOUS

This questionnaire is being sent out by the Institute for Employment Studies on behalf of the Learning and Skills Council. It is part of research that is being undertaken to try to improve the reporting of accidents involving apprentices and other learners, by looking at the barriers that stop people from reporting accidents and incidents.

We will very much appreciate your spending some time filling in the survey. To make it easy to complete, most of the questions require just a tick in response; only a few require a written reply.

The aim of the research is to explore the sorts of problems that are encountered by employers as a group when incidents or accidents happen at work. We realise that some of the questions we ask are of a somewhat sensitive nature and can assure you that there is no way in which your organisation can be identified, and it is absolutely not the intention of the work to identify any individual organisation.

Please answer the following questions as fully as you are able by ticking the boxes or writing in the spaces provided. Please return the completed questionnaire to IES in the reply-paid envelope provided. If you have any queries, please contact Linda Miller: telephone 01273 873114 or Peter Bates: telephone 01273 873681. Thank you for your co-operation.

Some information about your organisation and training arrangements

1. Please indicate the number of employees in your organisation *(Please tick one box only)*

   up to 50 ☐ 51-250 ☐ 251-500 ☐ >500 ☐

2. Please indicate the sector in which your organisation mainly operates *(Please tick one box only)*

Administration and Professional	☐ 1	Agriculture	☐ 2
Construction	☐ 3	Customer Service, Retailing and Wholesaling	☐ 4
Engineering	☐ 5	Finance, Insurance and Real Estate	☐ 6
Health and Beauty	☐ 7	Health, Care and Public Services	☐ 8
Hospitality	☐ 9	Manufacturing	☐ 10
Media and Printing	☐ 11	Recreation and Travel	☐ 12
Transportation	☐ 13		

3. What is your job title? *(Please tick one box only)*

   HR Manager ☐ 1 Personnel Manager ☐ 2 Training Manager ☐ 3 MD ☐ 4

   Line manager ☐ 5 Supervisor ☐ 6 Other ☐ 7

   (*Please specify*) .....

4. How many apprentices do you currently employ and/or E2E placements do you offer? (*Please give number in each relevant area)*.

	Apprentices	E2E		Apprentices	E2E
a. Administration and Professional	☐	☐	b. Agriculture	☐	☐
c. Construction	☐	☐	d. Customer Service, Retailing and Wholesaling	☐	☐
e. Engineering	☐	☐	f. Finance, Insurance and Real Estate	☐	☐
g. Health and Beauty	☐	☐	h. Health, Care and Public Services	☐	☐
i. Hospitality	☐	☐	j. Manufacturing	☐	☐
k. Media and Printing	☐	☐	l. Recreation and Travel	☐	☐
m. Transportation	☐	☐			

5. Do you directly supervise any apprentices or E2E learners? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

6. For the training/technical certificate component of the apprenticeship, are apprentices registered with: *(Please tick one box only)*

An FE college	☐ 1	None, all training is conducted in–house and we are an approved assessment centre	☐ 2
A private training provider	☐ 3	Other training provider	☐ 4
A group training provider	☐ 5	(*Please describe)*	

If you provide all training in-house, please go to Q15

7. Do you have a named contact at the training provider with whom you liase regarding the apprentice's training? *(Please tick one box only)*

yes ☐ 1 no ☐ 2 *If 'no', please go to Q10*

8. Is this the apprentice's tutor/assessor? *(Please tick one box only)*

yes ☐ 1 no ☐ 2 *If 'no', what role does this contact play at the training centre/college/other?*

.....

9. Have you been in contact with this person in the past year? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

Roughly how many times? *(Please enter number in box)* ☐

For what reason? *(Please describe)* .....

Accidents And Dangerous Occurrences At The Training Provider's Premises

10. Have any of your apprentices ever had an accident while at their training provider's premises? *(Please tick one box only)*

yes ☐ 1 no ☐ 2 don't know ☐ 3

If yes, what happened? (Please tick one box only)

The training provider contacted me/the apprentice's supervisor to let me/the supervisor know ☐ 1

The apprentice phoned in/told me/their supervisor the next day ☐ 2

Other (*Please describe*) ..... ☐ 3

.....

