**The Grampound Review**

**By**

**Dominic Adamson QC**

## Summary


1. On Friday 16 December 2016 a Highways Safety Inspector (the Employee) employed by Cormac Solutions Limited (Cormac) was working at Cormac's Grampound Road Depot (the depot) Cornwall. At or shortly after 2.20pm he was discovered in a cabin located in the depot by two Cormac Senior Operatives. The Employee had sustained a serious head injury. He was conscious but confused and disorientated. He was unable to provide any explanation as to how he had come to sustain the injury. To this day he has no recollection of the events of that day.

2. The circumstances in which the Employee sustained his head injury have never been resolved. Sadly, as a result of his injuries he never returned to work and he was subsequently medically retired. He remains profoundly affected by the consequences of whatever happened that day.

3. In the years that have passed since, there has been a significant amount of speculation about how the Employee sustained his injury. Theories include, but are not limited to, the following:-

    a. He suffered a spontaneous medical event which caused him to fall striking his head and sustaining the injury.
    b. He was struck at some point by during the process of a skip being delivered to the site.
    c. He was, in some way, struck by the heavy metal doors of the skip after it had been delivered to the depot.
    d. He tripped or fell in the depot yard and sustained injury as a result of the fall.

4. Cormac intended to close the depot. It was approaching the end of its operational use. Unfortunately, CCTV cameras at the depot were no longer operating at the time of the incident. If the cameras had been operational, it is possible that the incident would have been caught on camera.

5. This incident has attracted a significant amount of publicity as a result of concerns raised by a Cornwall Councillor about the accuracy of communications between Cormac and its parent company Corserv Limited (Corserv) and the Health & Safety Executive (HSE). He has also raised concern about the adequacy of the investigation carried out by Cormac into the incident. Corserv is wholly owned by Cornwall Council.

6. Cornwall Council and Corserv Limited (together they are the Commissioning Organisations) agreed to appoint a person to conduct an Independent Review into the events of the 16 December 2016 and its aftermath. On 16 February 2021 I accepted an invitation by the (now former) Leader of the Cornwall Council and the Chairman of Corserv to conduct that review. I have no association with any of the organisations involved in this incident. The Commissioning Organisations agreed a set of Terms of Reference. A full copy of the Terms of Reference can be found at appendix A to this report.

7. It is unusual that workplace incident should require an Independent Review. In about May 2017 the Cornwall Councillor contacted the Employee for unrelated reasons. He discovered that the Employee was off work as a result of an injury sustained whilst he was at work. The Councillor assumed that the matter would be investigated by Cormac and dealt with accordingly. However, when he next contacted him in the summer months of 2017 the Councillor formed the view that Cormac had not dealt with the matter sufficiently.

8. The Councillor became convinced that the reason the Employee's injuries were unknown was attributable to the inadequacy of the initial investigation and reporting of the incident by Cormac. That criticism extended to its parent company, Corserv and, thereafter, Cornwall Council.

9. Over time, the allegations against Cormac and Corserv have included the following:-

    a. Cormac failed to conduct a proper investigation into the events of 16 December 2016 at the time of the incident.
    b. Cormac notified the Health & Safety Executive (HSE) of the incident in '*deliberately false and misleading*' terms on 23 January 2017. It is alleged that the 'RIDDOR[1] report' to the HSE was not truthful about the extent of injury and failed to mention that the Employee had fractured his skull.
    c. A Cormac investigation of the incident conducted 8 months after the incident was inadequate.

[1] 'RIDDOR' is an acronym for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

d. Cormac and Corserv subsequently lied to the HSE about the extent of the Employee's injury in communications with the HSE in October 2017. The HSE was once again not informed that the Employee had suffered a fracture to his skull.
e. Cormac and Corserv misled the HSE on a third occasion in September 2019 when it attempted to explain why the original notification did not refer to the Employee's fractured skull.

10. For its part, Cornwall Council stands accused of failing to take appropriate action in respect of the failings detailed in paragraph 9 above. In addition, that Cornwall Council ought to have ensured that Cormac and/or Corserv made appropriate admissions to the HSE, and that Cormac/Corserv should have issued an unconditional apology to the Employee and arranged for a suitable compensation package.

11. The Councillor considered that the steps taken by Cormac/Corserv have fallen well short of what was appropriate. I have no doubt that he feels passionately that the Employee had been poorly treated. Such was the strength of his feeling; he resigned his position as a Cabinet Member of Cornwall Council as a result of what he perceived to be a refusal on the part of the Cormac/Corserv and the Cornwall Council to take appropriate action. I have little doubt that the Review I have conducted would not have occurred but for his tenacity.

12. When I accepted the invitation to carry out this Review, I emphasised the importance of both Commissioning Organisations approaching my Review with a spirit of candour and co-operation. I am quite satisfied that they did.

13. The Review is not a statutory inquiry established pursuant to the Inquiries Act 2005. Therefore, any person who assisted me did so voluntarily. I invited numerous individuals who I considered might have relevant information. No person was obliged to attend or answer questions. Some individuals did decline to attend an oral interview as was their right. Importantly, in my view, the individuals who were directly responsible for the supply of information by Cormac/Corserv to the HSE did assist my Review. I am satisfied that every person who attended an oral interview provided an honest recollection and did their best to assist me.

14. I have therefore considered the issues which fall within my Terms of Reference on the basis of historical accounts, documentary evidence and oral interviews of relevant individuals who were prepared answer questions about matters. This report sets out my conclusions in relation to the issues within my Terms of Reference.

15. For reasons which I explain in the body of my report, of the various theories, it is my view that the most likely explanation is that the Employee had an accident slip, trip or fall whilst

working in the yard and struck his head. I do not consider he was struck at some point during the process of a skip being delivered to the depot. I am not persuaded that he was somehow struck by the skip door whilst working in the yard. I am confident that he did not suffer a spontaneous medical event which caused him to fall.

16. Cormac's initial investigation into the incident had significant shortcomings. In particular, there are no adequate records of early enquiries into the possibility that the incident occurred during the process of a skip being delivered.

17. On 23 January 2017 Cormac submitted a RIDDOR report relating to the incident to the HSE. The RIDDOR Report was inaccurate. However, I do not accept that it was prepared with the intention of deliberately misleading the HSE. The reality is rather more mundane. It was simply erroneous. I think it is likely that the original notification of the incident to the HSE was prepared, probably hastily, on the basis of imperfect notes. In my view the RIDDOR report should have stated that the Employee had suffered a fractured skull. It did not.

18. Subsequent attempts by Cormac/Corserv to correct and clarify what the RIDDOR report ought to have recorded have, in differing ways, been deficient. In my view on 4 October 2017 Cormac had an opportunity to inform the HSE about the full extent of the injuries sustained. It did not seize that opportunity. Cormac's failure to provide that information at that time has aroused further and deeper suspicion. In September 2019, a further attempt by Corserv to finally clarify the position with the HSE was also inaccurate.

19. Serial deficiencies in communications with the HSE have led some to conclude that this was a '*cover-up*'. I do not accept that the individuals involved with those communications have sought to deceive. In my view some of the criticism that has been levelled at those responsible has, in my opinion, gone too far. One interviewee candidly observed that this was '*not our [i.e. Cormac's] finest hour*'. Quite so. But it was not a cover up.

20. I have concluded that the Officers of Cornwall Council acted appropriately at all times with respect to this matter. I do not consider that the Officers of the Council could reasonably have been expected to do more.

21. My greatest sympathy lies with and for the Employee. He suffered serious injuries and he has been left for years wondering how those injuries occurred. The inaccurate RIDDOR report and concerns about the way the incident was investigated and handled have caused him additional distress. I am indebted to him. He has provided me with enormous assistance during the course of this Review and has patiently awaited the outcome. His former colleagues rightly held him in the highest regard. It is a matter of great sadness

that he should have suffered such an injury and that his career should have been cut short in the way it has.

**Dominic Adamson QC**

**14 July 2021**

## Question 1

## What series of events led to the injury that the Employee sustained on 16 December 2016?

1. The Employee left school and took up employment with Cornwall Council and thereafter Cormac and Cormac Solutions. Although the identity of his actual employer had changed (as the Council divested some its functions to companies wholly owned by it) he had worked within the same organisation for decades.

2. The Employee worked as a Highways Safety Inspector. During the course of that work, he would identify and assess defects in the road. He would prioritise the condition of defects in order that resources could be appropriately allocated. He would allocate tickets to the teams carrying out repair work.

3. The Employee made judgments about safety day in day out. He regarded himself as personally responsible for the condition of the highways he inspected. He was an assiduous record keeper and kept a daily diary. He kept his records at the Grampound Road Depot. Liked and respected by his colleagues, Iam completely satisfied that he was a highly professional and diligent worker.

**Cormac Solutions Limited**

4. Cornwall Council has formed a number of companies to support the discharge of the Council's duties. Cormac is a company within the Council's group of companies. Cormac was formed in 2012 as a highways, engineering and construction specialist. Cormac is part of the Corserv group of companies that is wholly-owned by Cornwall Council.

5. Cormac describes itself as one of the most highly-regarded, trusted and well-known companies in the South West. It provides highway and environmental design and maintenance services, design and construction of major highway schemes.

**The Grampound Road Depot**

6. At the time of the incident which I am considering, Cormac operated from various locations. One such location was the Grampound Road Depot. The Depot was accessed from the Grampound Road. On the left-hand side of the depot there were bays in which skips could be placed. Further down was the office. On the right of the depot there was a cabin. A view into the depot from the road is provided in figure 1.


**Figure 1: A view into the Grampound Road Depot**

7. Cormac had taken a decision to close the depot. In December 2016, it remained operational but the working life of the site was coming to an end.

8. The gangs that carried out road and ground maintenance kept materials and equipment at the depot.

9. Estimates of the yard's dimensions varied. Some considered that the distance between the bays on the left and the cabin on the right was of the order of 30 feet, others thought it was more likely to be the length of a cricket pitch (66 feet). On any view, the yard was not particularly wide as can be seen from figure 1.

10. I was informed that the cabin on the right of the yard did not have electrical power.

11. There were CCTV cameras at the site but, at the time of the incident, these were no longer operational. The Employee informed me that his diary indicated that the CCTV cameras were disconnected in May 2016. The CCTV cameras were in place for security purposes i.e. to help deter activities such as theft and fly-tipping and to assist in identifying the perpetrators of such activities. They were not in place as a safety measure for depot yard activities. The depot was sparsely populated. Indeed, very often it would be empty.

12. Cormac prepared risk assessments in relation to tasks (e.g. patching a road or for roles of a Highway Inspector). There was no site-specific risk assessment for operations in the yard such as skip delivery. There was no formal traffic management system in place for the yard.

13. The yard was not a risk-free environment. There were electric cables passing over the site. I was informed that if, for example, a HIAB lorry[2] turned up at the site, care needed to be taken. If there was any risk of contact with the electricity cables during an unloading operation then it could not proceed. From time to time, skips would be collected and delivered to the depot and that was an operation which, in my view, could have given rise to risk to those in the yard.

14. A Highways Safety Inspector such as the Employee would not normally get involved in the process of skip delivery and collection. Indeed, I was told that he would not have any reason to work with skips on a day-to-day basis. He could not think of a reason why he would have climbed on to a skip or why he would have climbed on to the walls which surrounded the skip bays.

15. The yard in the depot could become wet and messy. Water could accumulate down the middle of the yard. It could run down the side of the yard towards the office and beyond. Photographs taken on the day of the incident show water accumulated in the middle of the yard.

[2] This a brand of mobile loader crane

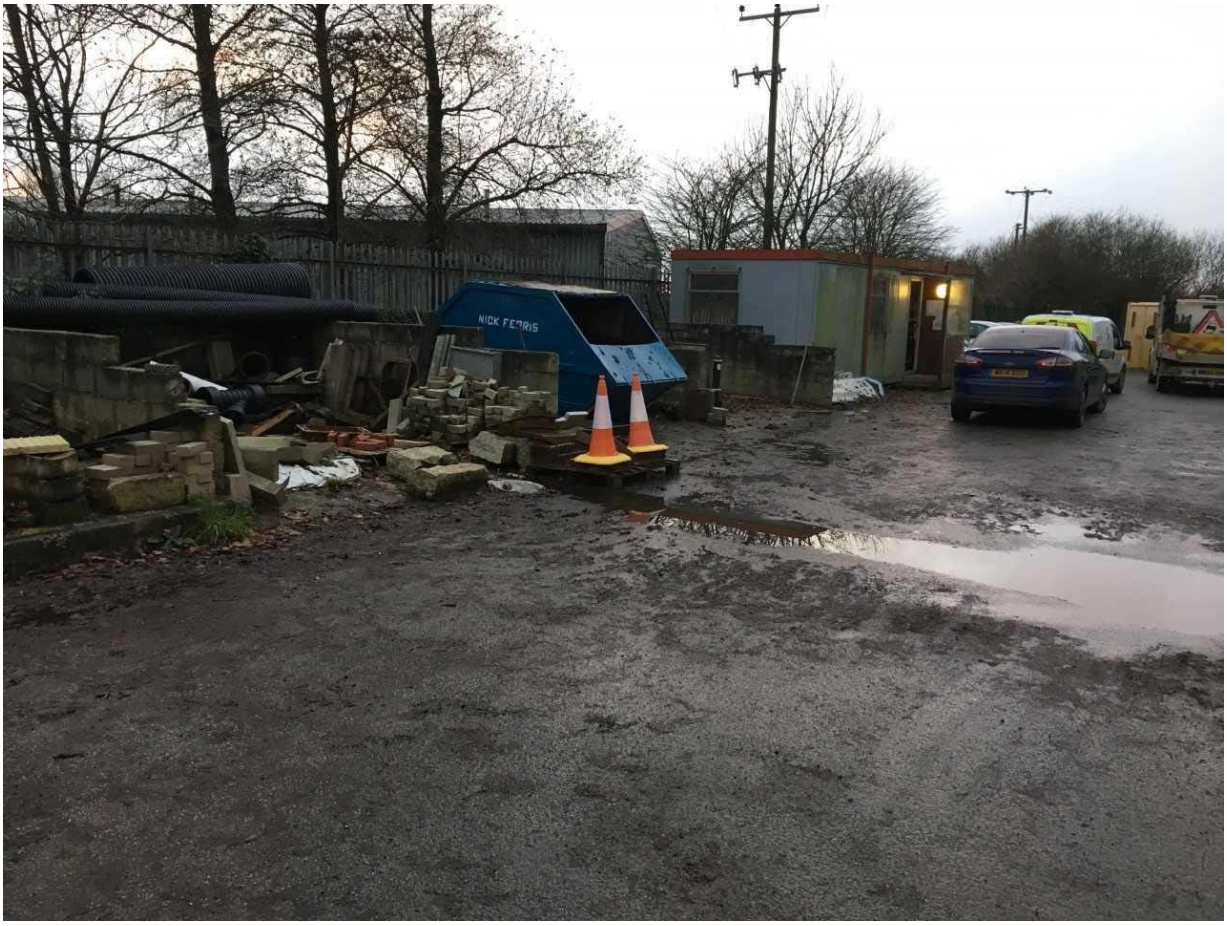



**Fig 2: A view of the bays, the skip and the office on the day of the incident**

**The Events of the 16 December 2016**

16. The Employee has been able to assist me with respect to his work activities that day by reference to the diary which he kept. It is unnecessary to set out the full details of his diary. His day commenced with an inspection of the Truro Park & Ride at 07.45hrs in the morning.

17. Amongst the notes he made for that day was the fact that his colleague (the Chargehand) who was – a charge hand – was working a half day. The final entry in his diary stated '*Dropped [the Chargehand) home…had ½ day holiday*'.

18. The Chargehand and the Employee had known each other for many years. The Chargehand was trained by the Employee. They were colleagues and friends.

19. The Employee agreed to take the Chargehand home because the latter was keen not to use the works vehicle which was being used by his team. He did not wish to leave them without a vehicle. They commenced their journey at about 11.55hrs and arrived at the Chargehand's home at about 12.15hrs. I was told how the Chargehand had spent the journey having a '*a bit of a rant*' about the lack of maintenance in the area where he had been working that morning. The Employee listened calmly and patiently and told him not to worry and to '*chill out*' given that he was now on holiday.

20. Given the length of time they had known each other, the Chargehand is well placed to say whether the Employee appeared unwell. He was clear that the Employee did not appear poorly or unwell when they parted company at 12.15hrs. The Employee returned to the depot.

21. It is clear that at some point after the Employee returned to the depot a skip was delivered to the site. I deal with the circumstances of the delivery in more detail below. The Employee signed the delivery note.

22. A person who knew the Employee recalls that she drove past the depot on the day of the incident at around 13.55hrs and she saw him in the yard shovelling material into one of the bays near the portacabin.

23. At about 14.20/30hrs two Senior Operatives who I will refer to as SO1 and SO2 arrived at the depot. They carried out ground work. Both have provided two written accounts.

24. In an account provided on the day of the incident SO2 stated that he and SO1 returned to the depot at 14.30hrs and started to unload their kit. His colleague, SO1, noticed that there was a pair of glasses on the floor. SO2 explained "*In the yard [the Employee's] glasses and a pair of gloves were on the floor. There was a shovel on the floor nearby and others leaning against the wall by the skip. There was no blood on the shovel but I did think that maybe he had been hit on the head with it. But because there was no blood on the shovel I didn't think it looked suspicious.*" He went onto to state that "*I think that the new skip came and that he was tidying up around it. There was some rubbish around the old one because it was so full. There was quite a lot of blood on the floor and I think that he fell over backwards*".

*25.* SO1 gave a broadly similar account on the day of the incident. He explained that they returned to the yard at about 14.20hrs He stated "*I could see a pair of glasses and gloves on the floor. There was also a shovel on the floor nearby and others leaning against the wall by the skip…The office was open and it all seemed a bit strange. Couldn't see [the Employee] anywhere. I went to the crib room and found him sitting in the chair. I shouted to [SO2]. It was obvious that he had had a fall. We rang the ambulance, made sure he*

*could hear me. Kept him chatting until the ambulance turned up. The skip was full this morning and empty now. The shovel was on the floor as well*".

26. SO1 and SO2 gave further accounts in August 2017. Those accounts were more detailed than their initial accounts but they were, in my view, consistent with their earlier accounts. Further detail was provided about the Employee's condition when they discovered him. SO1 stated that the Employee was providing muddled responses to questions. He describes who he contacted about the incident. In addition, he explained that as people began to arrive he decided to '*cone off the area around the shovel, gloves and blood stain*'. The area covered with sand in figure 3 is the approximate location of the shovel, gloves and blood stain.

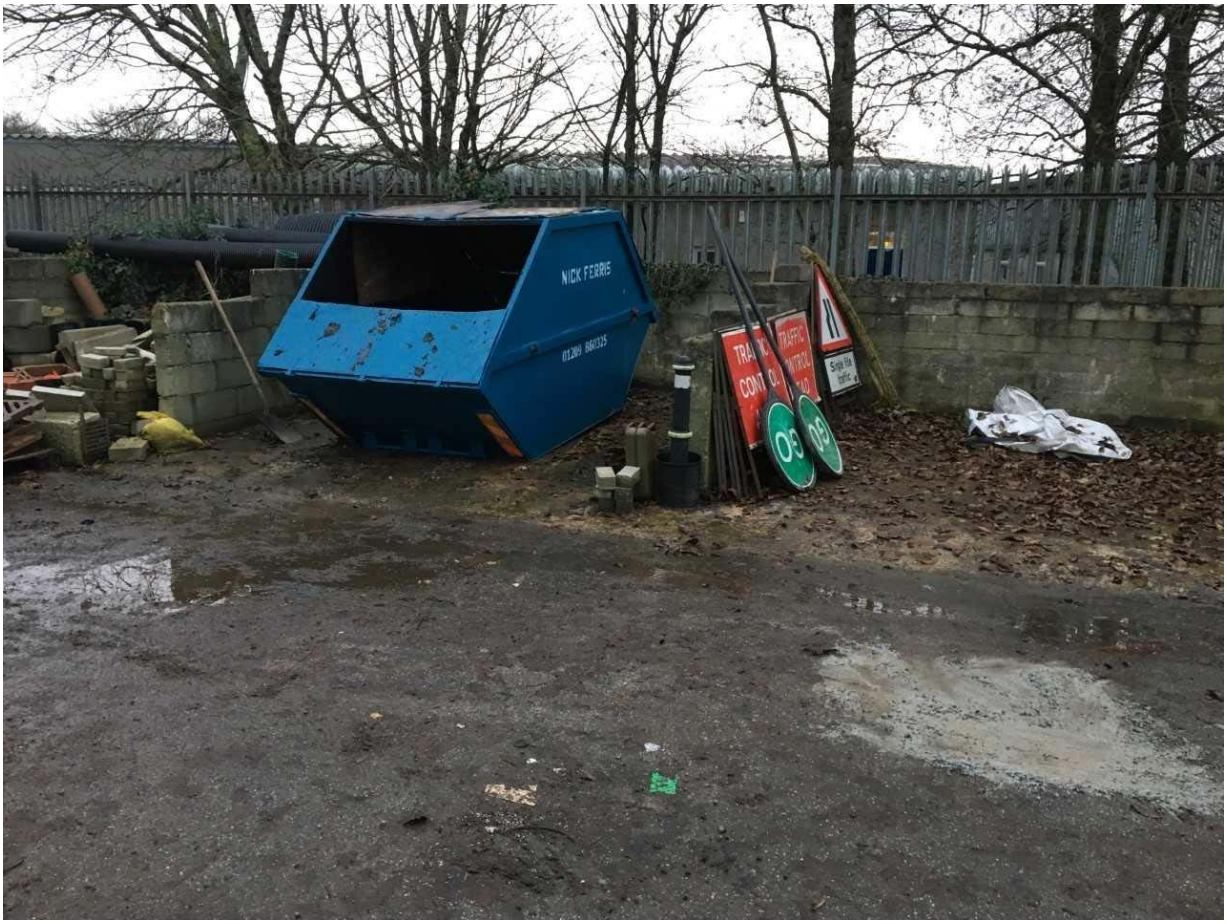



**Fig 3: The area where the Employee's blood had been found was covered with sand**

27. As noted above, the Employee was discovered sitting in what is known as the crib room (this is on the right-hand side of the yard when viewed from the entrance – see fig.1). In Cormac's investigation report it is stated that this was approximately 10 metres away

from the area where the blood was found. The Employee was sitting at a table and was bleeding from a wound at the back of his head. I have seen a photograph taken on the day of the incident, which shows the Employee holding a paper towel over the location of the injury.

28. The evidence indicates that the Employee was confused and disorientated. It was clear he had suffered serious injury. He was unable to explain what had happened.

**The Delivery of the Skip**

29. At some point after the Employee had returned to the depot having dropped the Chargehand home an empty skip was delivered to the depot. The driver of the vehicle on which the skip was delivered had considerable experience of this work. The Skip Driver had been driving skip delivery lorries for many years.

30. On the day in question the vehicle he was using was an 18 tonne Leyland skip loader. The loader is equipped with hydraulic equipment which enables skips to be raised and lowered off the rear flat bed of the vehicle. The skip is attached to the lifting equipment using chains. The controls for operating the hydraulic equipment to lift a skip on and off the back of the lorry are located on the driver's side of the lorry behind the cab.

31. The vehicle had a range of mirrors which provided visibility. There were mirrors providing a view down each side. The Skip Driver's recollection is that the vehicle he was using was not equipped with a rear view reversing camera. There was a tachograph.

32. The skip being delivered was an enclosed skip. I was informed by the Skip Driver that it could have weighed about ¾ tonne. Whatever the exact weight, on any view it was heavy. It had doors at the front and rear of the skip. At the front there were three hinged doors. He would normally deliver a skip with the doors closed. The skip doors required a '*fair bit*' of effort to open.

33. The Skip Driver was first contacted about the events of 16 December 2016 by no later than 20 December 2016 i.e. within 4 days of the incident. Unfortunately, the only record of that contact is in an e-mail dated 20 December 2016 from a member of the Cormac Health & Safety team appointed to carry out an investigation of the incident (I attach a copy of this e-mail as appendix B). It states '*the... skip delivery man...stated when he delivered the skip [the Employee] looked "rough as rats and not very well at all*'". That expression "*rough as rats*" also features in a statement signed by the Skip Driver on 15 August 2017. Therefore, there is some consistency between what was said in December 2016 and August 2017.