11. Was anybody else contacted by the training provider as far as you know? *(Please tick one box only)*

yes ☐ 1 no ☐ 2 don't know ☐ 3

If yes, who else did they contact? (Please tick any/all that apply)

a. LSC ☐ b. HSE ☐

c. Apprentice's family ☐ d. Local authority/environmental health ☐

e. Public health ☐ f. Employee's GP ☐

g. Other (*Please describe*) ..... ☐

Accidents And Dangerous Occurrences At The Employers' Premises

12. What would happen if one of your apprentices: *(Please tick one box in each column)*

	… had an accident at your premises, and could not attend their next scheduled training session at the training provider's premises?	… had an accident at your premises and could not see their tutor/assessor on the next scheduled visit of the tutor to your site?	… was likely to be absent due to an accident for some time so that they could not go to their training and/or see their tutor/assessor for several weeks?
No action	☐	☐	☐
I/their supervisor would expect the apprentice to contact the training provider to let them know	☐	☐	☐
I/their supervisor would contact the training provider	☐	☐	☐
I would expect the other apprentices to tell the tutor that s/he was away	☐	☐	☐
I would expect the apprentice to explain what had happened next time s/he saw their tutor	☐	☐	☐
Other (*Please describe)*	.....	.....	.....

13. If an apprentice could not continue with their apprenticeship for some time due to an accident, would your organisation contact/notify anyone? *(Please tick any/all that apply)*

a. The training provider	☐	b. The LSC	☐
c. The HSE	☐	d. Other (*Please describe)*	☐

14. Who would **usually** be responsible for this contact/notification? *(Please tick one box only)*

The Apprentice	☐	1
Myself	☐	2
The supervisor/manager of the apprentice/learner	☐	3
The Health and Safety Manager	☐	4
The Personnel/HR Manager/Officer	☐	5
No nominated person has this responsibility	☐	6
Other (*Please specify)*	☐	7 .....

Health And Safety Policy And The Reporting Of Accidents At Work

15. Do you have a health and safety policy? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

16. Does the health and safety policy have a section that covers incident reporting? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

17. What does the health and safety policy cover? *(Please tick any/all that apply)*

a. Illnesses	☐	b. Reportable diseases	☐
c. Injuries	☐	d. Incidents (slips and trips)	☐
e. Dangerous occurrences	☐	f. Accidents	☐
		g. RIDDOR-reportable injuries	☐

18. Are the supervisors/managers, apprentices and other learners made aware of the requirements for reporting of accidents, incidents and illnesses? *(Please tick one box only)*

yes ☐ 1 no ☐ 2 don't know ☐ 3

If yes, how does this usually happen? (Please tick any/all that apply)

a. Apprentices/learners are asked to sign a form to say they have read and understood the policy ☐

b. Supervisors/managers are required to tell apprentices/learners about the policy and bring reporting requirements to their attention ☐

c. Personnel/HR include this in briefing for all new employees/learners on H&S policy ☐

d. Other (*Please give brief details*) ..... ☐

19. Are data on reported incidents used in any way? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If yes, how are they used? Please describe) .....

20. Does anything happen when an incident has been reported (other than reporting to relevant authority) – in other words, are procedures reviewed, training reviewed *etc*? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If yes, what happens? (please tick any/all that apply)

a. Procedures reviewed ☐
b. Training reviewed ☐
c. Accident site inspected ☐
d. Incident victim is interviewed ☐
e. Incident victim's supervisor/manager is interviewed ☐
f. Any colleagues who observed incident are interviewed ☐
g. Risk assessment reviewed ☐
h. Other (*Please briefly describe*) ☐

.....

21. Approximately how many RIDDOR-reportable accidents have there been within your organisation in the past three years? *(Please enter number in box)*

☐

22. As far as you are aware, were any of these not reported to the HSE or local authority? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If yes, approximately how many? (Please enter number in box) ☐

23. Did any of these involve apprentices or learners? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If yes, how many? (Please enter number in box) ☐