34. In my view it is likely that the Skip Driver would have been able to remember his visit to the depot if asked about it 4 days after the incident. I also consider that the fact that he was contacted by Cormac is likely to have resulted in him remembering this delivery more so than others. Unfortunately, I have seen no record, beyond the brief e-mail to which I have referred, which sets out what the Skip Driver stated to the Cormac Health & Safety team on 20 December 2016.

35. I do not know if the Skip Driver was asked about the timing of his arrival at and departure from the depot. It would have been an obvious question to ask but I do not know if it was asked. I have been informed by a member of the Cormac Health & Safety team that notes were taken of his conversation with the driver which were used in the original incident report. I am unable to say if those notes were taken in December 2016 or subsequently.

36. In the statement dated 15 August 2017 the Skip Driver stated that he attended the depot at around 13.30hrs and he was at the site for about 10 minutes.

37. As mentioned above, an acquaintance of the Employee has provided a statement that she saw the Employee on 16 December 2016 at approximately 13.55hrs as she drove past the depot. Her statement, dated 22 August 2017, indicates that she was returning to work after her lunch hour and she saw him at work in the yard. Given that her lunch hour ended at 14.00hrs, I have no reason to doubt the reliability of her time-estimate. She indicated that the Employee appeared to be shovelling material from the floor into one of the bays near the portacabin. Therefore, it is clear that the employee had not suffered his injury. She made no mention of a skip. I am satisfied that this does not mean that a skip was not present. Her view into the depot yard must have been brief as she drove past the entrance.

38. If the Skip Driver's estimates of his time of arrival (13.30hrs) and departure (10 minutes later) from the depot are correct then the Employee was not injured during the process of the skip being delivered.

39. The Skip Driver's employer kept paper records at that time (this has since changed). The Skip Driver's delivery note does not contain details of the time of delivery. It was signed by the Employee.

40. Although the Skip Driver had a tachograph, these records were never obtained or analysed. I note that this was not the only delivery which he made on that day. Therefore, I doubt that it would now be possible to conduct a meaningful investigation of tachograph data without a full itinerary of the Skip Driver's movements on that day.

41. The Skip Driver assisted my Review. He was giving this account over 4 years after the events we are considering. He told me that he went to the portacabin on the left. He recalled that it was boiling hot in the portacabin. He thought that the person in the portacabin had been asleep. He described the person in the portacabin as looking groggy. He asked about where the skip should be placed. The Employee signed the paperwork. His recollection to me was that he deposited the skip between 2 Viridor skips.

42. I asked him if it was possible that the Employee was injured in the course of the skip being offloaded. He did not accept that this had happened. I observe that if the injury occurred whilst the skip was being offloaded then when the Skip Driver removed the chains from the skip, he would have been in an ideal position to see down the passenger side of the truck. The point where the gloves, shovel and blood stain were found would have been clearly visible to him. I am satisfied that the Skip Driver would not simply have left the scene in these circumstances. I note that there were CCTV cameras at the site. They were not operational. But that was not something that the Skip Driver could have known.

43. The Skip Driver did not think it was possible that he accidentally struck the Employee in the course of manoeuvring his vehicle out of the depot after offloading the skip. His thought was that it would have been possible to turn his vehicle out of the yard with a '*hard lock*' to the right from the position it was in to deliver the skip. Having regard to the dimensions of the yard, I have formed the view that some manoeuvring might well have been necessary. However, I am satisfied that the Skip Driver did not inadvertently and unknowingly strike the Employee in the course of manoeuvring his vehicle whilst leaving the yard.

44. I observe that the Skip Driver spoke to Cormac representatives in December 2016 and August 2017. He attended an oral interview for the purposes of my Review. I am satisfied that he has co-operated with all enquiries made of him by Cormac. I am satisfied that there is no reason to be concerned about the Skip Driver's statement dated 15 August 2017. It was not the first occasion when he was asked about his attendance at the depot. It is unfortunate, to say the least, that a proper record was not kept of the initial contact with him in December 2016 account. It has caused some to view his August 2017 statement with a degree of scepticism which I do not share.

**Did a medical event cause the Employee to fall?**

45. One possibility which has been raised is that the Employee suffered a medical event which caused him to fall. I was provided with access to the Employee's medical records. I am indebted to the Employee who gave his consent to enable me to consider this issue.

46. In the week following the incident there was also some consideration as to whether the Claimant may have suffered an episode of fainting and fallen as a result of medication he was taking.

47. In March 2017 he had a seizure which was witnessed by his wife. This caused one of his treating practitioners to express the view that an epileptic seizure was likely to have caused him to fall on 16 December 2016. Other treating practitioners were more circumspect. The incident in March 2017 revealed the fact that the Employee had a fracture dislocation of his shoulder. Investigations at that time suggested this was not a fresh injury and could be related to the incident on 16 December 2016. The records are clear that he did not fall as a result of the seizure in March 2017 and this was confirmed to me by the Employee and his wife who witnessed the event.

48. The Employee confirmed to me that he had no history of dizziness and fainting. His medical records contain no information to contradict that view. He also confirmed tome that he had no pre-incident history of epilepsy.

49. Given the possibility that a medical event might explain the incident and having regard to the conflicting views expressed in the medical records, I obtained an opinion from an independent Consultant Neurologist in order to assist me in reaching a conclusion as to whether a medical event could have caused the Employee to fall and suffer a head injury.

50. The Consultant Neurologist reviewed the medical records and reached the following conclusions:-

- It was highly unlikely that the Employee had a seizure which caused the index event. There were no factors in the past to suggest a liability to fits. He was of the opinion that the seizure which took place 3 months later was an isolated post-traumatic fit due to cerebral contusions.
- He did suffer a sub-arachnoid bleed on 16 December 2016. It was highly probably caused by the fall. In other words, it was highly unlikely that a sub-arachnoid bleed resulted in sudden loss of consciousness and thus a fall.
- There was nothing in the history to suggest that the Employee might have suffered an episode of dizziness/fainting.

51. I unhesitatingly accept the Consultant Neurologist's conclusions which rule out the possibility that a spontaneous medical event caused the Employee to fall and suffer his head injury or that he had an episode of dizziness or fainting whether related to medication or otherwise.

52. The Consultant Neurologist thought that a slip or fall was a possible explanation for the head injury. From a medical perspective, he thought that it was possible that he could have been struck on the back of the head by a metal skip door causing injury. He observed that being struck by a skip delivery driver truck seemed unlikely (although his rationale for this was based on the likelihood that the driver would have known of the mishap). I infer that from a medical perspective, and as a matter of common sense, he accepts that too was a possibility.

53. Whilst acknowledging that he is not an orthopaedic expert, he thought that the fracture dislocation of the shoulder occurred in the fall. Although orthopaedic injuries, strictly, are not his area of specialism, I also accept the Consultant Neurologist's view in this respect. Therefore, it is likely that he suffered a shoulder injury in the fall as well as the head injury on 16 December 2016.

**Conclusions as to the Cause of Injury**

54. Given that I have concluded that the Employee was not injured as a result of the skip being delivered and that he did not suffer a spontaneous medical event, what then caused his injury. There was no evidence of foul play/assault.

55. It has been suggested that he might have been injured whilst operating or opening the skip doors. However, the injury was to the back of his head. I have some difficulty in understanding how that could have occurred.

56. In my opinion the most likely explanation is that he suffered a slip, trip or fall whilst working in the yard and landed heavily. The evidence of his acquaintance indicates that he was working in the yard approximately 25-35 minutes before he was found. He may well have banged his head against an object such as the skip. The medical records suggest his head injury could have occurred as a result of him falling on to the skip. I cannot be sure that his head did strike the skip. However, I am satisfied that his head suffered a forceful impact that it caused a skull fracture and sub-arachnoid bleed. My conclusion is consistent with the medical opinion provided by the Consultant Neurologist.

## Questions 2 (i), 3 (i) & 4 : the 16 December 2016

**What did Corserv/Cormac know or discover about the Incident on 16 December 2016?**

**What actions and/or investigations were undertaken by Corserv/Cormac in response to the incident on 16 December 2016?**

**Were these actions and/or investigations adequate and/or appropriate in all the circumstances?**

57. A Cormac employee (**'The First Responder'**) attended the depot on the day of the incident after he was informed of the incident at 14.47hrs on 16 December 2016 by a telephone call. He was not part of the health and safety team at Cormac. He was not involved in formal investigations in relation to health and safety incidents or accidents at work. He had received a half day overview but he told me that he had received no formal training in relation to accident investigations. He was naturally concerned and decided to drive to the depot. He estimates that it would have taken about 30 minutes to drive to the depot. He arrived at or shortly after 15.15hrs. When he first arrived his first concern was to check on the Employee's condition. In common with other witnesses, he noted that the Employee was not making much sense. He was talking but not coherent. He was conscious. He tried to reassure him. A paramedic was in attendance.

58. The First Responder cannot recall the area of blood being coned off (but does not suggest that they were not). He thinks that the gloves and glasses had been removed. He was aware of the presence of a shovel. It is his recollection that it was suggested by someone that the Employee may have been clearing up in the yard and he was using the shovel.

59. The First Responder took some initial statements from SO1 and SO2. SO1's account was given at 15.50hrs. The account of SO2 was given at 15.40hrs. I have referred to extracts from these accounts above.

60. The First Responder took some photographs of the yard. These photographs were taken at or very shortly after 16.00hrs. He also took photographs of the Employee's diary and the skip delivery note.

61. The Chargehand returned to the depot because he had heard about the incident. The First Responder took an account from him as well. This was given at 16.10hrs. The First Responder explained to me that the Chargehand had information about the Employee's movements earlier that day and he felt it was important to record them.

62. The First Responder explained that he was focused on capturing what had happened to the Employee. He was confident that this would be needed for an investigation. His recollection from his overview training was that he needed to speak to persons there and then.

63. The brief accounts obtained from SO1, SO2 and the Chargehand were subsequently typed up. I accept that the typed versions reflect the gist of what they told the First Responder. These accounts have assisted me in reaching conclusions about the circumstances of the incident above. Although I have not seen the original notes, I am satisfied that they were converted into word documents by no later than 20 December 2016 when they were sent by e-mail to the Cormac Health & Safety team in charge of the investigation. Those initial accounts are consistent with more detailed accounts provided by each of the gentlemen who provided them.

64. Although the First Responder did not consider that he was carrying out a formal investigation, in my view he did an appropriate and adequate job of preserving relevant evidence. In particular, he took photographs of the scene and of potentially relevant documents at the scene. He plainly thought that the diary and the delivery note for the skip may be relevant and took photographs of them.

65. The police were not summoned to the scene. The First Responder informed me that he did not think there was a need to summon the police. I readily accept that others may have acted differently in the same circumstances but I am not critical of his decision. His assessment was that there was no obvious sign of a break-in or theft or foul play. The First Responder was not the only person present. There would have been nothing to stop any other Cormac employee who was present on the day from calling the police. In making this observation I wish to make it absolutely clear that I am not criticising any other employees who were present. Whilst it was not their function to call the police, there is no suggestion that any of the paramedics thought that the police should be summoned either.

66. Some concern has been raised about the First Responder's decision to arrange for the blood in the yard to be covered with sand. He thought it was inappropriate to leave blood on the floor. This was not an attempt by him to disguise or cover up the scene; given that the sand can clearly be seen it would not have been an effective disguise. I accept that it was an action that he took to mitigate the upsetting appearance of blood on the ground.

I accept that it was done with the best of intentions and it was appropriate for him to do so.

67. The First Responder was later informed by the Cormac Health & Safety team, which included a former police officer, that there was nothing more that the police could have done. I make no finding about this.

68. I am satisfied that the First Responder suspected that the Employee had fallen albeit for reasons which were unclear. He was not alone in forming that opinion. SO2's account suggests he had reached a similar conclusion. The enquiries he made on the day were, in my view, reasonable and appropriate.

69. The First Responder did not know the full extent of the Employee's injuries whilst he was at the depot. However, I am satisfied that he was probably told during a conversation with the Employee's wife later on that evening that the Employee had suffered a fracture to his skull.

## Question 2 (ii), 3 (ii) & 4: Pre-RIDDOR Report

## What did Corserv/Cormac know or discover about the Incident in its subsequent investigation?

## What actions and/or investigations were undertaken by Corserv/Cormac after 16 December 2016?

## Were these actions and/or investigations adequate and/or appropriate in all the circumstances?

**The Initial Investigation by the Cormac Health & Safety Department**

70. At the time of the incident the Group Health, Environment and Quality Manager for Cormac had overall responsibility for the health and safety function. He is now the Corserv HSEQ Director and I will refer to him as the HSEQ Director.

71. One member of the Health & Safety team had, historically, been responsible for carrying out significant health and safety investigations. However, there had been a considerable expansion of the organisation and the size and diversity of the activities carried out by the health and safety team. It was no longer sustainable for him to carry out all such investigations. Another individual who had been added to the health and safety team assisted.

72. A member of the Health & Safety team was given the task of leading the investigation into this incident. Another member of the Health & Safety team recalls that this was his first investigation.

73. One part of the investigation process – depending on the nature of an incident – was to notify the HSE of incidents where the duty to notify it of a work-related incident was engaged under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. This is often referred to as a RIDDOR Report. Although the health and safety team had recruited a senior person to assist with investigations, another member of the team retained responsibility for RIDDOR reporting as he had done previously.

74. The Health & Safety team were aware of the incident by Monday 19 December 2016. The HSEQ Director recalls being told that the Employee had '*passed out*' in the main yard and had struck his head. He does not know how that information about passing out came to be present.

75. A senior member of the Health & Safety team informed me he kept a notebook in which he would make notes. He suspects that he would have made notes in a notebook about this matter. Indeed, he said it was likely that those initial notes informed the content of

the RIDDOR Report, which was in fact submitted on the 23 January 2017. These notes have not been retained.

76. The HSEQ Director recalls that there was a belief that the Employee may have recently changed his personal medication. He suggested to a member of his Health & Safety team that he contact the Employee's wife about the Employee's medication.

77. It is not known if the Health & Safety team kept an investigation file for the purposes of this incident. No such file has been located or provided to me. Therefore, it is not possible to establish the true extent of the investigations which were conducted by the team in the weeks that followed the incident. However, I am satisfied that the Health & Safety team did embark on an investigation. A member of the team:

- Attended the scene of the incident.
- Received the information which had been collected by the First Responder on the day of the incident. On 20 December 2016 at 12.10hrs the First Responder sent copies of the initial statements he had taken from SO1, SO2 and the Chargehand.
- An internal email shows that on 20 December 2016 at 13.45hrs the team member had spoken to the Employee's wife and offered the Company's '*full support*'. During the course of that conversation the Employee's wife had relayed that the Employee was '*adamant he still doesn't remember anything*'. The e-mail indicates that the Health & Safety team member had discussed the Employee's medication with his wife and that he had conducted some internet research into that medication which indicated that the side effect of the medication could include '*fainting and extreme fatigue*'.
- Made contact with the Skip Driver although no formal statement was obtained.
- Obtained a detailed statement from the Chargehand.

78. In the e-mail sent at 13.45hrs on 20 December 2016 referred to above the member of the Health & Safety team indicated that it would not be prudent to interview the Employee until after the New Year and not until his doctor confirmed that it was appropriate to interview him. I infer from the e-mail that it was hoped that the Employee would, in due course, be able to provide important information about the circumstances of the incident.

79. The Skip Driver was the last person known to have had contact with the Employee. Given that the Employee had no recollection of the incident and having regard to the seriousness of the injury I consider that an adequate record of the Skip Driver's account would have been desirable and one ought to have been obtained and kept. A few lines in an e-mail does not, in my view, constitute an adequate record. There may have been a more detailed record taken at that time but I have not been provided with it.

80. Although initial accounts had been obtained by the First Responder these were not

detailed statements. A more detailed statement was obtained from the Chargehand on 20 December 2016. He confirmed that the Employee did not seem '*poorly or under the weather*'. This did not necessarily align with the account provided by the Skip Driverthat he looked '*rough as rats*'.

81. I am not aware of any other detailed statements being taken by the health and safety team in the early part of its investigation. I contrast the steps taken in August 2017 when a reinvestigation was ordered by the Group Managing Director of Corserv. At that time detailed statements were taken from the assistant to the First Responder ('**Assistant to the First Responder**') (which addressed amongst other things operations at the depot) as well as detailed statements from SO1 and SO2. He also obtained a detailed statement from the First Responder about his observations at the scene on the day of the incident. He also addressed the fact that the depot was closing and that the CCTV was not operational. This was a rather more detailed investigation.

82. The impression I have formed is that the investigation which was performed in the weeks after the incident was not detailed. This was probably influenced by the forlorn hope that at some stage the Employee might be able to provide the answer to the question of what had occurred.

83. In the weeks that followed Cormac was kept abreast of the Employee's progress. Cormac was in receipt of a sick note dated 28 December 2016 informing Cormac that the Employee had been signed off work for 8 weeks (as from the date of the incident). The Employee did not return to work in the New Year.

84. The Assistant to the First Responder kept in contact with the Employee. They spoke on 16 January 2017 and the Employee explained that he had fractured his skull. The Assistant to the First Responder was not part of the health and safety team but he updated Cormac's Human Resources Department about the Employee's condition by e-mail.

"*As discussed earlier are (sic) the notes from the conversation with [the Employee].*

*[The Employee] rang and informed me of his current condition, he has suffered a bleed on the brain and a fractured skull. He has regained most of his balance, although still experiences some vertigo when looking up and down. He no longer gets the really bad head aches and is much better in himself, although his (sic) still suffering memory loss. He remembers before the incident, although he has almost no recollection of the last month or so.*

*He informed me that the doctors have told him they think by the shape of the injury on his head it was caused by hitting his head on the skip, although they are not sure whether the bleed on the brain caused him to fall and sustain injury, or whether a fall caused him to sustain the injury and the bleed was a result of that injury.*

85. *[The Employee] is awaiting an appointment with a neurologist who will hopefully be able to provide him with some more information, however at this time the cause of the incident is not known*…"During the course of my review, it has been established that this e-mail was forwarded for information to the Health & Safety team on 16 January 2017. Therefore, the health and safety team did know on 16 January 2017 that the Employee had reported to the Assistant to the First Responder that he had suffered a fracture to his skull (I attach a copy of this e-mail at appendix C).

86. There was no reason to doubt the accuracy of the Employee's account that he had suffered a fracture to his skull. It is likely that written confirmation of this could have been provided if it had been sought. It was not.

87. On 23 January 2017, the RIDDOR Report was submitted. It did not refer to the fact that the Employee had suffered a fracture to his skull. I address the accuracy of that document separately below.

88. In conclusion I am satisfied that little progress had been made with the investigation at the time of the RIDDOR Report. In reality the only potentially significant information which the investigation had unearthed since the day of the incident was information obtained from the Skip Driver that the Employee looked unwell which potentially conflicted with information which was provided by the Chargehand. It is regrettable that full details of the account provided on 20 December 2016 were not retained. I am also satisfied that no investigation report had been completed.

## Issue 7, 8 & 9: The RIDDOR Report

**What information did Corserv/Cormac report to the Health and Safety Executive following the Incident including in the RIDDOR report?**

**Was the timing and content of the initial RIDDOR report (and any subsequent communications with the Health and Safety Executive) accurate, and appropriate in the circumstances?**

**What processes and procedures had Corserv/Cormac adopted at the time of the Incident for health and safety reporting and were these followed?**

### The Legal Framework for Reporting Work-Related Accidents under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013

89. In certain circumstances, employers are obliged to report injuries sustained as a result of work-related accidents to the relevant enforcing authority pursuant to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. A failure to report an incident when obliged to do so is a criminal offence. Submitting a deliberately false report is also a criminal offence.

90. The RIDDOR report (or notification) informs the relevant enforcing authority about deaths, injuries, occupational diseases and dangerous occurrences. It enables the relevant authority to identify where and how risks arise, and whether they need to be investigated. The HSE issued Guidance, INDG 453 (rev 1), which was published in October 2013. It indicates that RIDDOR 2013 allows the '*enforcing authorities to target their work*'.

91. The statutory duty to report work-related injuries is found in regulation 4. For present purposes the relevant parts of regulation 4 are as follows:-

> *(1) Where any person at work,* ***as a result of a work-related accident****, suffers—*
> *(a)* ***any bone fracture diagnosed by a registered medical practitioner****, other than to a finger, thumb or toe;*
> *…*
> *(g)* ***loss of consciousness caused by head injury*** *or asphyxia; or*
> *…*
> *the responsible person must follow the reporting procedure.*
>
> *(2)* ***Where any person at work is incapacitated for routine work for more than seven consecutive days*** *(excluding the day of the accident)* ***because of an injury resulting from an accident arising out of or in connection with that work****, the responsible person must send a report to the relevant enforcing authority in an approved manner as soon as practicable and in any event within 15 days of the accident.*

*[Emphasis added]*

92. Therefore, not all accidents need to be reported. A RIDDOR report is required only when:

a. the accident is work-related; and
b. it results in injury of a type which is reportable.

***Work-related accidents***

93. Regulation 2 defines an accident as '*work-related*' if it is '*an accident arising out of or in connection with work.*' The HSE's Guidance INDG 453 states that the key issues to consider are whether the accident was related to:

a. the way the work was organised, carried out or supervised;
b. any machinery, plant, substances or equipment used for work; and
c. the condition of the site or premises where the accident happened.

94. If none of these factors are relevant to the incident, it is likely that a RIDDOR report will not be required. Therefore, if an employee had a spontaneous medical event resulting in a fall on work premises that would not be a work-related accident. If a person tripped or fell because the surface of a traffic route was in poor condition that would be a work-related accident.

***Type of Injury***

95. Not all injuries are reportable. For example, fractures to a finger, thumb or toe are not reportable. All other bone fractures are reportable. However, the fracture must be '*diagnosed by a registered medical practitioner*'.

96. Pursuant to regulation 2:-

'"*diagnosis*" *means a registered medical practitioner's identification (****in writing, where it pertains to an employee****) of (a) new symptoms or (b) symptoms which have significantly worsened.*' (emphasis added)

97. Therefore, the regulation provides that a fracture is only reportable if it is diagnosed by a registered medical practitioner in writing where it pertains to an employee.

98. A head injury resulting in loss of consciousness is also reportable. However, this does not need to be diagnosed by a registered medical practitioner in order for the reporting obligation to be engaged.

99. Fractures (not including those to the finger, thumb or toe) and head injuries resulting in loss of consciousness are known as specified injuries.

100. There is a catch-all provision for non-specified injuries which result in a person being incapacitated from routine work for seven consecutive days. There is no need for a diagnosis by a registered medical practitioner for the 'over 7 day' provisions.

***The time to report***

101. Specified injuries falling within the scope of regulation 4 must be notified to the enforcing authority '*by the quickest means practicable without delay*' and a report of that incident should be sent to the relevant enforcing authority within 10 days of the incident.

102. Injuries resulting in incapacity for routine work for more than seven consecutive days must be reported within 15 days of the incident.

**The Reporting of the Incident on 23 January 2017**

103. The RIDDOR Report was submitted on 23 January 2017 by the Health & Safety team. A senior member of the Health & Safety team made it clear to me that he was responsible for its content and it was completed in accordance with his instructions.

104. The RIDDOR report stated "*The Employee **passed out** and sustained a head injury while within the car park of our operational depot at Grampound Road. There were no witnesses and The Employee has no recollection of the incident. The Employee was found conscious but dazed by **a work colleague who took him to hospital**. Subsequent examination has revealed a **head injury** but it is unclear how this was sustained.*" [emphasis added]

105. The senior member of the Health & Safety team instructed an administrative assistant to record the injury as an '*over 7-dayer*'. The Employee had been absent from routine work for a period of more than seven consecutive days. It was submitted 37 days after the incident.

106. I have been informed by the senior member of the Health & Safety team that he realised that the incident had not been notified to the HSE during a routine health and safety meeting in January 2017. He informed me that he had always thought that this was a reportable incident. His recollection is that it is likely that he relied on handwritten notes from his notebook. He told me he was embarrassed by the fact that a report had not been submitted. When he realised what had happened, he arranged for the matter to be reported.