24. As far as you are aware, was there any reason for these incidents not being reported to the HSE or local authority? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If yes, was this mainly because: (Please tick any/all that apply)

a. We are not sure what needs to be reported ☐
b. We are not sure how to report incidents ☐
c. We are not sure to whom incidents need to be reported ☐
d. Incident did not appear to need reporting at the time (appeared less serious than it was) ☐
e. No-one has particular responsibility for reporting incidents ☐
f. Oversight/forgetfulness ☐
g. Pressure of work ☐
h. Too much paperwork involved, so we avoid reporting unless a major incident ☐
i. Supervisors/managers did not report incidents to me/the relevant person until some time after they had happened, and it did not seem worth reporting at that point ☐
j. Apprentice/learner did not report incidents to me/the relevant person until some time after they had happened, and it did not seem worth reporting at that point ☐
k. The incident was the apprentice's/learner's own fault ☐
l. The person whose job it is to report accidents was away at the time ☐
m. Concerns about receiving a statutory warning and/or fine ☐

n. Fear of the consequences (*Please specify)* ..... ☐

o. Other (*Please briefly describe*) ..... ☐

25. Is there any type of incident that you believe tends not to be reported (although in principle they should be)? *(Please tick one box only)*

yes ☐ 1 no ☐ 2

If yes, what type is this? (*Please describe*) .....

26. At what point would you usually notify statutory bodies about continuing ill-health, reportable diseases, RIDDOR-reportable accidents, and dangerous occurrences *etc.*? Who would you notify? *(Please complete information in both columns for each line)*

	When would you notify statutory bodies?	**Who would you notify?**
Continuing ill-health	.....	.....
Reportable diseases	....	.....
RIDDOR-reportable accidents	....	.....
Dangerous occurrences	....	.....

26. Do you have any other observations or comments you would like to make regarding the reporting of accidents and incidents involving apprentices/learners?

.....

.....

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Thank you for completing this questionnaire. Now please place this questionnaire in the reply-paid envelope and return it to Dr Linda Miller at The Institute for Employment Studies, Mantell Building, University of Sussex, Falmer, Brighton, BN1 9RF

Glossary of Terms

The training and assessment for apprenticeships (formerly modern apprenticeships) are arranged in a variety of ways. Because of this, we have provided an explanation of the terms used in this questionnaire:

Apprentice — a young person (aged under 25) who is employed and, while employed, undertakes a programme of learning that leads to award of a level 2 or 3 apprenticeship (formerly, a foundation or advanced modern apprenticeship).

E2E learner — a young person registered on the 'Entry to Employment' (E2E) training scheme, who may undertake one or more placements with employers during the course of their learning programme.

Employer — the organisation that employs the apprentice, or provides a placement for E2E learners.

Employer's premises — the site at which the apprentice would normally work, when not attending off-site training sessions with a training provider

Supervisor/manager — the person who acts in a direct supervisory relationship with the apprentice/learner when the apprentice/learner is working for the employer

Training provider –- a college or training company, group training association, that provides training for apprentices, E2E or other learners.

Training provider's site/premises — the location at which a training provider offers training (this excludes mean training rooms or workshops on the employer's premises that may also used for off-the-job training).

Tutor/assessor — a person employed by the training provider to teach and/or assess apprentices or other learners (this excludes supervisors or managers employed by the apprentice's employer who in some situations may contribute to training or assessment).

LSC –- the Learning and Skills Council, the body that funds all further education and training for young people aged 19 – 25 in England

HSE — the Health and Safety Executive, which oversees health and safety at work in the UK.

RIDDOR-reportable — This refers to injuries that are reportable under the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1995 (RIDDOR 95). There are three categories of reportable injury to workers defined under the regulations: fatal, major and over-three-day injury. Examples of major injuries include: fractures (except to fingers, thumbs or toes), amputations, dislocations (of shoulder, hip, knee, spine) and other injuries leading to resuscitation or 24 hour admittance to hospital. Over-three-day injuries include other injuries to workers which lead to their absence from work, or inability to do their usual job, for over three days.

Appendix 4: Letters to Providers and Employers

Learning+Skills Council

ies institute for employment studies

7 January, 2005

Dear Sir or Madam

I am writing to request your participation in some research that has been commissioned by the national Learning and Skills Council. The research is investigating the under-reporting of accidents and incidents involving apprentices and E2E learners. It is being conducted on our behalf by the Institute for Employment Studies, an independent, apolitical, research organisation.

I would very much appreciate your assistance with this work. Enclosed with this letter is a questionnaire that I would like to ask you to complete and return to IES. A reply-paid envelope is included for your use. You are not required to provide either your name or the name of your organisation or any other details that might be used to identify it, such as the region in which you operate.

We envisage the final report being made available via the LSC's web-site following the project's conclusion in March. May I thank you in advance for your help with this research by filling in and returning the questionnaire.