107. The HSEQ Director's recollection is a little different. He recalls that there were initial discussions on 19 December 2016. The information available suggested that the injury may not have been related to the Employee's work (and, therefore, it may not have been reportable). Additional details were required. He states that after the Christmas break

there were no lines of enquiry which needed to be followed up and that the only person who was likely to be able to inform the enquiry further was the Employee himself. He met a senior member of his Health & Safety team on 23 January 2017 and discussed the incident. Whilst there was no clear evidence linking the Employee's injuries to any work activity being undertaken at the time, this equally could not be ruled out. His recollection is that a decision was taken to report the incident on a precautionary basis.

108. The senior member of the Health & Safety team who completed the RIDDOR report did not seek the HSEQ Director's approval on the content of the RIDDOR report. I accept that there would have been no need for this to be done. In my view, the reporting of an incident such as this was an important but relatively routine task. This senior member of the Health & Safety team had sufficient experience. I consider it was appropriate for him to issue this report.

109. I also accept that that the senior member of the team probably relied upon notes handwritten into a notebook in order to provide the detail in the RIDDOR report.

**The Factual Errors**

110. In my view the fact that the Employee is described as having passed out probably reflects a degree of supposition based on the information which was known from the day of the incident. When the Employee was found he was confused and disorientated and with a significant head injury. As a matter of fact, I think it is likely that the Employee did lose consciousness. I am satisfied that the fact that the RIDDOR report erroneously refers to the Employee being taken to hospital by a colleague was just a simple error. I would observe that the person who submitted the report did not attend the scene of the incident and had no direct involvement on the day. The manager who was present at the scene on the day had no involvement in the submission of the RIDDOR report.

**Was the incident work-related?**

111. There is an argument that this incident was not reportable at all because there was uncertainty over exactly what had happened. In other words, Cormac could not be satisfied that it was a work-related incident.

112. In my view the incident probably ought to have been treated as a work-related incident on the basis of what was known. When the Employee was discovered, he had suffered a serious head injury which had caused blood to be left on the ground in the depot yard in close proximity to a shovel, a pair of work gloves and the Employee's glasses. There were reasonable grounds to suspect that this was a work-related accident.

113. Whilst it was possible that his injury had occurred as a result of a spontaneous medical event in my view the prudent course was for the matter to be reported. I recognise that

decisions about whether an injury is or is not work-related are not taken with the benefit of hindsight. A member of the Health & Safety team recalls that he always thought it was reportable and he was acutely embarrassed that it was not reported in good time. I also note that the HSEQ's Director's recollection is that it was reported as a precaution.

114. I am satisfied that reporting the incident was the correct thing to do.

**What type of injury ought to have been reported?**

115. The online portal for completing the RIDDOR report requires the responsible person to identify the type of injury which has triggered the reporting obligation. In this instance it was reported as an '*injury preventing the injured person from working for more than 7 days*'. The Employee had been absent for more than 7 days. In that sense, the RIDDOR was not wrong.

116. Nevertheless, at the time the incident was reported, the health and safety team did know that the Employee had suffered a skull fracture albeit it did not have this information in the form of a registered medical practitioner's written diagnosis.

117. I was informed that the general practice was for reliance to be placed on written diagnoses provided by registered medical practitioners.

118. The strict wording of the regulation does permit an argument that the obligation to report the fracture was not engaged. The GP's sick note referred to a head injury. However, in my view there was no reason to doubt the accuracy of the information supplied by the Employee to the Assistant to the First Responder on 16 January 2017 about the extent of the injuries. I am not aware that the Employee was asked to provide a confirmation of the diagnosis from a registered medical practitioner. Written confirmation of the skull fracture from a registered medical practitioner could have been requested. In my view Cormac's RIDDOR Report ought to have identified the skull fracture.

**Was the timing of the Report appropriate?**

119. No, it was not. The RIDDOR report was unquestionably late whether it was a specified injury (report within 10 days) or an 'over 7 day' injury (report within 15 days).

120. If the report had been filed within the relevant period the conversation between the Employee and the Assistant to the First Responder on 16 January 2017 would not have taken place. I do not think that this mitigates the fact that Cormac did not report the fracture for two reasons. First, it was known by the First Responder on the day of the incident that the Employee had suffered a fractured skull. I am satisfied that accurate information about the Employee's injury could have been obtained if the report had been made earlier. In any event, the report was not made at an earlier stage and at the time it

was made the fact of the fracture was known.

**Shortcomings in the RIDDOR Report**

121. In summary in my view the RIDDOR report was deficient in four respects.

122. First, it states that the Employee had passed out. Strictly, there was no specific evidence that he had passed out. I think this was a minor deficiency. Given his condition when he was found, it would have been reasonable to assume that the Employee had lost consciousness at some point.

123. Second, it wrongly referred to the Employee as having been taken to hospital by a colleague when he had in fact been taken by hospital in an ambulance.

124. Third, it ought to have referred to the fracture.

125. Fourth, it was late. It was notified 37 days after the incident. Whatever view one takes of the correct categorisation it should have been notified within 10 or 15 days. In either event, it was submitted well passed the relevant deadline.

**Was the content of the RIDDOR constructed so as to underplay the incident and/or mislead so as to avoid scrutiny by the HSE?**

126. I am entirely satisfied that it was not. Although the RIDDOR Report did not include information about the skull fracture the fact that a report was made indicates powerfully that there was no desire to avoid scrutiny by the HSE. If that had been the intention, Cormac could have adopted the stance that the incident was not notifiable on the basis that it was not a work-related accident. It did not adopt that stance.

127. A late report is likely to attract more attention than a report made in good time. If the intention was to avoid scrutiny reporting late does not seem to me to be a very good way to go about that task.

128. Moreover, whilst the RIDDOR report did not refer to the skull fracture it did refer to the Employee having passed out and a head injury. In my view these words do not suggest that there was an attempt to underplay the incident. It reads as if it is a serious matter.

129. It is not part of my function to determine if the HSE would have acted differently if they had received a notification in a different form although, for what it is worth, I very much doubt that there would have been a different outcome.

130. I would also add this final observation. I have interviewed the person who submitted the report and the head of the department I am entirely satisfied that both have dedicated the larger part of their professional careers to health and safety. I do not consider that it is likely that they would have acted in this manner.

## Question 2 (ii), 3 (ii) & 4: Post RIDDOR Report

**What did Corserv/Cormac know or discover about the Incident in its subsequent investigation?**

**What actions and/or investigations were undertaken by Corserv/Cormac after 16 December 2016?**

**Were these actions and/or investigations adequate and/or appropriate in all the circumstances?**

### The Revival of the Investigation

131. In about May 2017 a Cornwall Councillor contacted the Employee for unrelated reasons. During their conversation he discovered that the Employee was off work as a result of the incident on 16 December 2016. The Councillor assumed that the matter would be investigated by Cormac and dealt with accordingly. However, when he next contacted the Employee in the summer months of 2017 he was concerned about progress of the investigation.

132. The Councillor suggested that the police should be contacted which was done on 11 August 2017. Two police officers attended the Employee's home to discuss the matter with him. The officers did not take any formal statement at that time. No further action was taken by the police.

133. On 15th August 2017 the Councillor prepared a briefing note setting out his concerns about the progress of the investigation which had been carried out by Cormac. The Councillor was concerned about the accuracy of the information contained within the RIDDOR report to which he had gained access. He submitted the briefing note to the Chief Executive of Cornwall Council in advance of a meeting with her on 16 August 2017.

134. It is also clear to me that the Councillor was also planning to meet with the Managing Director for Corserv on 16 August 2017 and that he knew that the Councillor wished to discuss this incident. The Managing Director for Corserv requested an update about the progress of Cormac's investigation on 15 August 2017.

135. A 7-page draft Incident Report was in existence (later versions of the Incident Report had 11 pages). It was not finalised. The Executive Summary of the report refers to the skull fracture. The body of that draft report identifies the author's '*supposition*' that the Employee had somehow hit his head on the lid to the skip '*either when trying to lift it alone and losing his grip on the wet metal*'. I am unable to say when this document was produced. The properties of the document suggest it was created on 15 August 2017

although that may not be conclusive. It refers to the account given by the Skip Driver. I note the Skip Driver's statement is dated 15 August 2017. It also refers to the account provided by the Acquaintance of the Employee who had seen him in the yard as she drove past at 14.00hrs. Therefore, Cormac must have had access to an account from her by no later than 15 August 2017.

136. On 16 August 2017 the Councillor met with the Chief Executive of Cornwall Council and the Managing Director of Corserv. This incident was discussed. The upshot of these meetings was that the Managing Director of Corserv ordered a re-investigation of the case.

137. The Managing Director of Corserv notified the Chief Executive of Cornwall Council of his decision by e-mail. In the circumstances, I am satisfied that there was nothing more which the Chief Executive of Cornwall Council could be expected to do. The e-mail was copied to the then Chief Operating Officer of the Cornwall Council (she subsequently became the Managing Director of Corserv in March 2018). However, I do not consider that this e-mail demanded any action on behalf of the then Chief Operating Officer. I am satisfied that the Councillor was satisfied that there would be a re-investigation.

138. The Cormac Health & Safety Team was ordered to deal with the re-investigation as a matter of urgency on 16 August 2017. The re-investigation was undertaken by a senior member of the Health & Safety team. It is right to record that there was a significant amount of activity in the following days. More detailed statements were obtained from SO1 and SO2. Statements were taken from the Acquaintance, the First Responder and the Assistant to the First Responder. Although it is clear that there was significant amount of work as a result of the re- investigation, I do not consider that these enquiries provided significant new information.

139. A more detailed Incident Report was prepared by the Cormac Health & Safety team which was completed by about 25 August 2017. The report accurately summarised the evidence available save in one respect. The account provided by the Acquaintance did not accord with her statement. Whereas the report suggested that when she had driven past the yard she had observed the Employee shovelling material into '*one of the bays near the skip and portacabin*' her statement made no reference to a skip. It stated that he '*appeared to be shovelling material from the floor into one of the bays near the portacabin*'. I accept that this was a misquote and nothing more than that. I do not consider that anything significant turns on this. I do not consider the absence of reference to the skip in the statement means that there was no skip present. The Acquaintance's view of the yard must have been fleeting.

140. The Incident Report reached the following conclusion:-

"*Due to the lack of evidence, witness accounts, and The Employee memory loss the report is inconclusive, however there are a number of possibilities which may be considered;*

- *The Employee may have suffered a bleed on his brain while working within the yard. This may have caused him to fall and strike his head, and fracture his skull.*
- *He may have fallen while he was working, striking his head as he fell, and sustaining the fracture which then led to the bleed on the brain. This fall may have been as the result of a slip or trip at ground level, or potentially a fall from height if he had climbed on to either the skip or the wall next to it.*
- *The head injury may have been sustained by the lid of the skip blowing shut on him while he was loading material into it, or potentially dropping on to his head as he attempted to open it in order to load material.*
- *The head injury may have been as a result of him being struck by an object either wielded or thrown by a third party.*"

141. I accept that these were all possible explanations for the incident although I think some were rather less likely than others.

142. The report does not identify the possibility that the Employee had been injured at some point during the course of the delivery of the skip. I have little doubt that this was because the account provided by the Skip Driver was in general terms accepted. It is possible, with hindsight, to say that more should have been done to explore whether the Skip Driver's estimated time of arrival at the depot was correct. However, in my view, it was reasonable to accept the Skip Driver's account.

143. I have seen two versions of this Incident Report. One version contains a contents page which includes reference to a section called '*part 4*' which was for '*Recommendations*'. The footer does not identify the author and the date of the report. There are no recommendations in the report. The other (later) version has the reference to '*Recommendations*' removed. The footer identifies the author of the report and states that the report is dated 25 August 2017. The substantive content of the two versions is identical.

144. I have been informed that the reference to '*recommendations*' was removed by the HSEQ Director before he attended a meeting with the HSE on 31 October 2019. It was a tidying up exercise because he was intending to supply a copy of the Incident report to the HSE on that date. The HSEQ Director informed me that he did so in order to avoid confusion. He did not want the HSE to think that there was a section of the report containing recommendations which was missing from the report. In my view this is understandable.

145. A member of the Cormac Health & Safety team informed me that recommendations would have been identified at a '*Pre-Close Out Meeting*'. There was no such meeting. He said the report was not the finished article. In my view a 'Pre-Close Out Meeting' probably ought to have been carried out. Given the various possibilities which had been outlined, it would have been prudent to consider whether there were any actions that Cormac could take forward in order to avoid such an event recurring.