Yours sincerely

Jill M Joyce
National Health and Safety Adviser,
Learning + Skills Council

email: linda.miller@employment-studies.co.uk
direct line: +44 (0) 1273 873114

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I would very much appreciate your assistance with this work. Enclosed with this letter is a questionnaire for you to complete and return as the LSC's main named contact for your organisation. A reply-paid envelope is included for your use. You are not required to provide your name or the name of your organisation or any other details that might be used to identify it, such as the region in which you operate.

In addition, I am including three additional packs which each contain a letter, questionnaire and a reply-paid envelope. I would very much appreciate it if you would pass on these packs to the following individuals:

- The health and safety manager/co-ordinator for your organisation (if this is not your role)
- The work-based training manager/co-ordinator for your organisation (if this is not your role)
- A work-based training tutor/assessor.

If you do not have either a health and safety manager/co-ordinator and/or a work-based learning manager/co-ordinator may I ask you instead to pass the additional questionnaire packs to work-based learning tutors/assessors. There is no need for you to gather up the completed questionnaires as all the packs have their own reply-paid envelopes.

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Registered charity no. 258390

We envisage the final report being made available via the LSC's web-site following the project's conclusion in March. May I thank you in advance for your help with this research, both in filling in the questionnaire and in passing on the additional packs to your colleagues.

Yours sincerely

Jill M Joyce
National Health and Safety Adviser,
Learning + Skills Council

Learning+Skills Council

ies institute for employment studies

7 January, 2005

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I would very much appreciate your assistance with this work. Enclosed with this letter is a questionnaire for you to complete. A reply-paid envelope is included for your use. You are not required to provide your name or the name of your organisation or any other details that might be used to identify it, such as the region in which you operate.

We envisage the final report being made available via the LSC's web-site following the project's conclusion in March. May I thank you in advance for your help with this research by filling in and returning the questionnaire.

Yours sincerely

Jill M Joyce
National Health and Safety Adviser,
Learning + Skills Council

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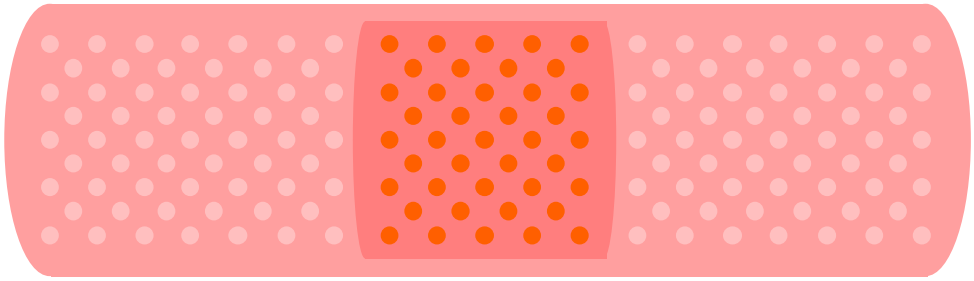
Appendix 5: Materials for Recruiting Learners and Focus Group/Interview Guide

Have you had an accident at work or college?

Or do you know someone who has?



If so – we want to talk to you!

Small discussion groups lasting approximately 1 hour will be running in this college on Thurs 17 March at 1pm and 4pm

£10 Gift voucher for taking part plus your travel costs reimbursed. Refreshments will be available.

Interested? Then contact

Karen Akroyd at the Institute for Employment Studies on 01273 873689 or email us on

focus-groups@employment-studies.co.uk

to book a place on one of the sessions

Institute for Employment Studies
Mantell Building
University of Sussex

22 February 2005

Have you ever had an accident at work or college? Or do you know someone who has?

We are carrying out research on accidents involving learners for the Learning and Skills Council – the organisation that funds your education/training programme. They want to hear about what happens to young people who have accidents and why many incidents end up not getting reported. This includes accidents at work and those that have taken place while you are at your college or training organisation.

Would you be willing to take part in a small discussion group about how accidents are reported? If you took part you would receive a £10 gift voucher (your choice of either HMV or Boots), and would have your transport costs refunded. The discussion would last about an hour and will be held on Thursday 3 March at: XXXXXXX.

Drinks and biscuits will be provided.

There will be sessions held at 12.15-1.15pm and again at 4.15-5.15pm.

You might be worried that you could be identified if you took part. I can assure you that taking part would be on a strictly anonymous basis – this means you will not be named and no comments made in the discussion will be identified as being said by a particular person.