146. I have reached my own conclusions about what happened. However, I consider that the investigation report produced by the Cormac Health & Safety team was reasonably thorough. It was a more comprehensive report than the first draft which had been prepared. I think it identified potentially relevant explanations. I think there ought to have been a close out meeting to consider whether there were any recommendations. The fact that no definitive conclusion had been reached about the cause of the incident does not mean that there were no lessons to be learned.

## Questions 7 & 8: Communications with the HSE about the RIDDOR Report

### What information did Corserv/Cormac report to the Health and Safety Executive following the Incident including in the RIDDOR report?

### Was the timing and content of the initial RIDDOR report (and any subsequent communications with the Health and Safety Executive) accurate, and appropriate in the circumstances?

**Communications with the HSE in October 2017**

147. The Investigation Report was prepared following the re-investigation ordered by the Managing Director of Corserv. The Councillor had formed the impression that he would be provided with a copy. The Managing Director of Corserv declined to provide a copy of the report in an e-mail on 2 October 2017.

148. On 3 October 2017 the Councillor asked the Managing Director of Corserv whether the RIDDOR report had been re-submitted. If the RIDDOR report had not been re-submitted he wished to know whether the company was not in breach of health and safety law.

149. The Managing Director of Corserv requested assistance from the health and safety team in relation to this enquiry an e-mail timed at 06.23hrs on 4 October 2017. This resulted in the Cormac Health & Safety team contacting the HSE by telephone.

150. Following that, a member of the Cormac Health & Safety team sent an e-mail to the HSE

at 13.04hrs. It stated:-

*"Thank you for your attention earlier when we discussed the possibility of making amendments to the detail of one of our notified incidents.*

*I advised you that there had been two amendments to the details on the initial report, which had subsequently become apparent during the course of the investigation.*

…

*The amendments are as follows;*

*Within the section 'About the kind of incident'---'What Happened'- Our information noted that '* ***The Employee passed out and sustained a head injury while within the car park of our operational depot at Grampound Road****'.*

*There is no evidence that he actually lost consciousness.*

*Also, our report states that the Employee was found by '****a work colleague who took him to hospital****'*

*The work colleague actually called the emergency services and The Employee was taken to hospital by ambulance.*

*As such, please amend the record to read, within the 'What Happened' section;-*

***The Employee sustained a head injury while within the car park of our operational depot at Grampound Road. There were no witnesses and the Employee has no recollection of the incident. The Employee was found conscious but dazed by a work colleague who called for an ambulance which took the Employee to hospital. Subsequent examination has revealed a head injury but it is unclear how this was sustained.***

*Could you please confirm that, as per our earlier telephone discussion, we are making these amendments to ensure that our records align accurately with yours?*

*There has been no change to the Injured Person's condition, or the category of the injury."*

151. This communication corrected two of the deficiencies in the original RIDDOR Report. It did not address the skull fracture.

152. The HSEQ Director informed me that at this time the focus was not on the skull fracture. The focus was on the issue of loss of consciousness. It will be recalled that a head injury resulting in loss of consciousness is, in itself, a specified injury. Therefore, if the Employee had not passed out (as had been suggested in the RIDDOR report) then the incident remained reportable on the basis that the Employee had been absent from work for over 7 days.

153. A senior member of the Cormac Health & Safety team recalls that they had not seen any

actual confirmation that the injury suffered was a skull fracture diagnosed by a registered medical practitioner. Therefore, it was still technically correct to treat his injury as reportable on the basis that it was an '*over 7 day*' injury.

154. Both considered that the classification was correct albeit they suggest this was for different reasons. I am satisfied that at the time of this communication with the HSE the health and safety team was influenced by the argument that on a strict interpretation of RIDDOR 2013 the reporting obligation was not engaged in respect of the skull fracture because of the absence of a written diagnosis from a registered medical practitioner. This view was genuinely held that this was not a specified injury because they, personally, had not seen a registered medical practitioner's diagnosis of a skull fracture and that weight was being attached to the absence of such documentation at the time of the report.

155. Whilst this stance was not entirely without merit in my view this was a poorly-judged time to rely on a strict interpretation of whether there was a reporting obligation. Cormac had already admitted that the original report was deficient in two respects. As a matter of fact, the health and safety department had known of the fracture since 16 January 2017 (albeit not via registered medical practitioner). The recently completed Investigation Report referred to the fact that the Employee had suffered a skull fracture. As a matter of fact, Cormac's HR Department was in possession of Occupational Health Reports which referred to the fracture. Cormac did know that the Employee had suffered a fracture. In my view, by far the better course was for Cormac to adopt a transparent 'cards on table' approach.

156. This contact with the HSE was intended to clarify matters. It was a missed opportunityto set the record straight. The correspondence would also have the unfortunate consequence of providing the basis for further criticism of Cormac/Corserv later down the line.

**The Corserv letter to the HSE dated 17 September 2019**

157. Corserv's next communication with the HSE did not take place until September 2019. It is necessary to set out some of the background to that communication. In March 2018, Cornwall Council's Chief Operating Officer became the Interim Corserv Group Managing Director. She assumed the role on a permanent basis in October 2018.

158. On 31 May 2018 she had a meeting with the Councillor. Prior to that meeting the Councillor had prepared a briefing note. This was an updated version of the briefing note he had prepared for his meeting with the Chief Executive of Cornwall Council in August 2017. Once again, it referred to his concerns about the accuracy of the RIDDOR report. At the meeting on 31 May 2018, the Managing Director of Corserv listened to what the Councillor had to say about the incident. She believed that she had no prior knowledge of

this incident. However, she accepts that she had been copied into the e-mail on 16 August 2017, which her predecessor as Managing Director of Corserv sent to the Chief Executive of Cornwall Council to notify her of his decision to order a re-investigation into the incident. I accept that there was no particular reason for her to remember that e- mail.

159. During the course of the meeting, the Councillor talked through the issues in the briefing note and his concerns about the RIDDOR report. It was a cordial meeting. The Managing Director of Corserv was concerned about what she had been told and she agreed to look into the matter. She spoke to the Managing Director of Cormac. He had many years of experience in the construction industry and she thought he would be well placed to look into the matter. There was a subsequent meeting between the Managing Director of Cormac and the Councillor on 3 July 2018. The Managing Director of Cormac subsequently died.

160. The Managing Director of Corserv heard nothing further about this matter until late August 2019. The Councillor prepared a letter dated 30 August 2019 attaching a further updated briefing note which he supplied to the Chief Executive of Cornwall Council and the Managing Director of Corserv. It stated:-

"*I now have the evidence that shows without a shadow of doubt that Cormac committed a criminal offence in submitting, knowingly and deliberately, a false RIDDOR report to the Health and Safety Executive. Furthermore, when I raised the issue with Cormac…Cormac contacted the HSE and, again, knowingly and deliberately withheld information that should have been provided in the RIDDOR report. It is clear that the so-called investigation commissioned … in August 2017 was a cover-up of the original failure to investigate the incident properly. Several employees of Cormac were complicit in this cover-up.*"

161. It went on to state:-

*"I ask that [the] chief executive of Cornwall Council, or [the] chief executive of Corserv Ltd., takes personal responsibility for notifying the HSE that Cormac committed the offence of failing to submit an accurate RIDDOR report and that you ask the HSE to a) take the appropriate action against Cormac for that failure, and b) appoint an independent health and safety expert from outside of Cornwall to conduct a thorough investigation of the failings of the organisation, such investigation to be paid for by Cormac. I ask also that you advise the HSE that I am an interested party in this matter and that they should ask me to provide evidence to them."*

And

"*I, therefore, expect Cormac to issue an unreserved apology to [the Employee] for its failings and to offer a sum of compensation comparable to what could have been reasonably achieved through a claim in court*"

162. There was a significant escalation in the tone of this correspondence when compared with the earlier briefing notes. In my view it is clear that the Councillor had plainly made up his mind. Whilst I recognise that he was determined to represent and serve his constituent's interests I do not accept his analysis. In particular I reject the suggestion that the RIDDOR report was '*knowingly and deliberately false*'. I also reject the suggestion that the re-investigation was an attempt to cover up the failure to investigate the matter properly in the first instance.

163. A meeting took place between the Councillor, the Chief Executive of Cornwall Council and the Managing Director of Corserv. The Councillor demanded immediate action along the lines set out in his letter. The impression I have formed is that this was a fractious meeting.

164. It was agreed between the Chief Executive of Cornwall Council and the Managing Director of Corserv that it was appropriate for the latter to revisit the information which had been supplied to the HSE. She would write to the HSE if there were still errors.

165. The Managing Director also agreed with the Chief Executive of Cornwall Council that she would arrange for an independent review of the health and safety practices within the company to provide reassurance.

166. In the aftermath of this meeting the Managing Director of Corserv made various enquiries. She liaised with the Cormac Managing Director, the HSEQ Director, the First Responder and the Corserv Company Secretary. She wanted to be sure that there was no '*cover-up*'.

167. The HSEQ Director suggested that it was around this time that he realised that the RIDDOR was deficient because it did not refer to the fracture. I think his recollection about this is probably mistaken. As I have indicated, I think that the prevailing view in October 2017 was that – on a strict interpretation – the fracture was not reportable.

168. The Managing Director of Corserv sent a letter to the HSE on 17 September 2019. A draft of the letter was considered by the HSEQ Director before it was sent. The letter to the HSE stated:-

*169.* "*The Cormac Company notified you of the incident on 23 January regarding the incident and at that time reported that it was a head injury with the severity of the injury being "injury preventing the injured person from working for more than 7 days". This was*

*consistent with the GP Statement of Fitness for Work which was received by the Company. All of the GP's fitness to work statements for the whole period of his absence from work until he retired due to ill health referred to a head injury and did not reference a fractured skull.*

*The employee … self-reported to his line manager that he had suffered a bleed on the brain and a fractured skull on the 16th January 2017. He advised that the doctors were unsure whether the bleed on the brain caused him to fall or vice versa.*

*The Employee has been supported through Cormac's occupational health support services throughout the period since his injury, including appointments with qualified clinicians. Confidential correspondence from the clinicians to our Human Resources team discussing [the Employee's] case indicated on 9th February 2017 that "he suffered a major head injury and it is not clear what the aetiology of this was. However, he suffered a fractured skull with bruising on his brain and also a subarachnoid bleed."*

***"The indication of the fracture should also have triggered a specified injury category to be assigned to the incident notification report, however the confidential nature of the medical correspondence hampered this.*** *We have made changes to our internal systems to ensure relevant diagnosis information relating to incidents is passed from the HR function to our health and safety support team, who notify incidents to the enforcing authorities.*"

[Emphasis added]

170. This letter gives the impression that the confidential nature of medical correspondence hampered the ability of Cormac to report the injury correctly (see highlighted text). It also gives the impression that the health and safety team's ability to know about the fracture was hampered by this.

171. I do not consider that is in fact correct. The health and safety function was aware of the Employee's self-report of the fracture by no later than 16 January 2017 (see appendix C). Therefore, I think the impression this letter gives is erroneous. I am satisfied that the Managing Director of Corserv was not aware of appendix C (the e-mail dated 16 January 2017) when the letter of 17 September 2019 was sent. I am also satisfied that the HSEQ Director was probably not aware of the e-mail dated 16 January 2017 and, even if I am wrong about that, it was not in his mind when the letter dated 17 September 2019 was being drafted. The Health & Safety team who did receive the e-mail of 16 January 2017 were not involved in the process of drafting the letter. In my view the letter was not deliberately misleading. I would also add that I do not consider that it is correct to treat every discrepancy as evidence of bad faith.

172. I was told by the Managing Director of Corserv that had she been aware of that e-mail she would have worded the letter to the HSE differently. I accept her account. In my view the letter was not deliberately misleading. However, given the shortcomings with previous communications with the HSE it is clearly unfortunate that there was yet another

inaccuracy in a Corserv/Cormac communication to that organisation.

**Further Communications with the HSE**

173. On 28 October 2019, the HSE requested to see a copy of the Cormac's internal investigation. The HSEQ Director attended a meeting with the HSE on 31 October 2019. At that meeting he supplied a copy of the Cormac Investigation report. It will be recalled that there were two versions of this report.

174. Prior to this meeting the HSEQ Director 'tidied up' the contents page of the Investigation Report so that the reference to 'recommendations' was removed. I accept that he did so in order to avoid confusion. He did not modify the substance of the report. I am conscious that the existence of two versions of the same report albeit with modest presentational differences has aroused suspicion. In my view the decision to tidy up a report which was being provided to a regulatory authority was in my view understandable.

175. During this meeting the HSE was informed about a RIDDOR flow chart which had been created (I attach as appendix D). This was created to assist personnel within the Corserv group to understand whether an incident was reportable and, if so, on what basis. In my view this is a helpful document. Coupled together with the changes to ensure that relevant diagnosis information is supplied by the HR function to the health and safety department, I am satisfied that Cormac has improved its process and it is well placed to ensure that incidents are reported accurately and promptly.

176. I am not alone in reaching this conclusion. On 16 April 2020 the HSE wrote to the Managing Director of Corserv stating:-

"*Having carried out a full review my investigation concludes that the reporting procedures in place at the time of the incident fell short of what was required resulting in miss reporting and delays in completing an incident investigation. In light of these failings and in line with the HSE's Enforcement Management Model I have given due consideration to enforcement action in the form of an improvement notice (IN). However it is evident from discussion and documentation reviewed that there have been significant changes to your health and safety management systems in the intervening years which have improved your incident reporting policy and procedure making the issue of an IN unnecessary and inappropriate.*"

**Questions 10 & 11**

**What changes have been made to health and safety reporting procedures following the Incident?**

**Were these changes: (i) Adequate and appropriate in all the circumstances; (ii) Adopted with appropriate governance and oversight; and, (iii) Communicated in a clear and transparent manner.**

**The RIDDOR Flow Chart**

177. The RIDDOR flow chart has been introduced. This is a useful document it ought to reduce the risk of a RIDDOR report being completed erroneously. The precise circumstances in which this document was created has been the subject of concern. The final interactive digital flowchart was not created until 18 September 2019 (the day after Managing Director's letter to the HSE on 17 September 2019).

178. I have been informed by the HSEQ Director that the RIDDOR Report was created because he could not be sure that within Cormac a similar error could not occur again. I have been told that the preparation of the flow chart was solely concerned with ensuring that lessons were learned and that there was continual improvement as required by the relevant ISO Standards Accreditations held by the Cormac/Corserv. The company was in fact to undergo an ISO assessment in the near future. I have been informed that the Flow Chart was not prepared with the thought of it being used in any discussions with HSE or with any potential enforcement action by that organisation in mind. I am satisfied that it was not created at the behest of the Managing Director of Corserv.

179. It could not be suggested that this alteration was introduced promptly as a result of the incident. The RIDDOR flowchart was not created as a result of Cormac's investigation into the incident given that it had concluded 2 years beforehand and no recommendations were made in the report.

180. On 13 October 2020, in response to a Freedom of Information (FOI) Act request the Councillor was informed that this checklist was introduced internally in July 2019 '*in order to bolster the existing reporting arrangements for health and safety incidents across the Corserv Group of Companies*'. The Councillor analysed the pdf and established that it was created on 18 September 2019. He requested the '*Microsoft-Visio file*'. He was told that it had been deleted after it was converted into the interactive pdf file.

181. The Councillor has suggested that it was '*fabricated*' in a '*desperate ploy to have something to present to the HSE*'. I would express myself in more moderate terms. I am satisfied that the HSEQ Director was concerned about the possibility that a similar error could recur and he wanted to avoid that. In that sense it could be said to have been introduced as an operational improvement on the part of Cormac/Corserv as part of its drive for continual improvement. However, the timing of its creation indicates to me that the creation of the RIDDOR flow chart was at least in part motivated because it was known that Corserv was likely to be communicating with the HSE about the accuracy of the RIDDOR report on 23 January 2017. The HSE's reaction to any such communication could not be known. It was likely to be in Corserv's interests to have evidence of meaningful change if the HSE wished to investigate the matter further.

**Organisational Changes**

182. There have been organisational changes. The HSEQ Director now reports to the People and Digital Transformation Director. The purpose of this is to allow a '*joined up*' approach and to facilitate ease of communications between the two functions. Whilst I do not consider that a lack of communication between the HR department and the health and safety team resulted in this incident not being reported correctly, I accept that this organisational change will assist. It enables relevant information to be provided to the health and safety department by the human resources function. That ought to assist in ensuring that injuries in RIDDOR reports are accurately described.

183. I have been informed that the HSEQ Director attends the Cormac/Corserv Board meetings and health and safety is the first item on the agenda. Therefore, there is an opportunity for any incidents to be discussed with the Boards when necessary.

**Other Improvements**

184. I am satisfied that Corserv/Cormac is a responsible organisation which takes its health and safety responsibilities seriously. Corserv has recently achieved BSI 45001 Standard. This is the international standard for health and safety management.

185. There have been substantial improvements within Corserv/Cormac since this event in areas which are not directly relevant to the incident:-

- Any event or significant near miss is now discussed at Board level alongside any actions which need to be taken e.g. revising risk assessments or operating practice.
- There have been improvements to Corserv's Entropy Health & Safety system to enable it to be used for near misses.
- There has been a real focus on encouraging employees to report near misses.

- There are comprehensive health and safety plans to address areas of risk and to drive continuous improvement.
- Corserv is regularly audited by BSI and it produces action plans.
- There is more rigorous reporting to the Board through a comprehensive Significant Event Tracker which allows trend analysis of incidents to identify areas of health and safety concern.

186. After the Corserv sent its letter to the HSE on 17 September 2019 it appointed an external consultant to conduct an independent review of the Corserv/Cormac's Strategic Safety Arrangements. In his report the external consultant stated:-

"*During the review, a number of interviews were conducted and documents examined. Throughout the visit there were a number of examples of best practice identified. Event reporting utilizing the BSI "Entrophy" database and the Costain behavioural campaigns along with usage of the HSL Climate Tool Survey are all considered to be exemplars and the organisation is commended for employing such initiatives to secure the moral, legal and economic benefits that can be achieved by implementing a robust Safety Management System and promoting positive behaviours. The provision of the "Event Tracker" to secure ownership and closure of significant events (including near misses) at Board level is tangible evidence of best practice in event reporting.*"

187. He went on to state:-

"*From the evidence presented and the discussions held it is apparent that health and safety is in the blood-stream of the organization. The Safety Management System is mature with clear evidence of the "Demming Cycle" (Plan, Do, Check and Act) in operation.*"

188. He concluded that:-

"*Based on my experience and knowledge, I am of the opinion that the strategic HS&EP arrangements are operating at substantial assurance.*"

189. I am therefore satisfied that there are established mechanisms to enable significant incidents/near misses to be identified and brought to the attention of senior management.

## Questions 5 & 6

### What support did Corserv/Cormac provide to the employee following the incident?

### Was this support sufficient and/or appropriate in all the circumstances?

190. Between December 2016 and early January 2017 there was contact between Cormac and the Employee. It was made clear that the Employee was to be given full support.

191. The documentary material indicates to me that the Assistant to the First Responder was in regular contact by telephone throughout 2017. He also visited him on a number of occasions at his home. The First Responder and the Assistant to the First Responder visited him together on 1 September 2017.

192. The Employee underwent regular occupational health assessments. He attended an assessment on 9 February 2017. The report also confirms the skull fracture diagnosis. He underwent a further assessment on 10 May 2017. The report refers to the seizure which occurred in March 2017. In addition, it is also noted that he had a fracture dislocation which was thought to date back to the original incident. There was a further occupational health review on 2 August 2017 when it was noted that his condition had not changed. He was seen again on 22 November 2017 at all stages he was deemed unfit for work.

193. The occupational health department conducted a Sickness Welfare Review on 9 June 2017. There was a further Sickness Welfare Review conducted on 21 September 2017. Comprehensive records were kept of these meetings. In the meeting in September 2017 the Employee was joined by the Assistant to the First Responder, his Trade Union Representative and the relevant person from the Human Resources Department. It was noted at that stage that unless there was improvement in the Employee's condition Cormac may need to consider terminating his employment on capability grounds.

194. The Employee was ultimately medically retired on a full pension. In my view the support that the Corserv Group provided through its human resources and occupational health assessment was sufficient and appropriate in all the circumstances.

## Question 12

**Is there anything further that the Reviewer considers appropriate to draw to with regard to the issues identified above.**

195. Although I have acknowledged that appropriate changes have been made there are a number of possible improvements which I think Corserv ought to consider:-

- I was concerned that there was no risk assessment in relation to the Grampound Road depot. Whilst I recognise that not every site owned and/or operated by Cormac/Corserv would necessarily require a site-specific depot or traffic management plan I was concerned that there was no pre-accident site specific risk assessment for a depot like Grampound Depot. Consideration should be given to whether site-specific risk assessments are required at Corserv depots particularly in relation to traffic management.
- The First Responder did a respectable job in terms of securing initial accounts and retaining evidence he was not an accident investigator. Notwithstanding this, in my view an event as serious as this one probably merited attendance from the health and safety team on the day of the incident. Corserv should consider issuing further guidance over when operational managers should summon the assistance of the health and safety team.
- There were some deficiencies in the record keeping in relation to the incident investigation. In particular, original notes of interviews with witnesses were not retained. I consider that Corserv should establish clear systems for collating records relating to serious accident investigations to ensure that initial accounts are adequately recorded. There ought to be an investigation file which would enable such materials to be easily stored.

## Question 13

**What information was provided to Cornwall Council about the incident, to whom and when? On being made aware of the Incident, were the actions of the officers of the Council sufficient and/or appropriate in all the circumstances?**

196. The incident was first brought to the attention of the Chief Executive of Cornwall Council via the Councillor's briefing note on 15 August 2017. She met the Councillor on 16 August 2017 to discuss the matter. The Councillor met the Managing Director of Corserv who agreed to conduct a re-investigation. The Chief Executive of Cornwall Council was aware that the Councillor was concerned about the accuracy of the RIDDOR report and the adequacy of Cormac's investigation and she was notified by the Managing Director of Corserv would be commissioning a re-investigation.

197. In my view there was nothing more that the Chief Executive of Cornwall Council could have been expected to do at that stage. It was not her role to carry out health and safety investigations. It was entirely appropriate that she should leave this to Corserv/Cormac to re-investigate. The Councillor indicated that he was grateful to her for her input. He was pleased that there had been prompt and positive response to his concerns.

198. Thereafter, the Chief Executive had no further involvement until the matter was raised with her once again in his letter dated 30 August 2019 and the subsequent meeting on 4 September 2019. I have set out above details of the Councillor's letter above and do not repeat it (see paragraph 161 to 172 of this report).

199. I consider that the Chief Executive of Cornwall Council acted appropriately.

- She agreed that the Managing Director of Corserv would look into the matter and consider whether the matter was reported appropriately to the HSE and whether subsequent communications were correct. The HSE would be notified if any errors were identified. She was aware that the Managing Director of Corserv did write to the HSE on 17 September 2019.
- The Chief Executive of the Cornwall Council could not sensibly ask the HSE to take action against Cormac despite the Councillor's demand that he should do so. Decisions about enforcement action are a matter for the HSE. The HSE received the letter dated 17 September 2019. It met with the HSEQ Director. The HSE decided to take no further action.

200. From this point onwards, this matter was ventilated by the Councillor in the political

arena.

201. On 9 March 2020, the Councillor presented a lengthy Cabinet report to his Cabinet colleagues. The tone and content of the Cabinet report was similar to the tone of the letter dated 30 August 2019 to the Chief Executive of Cornwall Council. For example, the report indicated that the Councillor had formed the view that Cormac had filed a deliberately false and misleading RIDDOR. He explained that there was no investigation until 8 months after the incident and a further false report was then submitted to the HSE.

202. In his Cabinet report prepared for Cabinet Members, the Councillor made three recommendations:-

"*1. Cabinet requires the chief executive of Cornwall Council and the chief executive of Corserv Ltd., along with the Monitoring Officer, to attend a Cabinet pre brief in order to receive this report.*

*2. The chief executive is strongly advised to write a formal letter of unconditional apology to the Employee for the failure of Cornwall Council or Corserv to properly investigate the incident in which he incurred life changing injuries.*

*3. The chief executive is strongly advised to invite the Employee to meet Council officers to discuss and agree a suitable compensation package for the loss and injury caused by the failure of Cornwall Council and Corserv to investigate the incident, such failure meaning that the cause of the injuries will probably never be known and thus Mr will never have the opportunity to recover damages from any third party.*"

203. It is my understanding that the Cornwall Council Cabinet was reluctant to take the action which the Councillor requested without carrying out further enquiries. The Leader of the Council indicated that he would consider the matter.