Your college/training organisation has agreed to help us with this work by passing this letter on to you. We do not have your personal details. Therefore, if you would like to take part, please contact Karen Akroyd at the Institute for Employment Studies on 01273 873689 or email me at the following address:

focus-groups@employment-studies.co.uk

Many thanks,

Karen Akroyd
Research Officer

E mail text (to be circulated to all young learners)

From: The Institute for Employment Studies

Have you ever had an accident at work?

Or do you know someone who has?

If so, are you willing to take part in a small discussion group about how accidents are reported where you work?

You would receive a £10 HMV voucher, and would have your transport costs refunded.

If you would like to take part, please contact Karen Akroyd at the Institute for Employment Studies on 01273 873689.

karen.akroyd@employment-studies.co.uk

Many thanks

References

Adams N L, Hartwell N M (1977), 'Accident-Reporting Systems: a basic problem area in industrial society', *Journal of Occupational Psychology*, 50, pp. 285–298

Bourn J (1994), *Enforcing Health and Safety Legislation in the Workplace*, HSE

Clarke S (1998), 'Organisational factors affecting the incident reporting of train drivers', *Work & Stress*, 12, pp. 6–16

Frederick J, Lessin N (2000), 'Blame the worker: the rise of behavioural-based safety programmes', *National Monitor*, 21 (11)

Glendon A I (1991), 'Accident data analysis', *Journal of Health and Safety*, 7, pp. 5–24

Gyi D E, Gibb A G F, Haslam R A (1999), 'The Quality of Accident and Health Data in the Construction Industry: interviews with senior managers', *Construction Management and Economics*, 17, pp. 197–204

HSC (2004), *A strategy for workplace health and safety in Great Britain to 2010 and beyond*

HSE (1998), *Audit of RIDDOR reporting in large coal mines*, June

HSE (2003), *Self-reported work-related illness in 2001-02: results from a household survey*, Epidemiology and Medical Services Unit

HSE (2004), *Health and safety statistics highlights 2003/04*, November

HSE/Local Authorities Enforcement Liaison Committee (HELA) (2005), *Health And Safety (Enforcing Authority) Regulations 1998 (Revised 2000): A-Z Guide To Allocation*, Local Authority Circular 23/15, http://www.hse.gov.uk/lau/lacs/23-15.htm

HSL (2002), *Young People's Attitudes to Health and Safety*

Incomes Data Services (2003), *Bonus schemes*, IDS Studies, January

Jefferson J R, McGrath P J (1996), 'Back Pain and Peripheral Joint Pain in an Industrial Setting', *Archives of Physical Medicine and Rehabilitation*, 77, pp. 385–390

Lucas D A (1991), 'Organisational Aspects of Near Miss Reporting', in van der Scaaf T W, Lucas DA Hale A R (eds), *Near miss reporting as a safety tool*, Butterworth-Heinemann, pp. 127–136

Mullen J (2004), 'Investigating Factors that Influence Individual Safety Behaviour at Work', *Journal of Safety Research*, 35 (3), pp. 275–285

Oleinick A, Guire K E, Hawthorne V M, Shock M A, Gluck J V, Lee B, and La S (1993), 'Current Methods for Estimating Severity for Occupational Injuries and Illnesses: data from the 1986 Michigan comprehensive compensable injury and illness database', *American Journal of Industrial Medicine*, 23, pp. 231–252

Powell P I, Hale M, Martin J, Simon M (1971), *2000 accidents: a shopfloor study of their causes*, report 21, National Institute of Industrial Psychology

Robens Institute (1997), *An investigation of the reasons for the non-reporting of accidents to participants in training programmes funded by the DfEE*, University of Surrey

Russell, J (2001) *Report to the Health and Safety Commission: HSE Activity on Young People*,
http://hse.gov.uk/foi/hsc_meetings/2001/c166/index.htm

Seligman P J, Sieber W K, Pedersen D H, Sundin D S, Frazier T M (1988), 'Compliance with OSHA record-keeping requirements', *American Journal of Public Health*, 78, pp. 1218–1219

Trommelen M (1991), *Causes of, and backgrounds to human error in accidents in the nylon plant, internal report*, Leiden University

Tucker J, Holstege S (2005), *Injury record questioned: nearly perfect safety reports cast doubt on accuracy*,
http://www.insidebayarea.com/portlet/article/html/fragments/print_article.jsp?article=2643795

Weddle M G (1996), 'Reporting occupational injuries: the first step', *Journal of Safety Research*, 27 (4), pp. 217–223