204. I am satisfied that the Leader of the Council did consider the Cabinet report in detail in order to form his own view about the allegations contained within it. He also requested and received a detailed e-mail briefing from the Chief Executive on 6 April 2020, which set out the chronology as far as she was concerned. He considered other reports including the Assurance Review which had been prepared by the external consultant in October 2019 (I refer to this at paragraph 185 above).

205. The Leader was aware, amongst other things, that the HSE had reviewed the matter after the meeting between the Councillor and Chief Executive on 4 September 2019 and the subsequent correspondence sent by Corserv to the HSE. He felt that if the HSE had been sufficiently concerned about the matter then they would have investigated further. He did not accept that the RIDDOR report was a work of fiction. He considered that it was not perfect and reflected what people thought at the time albeit possibly mistakenly. He

was aware that solicitors had been appointed by the Employee but that ultimately a claim had not been pursued. In general, he did not agree with the thrust of the Councillor's Cabinet report.

206. The suggestion of compensation being provided by the Council was not something which could simply be agreed. The Council had and has a responsibility to the public purse to ensure that public funds are used responsibly. There was no outstanding claim to settle.

207. In the event, the Councillor did resign his position from the cabinet. Thereafter, he turned his attention to various Freedom of Information Act (FOI) requests. These included requests for copies of the Leader's investigation into the matters raised in his Cabinet report. The Leader did not produce an investigation report. The Councillor also pursued FOI requests relating to the generation of the RIDDOR flow chart. These were matters for Corserv.

208. On 6 November 2020, the Councillor wrote a lengthy e-mail meeting to all Councillors concerning the '*ongoing saga*' of the incident at Grampound Road in December 2016. The breadth and depth of criticism in the e-mail is striking. It repeats previous criticisms of Corserv/Cormac. But it also raised concerns about the alleged role of the Leader and the Monitoring Officer in '*this scandal*'. Many of the contentions in the e-mail are far removed from the events at the depot on 16 December 2016. That e-mail concluded with a demand for an independent inquiry. In the event the Commissioning Organisations agreed to appoint me to carry out this review.

209. I am satisfied that the officers of Cornwall Council have acted appropriately.

**Dominic Adamson QC**

**14 July 2021**

## Acknowledgments

I would like to thank the following individuals without whom I would not have been able to complete this exercise:-

- Rebecca Mabelle, Cornwall Council
- Richard Zmuda, Corserv Limited
- Matthew Lohn, Fieldfisher
- Olivia Rogers, Fieldfisher
- The Independent Consultant Neurologist
- All those who agreed to attend oral examinations and responded to my requests for documentary material

Finally, I would like to thank the person whom I have referred to as the Employee for his assistance and patience.

**The Grampound Review**

**By**

**Dominic Adamson QC**

# APPENDIX A

# The Grampound Review

Background

On 16 December 2016, an employee ("**the employee**") of Cormac Solutions Limited (**"Cormac"**) suffered an injury while working at Cormac's Grampound Road depot ("**the Incident**"). Corserv Limited (**"Corserv"**) (as the parent company of Cormac) and Cornwall Council (**'the Council'**) have co-commissioned this independent review ("**the Review**") to examine whether the actions taken by Corserv/Cormac[1] and the Council from the date of the Incident on 16 December 2016 until the commissioning of this review in response to the Incident were adequate and appropriate in all the circumstances. The Review will also seek to determine whether the improvements made by Corserv/Cormac to its Health and Safety processes and procedures as a result of the Incident were adequate and appropriate and whether these processes are now fit for purpose should a similar event occur in the future.

The Review will determine and agree the chronology of events in respect of the incident and subsequent actions taken by Corserv/Cormac and the Council.

Terms of Reference

**On behalf of Corserv/Cormac**

The Review shall answer the following questions in connection with the Incident:

1. What series of events led to the injury that the employee sustained on 16 December 2016?

2. What did Corserv/Cormac know and/or discover about the Incident:
   (i) On 16 December 2016, and
   (ii) In its subsequent investigations into the incident.

3. What actions and/or investigations were undertaken by Corserv/Cormac in response to the Incident:
   (i) On 16 December 2016, and
   (ii) Subsequently thereafter.

4. Were these actions and/or investigations adequate and/or appropriate in all the circumstances?

5. What support did Corserv/Cormac provide to the employee following the Incident?

6. Was this support sufficient and/or appropriate in all the circumstances?

7. What information did Corserv/Cormac report to the Health and Safety Executive following the Incident including in the RIDDOR report?

[1] References to 'Corserv/Cormac' in these Terms of Reference shall refer to the Corserv/Cormac Board and/ or employees.

8. Was the timing and content of the initial RIDDOR report (and any subsequent communications with the Health and Safety Executive) accurate, and appropriate in the circumstances?

9. What processes and procedures had Corserv/Cormac adopted at the time of the Incident for health and safety reporting and were these followed?

10. What changes have been made to health and safety reporting procedures following the Incident?

11. Were these changes:
    (i) Adequate and appropriate in all the circumstances;
    (ii) Adopted with appropriate governance and oversight; and,
    (iii) Communicated in a clear and transparent manner.

12. Is there anything further that the Reviewer considers appropriate to draw attention to with regard to the issues identified above.

**On behalf of Cornwall Council**

13. What information was provided to Cornwall Council about the incident, to whom and when? On being made aware of the Incident, were the actions of the officers of the Council sufficient and/or appropriate in all the circumstances?

**The Grampound Review**

**By**

**Dominic Adamson QC**

**APPENDIX B**

[redacted]

**From:** [redacted]
**Sent:** 20 December 2016 15:33
**To:** [redacted]
**Subject:** FW: update and contact details for [redacted] incident.

[redacted]

Please see update below. Also contained is [redacted] address.

A card is being sent from colleagues [redacted]

[redacted]

**From:** [redacted]
**Sent:** 20 December 2016 13:45
**To:** [redacted]
**Cc:** [redacted]
**Subject:** update and contact details for [redacted] incident.

Hi [redacted]
I have spoken to [redacted] and offered our full support, she also has my mobile number 24hrs contact should she need it.
She is adamant he still doesn't remember anything .

As you know I was a senior interview advisor and was specially trained to interview people in these circumstances. Given his medical condition this wouldn't be prudent until after the NEW Year and certainly after his Dr says its ok to complete a witness testimony interview.

Interestingly the [redacted] skip delivery man [redacted] stated when he delivered the skip [redacted] looked " rough as rats and not very well at all "
[redacted] wife states the only medication he is on is for his thyroid. On checking the medication on the internet it is clear that these can however have side effects for fainting and extreme fatigue.

[redacted]

Investigations continue.
Kind regards

[redacted]
CORMAC Collective
[redacted]
www.cormacltd.co.uk

**The Grampound Review**

**By**

**Dominic Adamson QC**

**APPENDIX C**

[redacted]

**From:** [redacted]
**Sent:** 16 January 2017 16:14
**To:** [redacted]
**Cc:**
**Subject:** FW: Conversation notes [redacted]

[redacted]

For information and further to our discussion this morning.

[redacted]

**From:** [redacted]
**Sent:** 16 January 2017 16:10
**To:** [redacted]
**Subject:** Conversation notes [redacted]

[redacted]

As discussed earlier are the notes from the conversation with [redacted]

[redacted] rang and informed me of his current condition, he has suffered a bleed on the brain and a fractured skull. He has regained most of his balance, although still experiences some vertigo when looking up and down. He no longer gets the really bad head aches and is much better in himself, although his still suffering from memory loss. He remembers before the incident, although he has almost no recollection of the last month or so.

He informed me that the doctors have told him they think by the shape of the injury on his head it was caused by the hitting his head on the skip, although they are not sure whether the bleed on the brain caused him to fall and sustain the injury, or whether a fall caused him to sustain the injury and the bleed was a result of that injury.

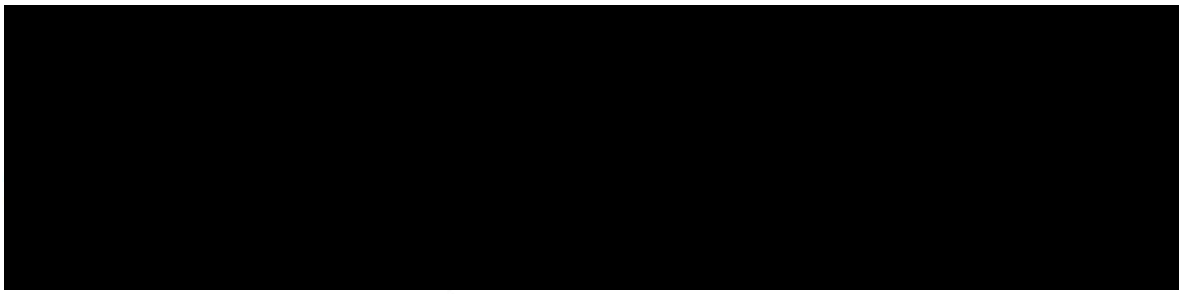
[redacted] is awaiting an appointment with a neurologist who will hopefully be able to provide him with some more information, however at this time the cause of the incident is not known. This unknown factor is causing [redacted] the most anguish at present and is what he is finding most unsettling, the not knowing.

[redacted] is a very conscientious member of staff and is already making noises about returning as soon as he can, for which we have to be prepared for a phased return, light duties, duties that may not include lone working or driving (decisions on which to be made by senior management). There are still a lot of unknowns, so as you have advised it is a good idea to fill in an extension of sick pay and an application to have returned the loss of his first 3 days pay due to sickness, and also a referral to Occupational Health so we are prepared for his return, in whatever capacity, when the appropriate time comes.

I will fill in the forms for us to review at our meeting next week, prior to submitting them.

With thanks,

[redacted]



If you use the environmental message please use this format:

Please consider the environment. Do you really need to print this email?
If you use an accessibility statement please use this format:

Please let us know if you need any particular assistance from us, such as facilities to help with mobility, vision or hearing, or information in a different format.

**The Grampound Review**

**By**

**Dominic Adamson QC**

**APPENDIX D**

# RIDDOR Reporting Decision Flowchart

**Work related**

If any of the following played a significant role

- The way the work was carried out
- Any machinery, plant, substance or equipment used for work
- The condition of site or premises were the accident happened

**Specified Injuries**

- Fractures, other than to fingers, thumbs and toes
- Amputations
- Any injury likely to lead to permanent loss of sight or reduction in sight
- Any crush injury to the head or torso causing damage to the brain or internal organs
- Serious burns (including scalding) which:
  1. Covers more than 10% of the body
  2. Causes significant damage to the eyes, respiratory system or other vital organs
- Any scalping requiring hospital treatment
- Any loss of consciousness caused by head injury or asphyxia
- Any other injury arising from working in enclosed space which:
  1. Leads to hypothermia or heat-induced illness
  2. Requires resuscitation or admittance to hospital for more than 24 hours

**'Over-7-day' Injuries/Incapacitation**

Was the injured party (IP) away from work or unable to perform their normal work duties for more than 7 consecutive days? (Not counting the day of the accident)

**Reportable Dangerous Occurrence**

Dangerous occurrences are certain, specified near-miss events. Not all such events require reporting.

There are 27 categories of dangerous occurrences that are relevant to most workplaces, for example:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment
- Plant or equipment coming into contact with overhead power lines.
- The accidental release of any substances which could cause injury to any person.

The full list of dangerous occurrences can be found in Schedule 2 of RIDDOR

If you suspect that a reportable dangerous occurrence has occurred, please contact a Health and Safety Manager

**Reportable Occupational Disease**

The diagnoses of certain occupational diseases may be reportable where they are likely to have been caused or made worse by their work: These diseases include:

- Carpal tunnel syndrome
- Severe cramp of the hand or forearm
- Occupational dermatitis
- Hand-arm vibration syndrome
- Occupational asthma
- Tendonitis or tenosynovitis of the hand or forearm
- Any occupational cancer
- Any disease attributed to an occupational exposure to a biological agent