Report of the
Service Director Finance

Agenda Item No:
Meeting: 25 January 2011

NORTH LINCOLNSHIRE COUNCIL

AUDIT COMMITTEE

RISK MANAGEMENT PROGRESS REPORT

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 To inform members of key issues arising from Risk Management work.

1.2 Regular reporting on Risk Management issues is an important source of assurance for Members to fulfil their role and provides supporting evidence for the annual approval of the Governance Statement.

2. BACKGROUND INFORMATION

2.1 The revised Strategic Risk Register was reported to Members in September. Lead responsibility for each risk has been designated to senior officers and an evaluation of controls is underway. The outcome of this work will be reported in the Internal Audit's progress report in April.

2.2 The annual council wide review of operational risk registers (ORRs) is underway. Fifty six percent of registers have been received so far. The majority outstanding belong to Neighbourhood and Environment, Children & Young People and Adult Social Care (details are provided in Appendix A). Several reminders have been sent and SRMG representatives have been asked to raise this issue at departmental SMT meetings. Relevant Service Directors have been contacted and further reminders are incorporated in Internal Audit's quarterly reports issued in January highlighting these examples of delays in compling with this important control process.

2.3 Progress against this year's Risk Management action plan is monitored by the Strategic Risk Management Group (SRMG). Overall completion is on target (action plan summary is provided in appendix B)
Management of key risks to the council are also monitored by SRMG. Two recent examples include:

- Managing the impact of the funding settlement on budgets and future financial planning – the Service Director Finance made a presentation to the group, it demonstrated how risk implications

are clearly identified in respect of decisions taken through the Budget process.

- Risk management in procurement – the Strategic Procurement Manager presented the progress made in identifying critical contracts along with business continuity arrangements. The impact of economic conditions has also been factored into risk assessments.

2.4 An important aspect of the risk management action plan is to continue to raise awareness across the council. This is achieved through comprehensive training programmes and communication networks. Regular risk management training is available and in November training was provided as part of the induction for new managers' programme. In addition to information available on the web page and intralinc the 6th edition of the Risk Roundup newsletter was also issued in November (appendix C).

2.5 In September Members were advised that the council had submitted data to CIPFA/ALARM's risk management benchmarking club. Results have now been received which show an encouraging level of compliance with best practice and risk maturity. Data was analysed over 7 factors and scored on a scale 1 to 5 (1 being lowest and 5 highest). A summary of the results are provided is provided in appendix D, and shows arrangements are evaluated as level 4 (Embedded and Integrated) or level 5 (Driving).

Feedback provided at the benchmarking review meeting highlighted some refinement necessary to the scope and clarity of questions to ensure consistency of data provided. Whilst this is not unusual in the development of newly formed benchmarking clubs these results still provide sufficient assurance that effective risk management arrangements are in place which meet best practice guidance.

3 OPTIONS FOR CONSIDERATION

3.1 The Committee should consider whether this update provides sufficient assurance on the adequacy of risk management arrangements detailed in this report. The Committee should ask questions about the contents of the report and seek clarification as necessary.

3.2 The Committee may consider that the report does not provide sufficient assurance on the adequacy of risk management arrangements detailed in this report or may seek further clarification.

4. ANALYSIS OF OPTIONS

4.1 The progress reports on key internal control issues and complies with professional guidance available and designed to provide this Committee with the assurance required. Members should ask sufficient questions to ensure adequate assurance is provided.

4.2 The option set out in paragraph 3.2 represents an opportunity missed to receive an important source of assurance to assist the Committee to fulfil its role effectively if adequate clarification is not provided.

5. RESOURCE IMPLICATIONS (FINANCIAL, STAFFING, PROPERTY.IT)

5.1 Resources are met from Internal Audit and Risk Management budget.

5.2 Regular reviews of risk management arrangements should safeguard the council's assets and ensure that value for money is achieved in the use of resources. There are no staffing, property or IT implications.

6. OTHER IMPLICATIONS (STATUTORY, ENVIRONMENTAL, DIVERSITY, SECTION 17 – CRIME AND DISORDER, RISK AND OTHER)

6.1 The Chief Financial Officer has a statutory duty under the provisions of the Local Government Act 1972 to ensure the proper administration of the council's financial affairs. The council also has a duty under the Local Government Act 1999 to make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

6.2 The evaluation of the council's arrangements will help to promote good corporate governance. Risk management work, as a component of the council's internal control framework is a key source of assurance to support the Annual Governance Statement. The risk management framework addresses all key risks the council may face. It promotes appropriate action to manage risks to an appropriate level.

7. OUTCOMES OF CONSULTATION

7.1 The Strategic Risk Management Group is made up of representatives from all services and is therefore risk management outcomes are the result of a comprehensive consultation process.

8. RECOMMENDATIONS

8.1 The Audit Committee should consider the assurance provided by the Risk Management progress report on the adequacy of risk management arrangements detailed.

SERVICE DIRECTOR FINANCE

Pittwood House
Ashby Road
SCUNTHORPE
North Lincolnshire
DN16 1AB
Author: Carol Andrews
Date: 28 December 2010

Background Papers used in the preparation of this report

Risk Management Strategy and Action Plan 2010-2011

App A

List of 2010/2011 ORRs received

Service Area	No. of ORRs required for service (from list supplied by Director)	No. of ORRs received from service	% received
Finance Services	4	4	100
Community Planning & Resources	9	9	100
Legal & Democratic Services	3	3	100
Neighbourhood & Environment Serv.	11	2	18
Highways & Planning	7	7	100
Asset Management & Culture	6	5	83
Human Resources	4	4	100
Adult Social Services	12	0	0
Children & Young Peoples Serv.	4	0	0
Strategy Development	1	0	0
Strat. Regen,Housing & Development	1	1	100
TOTALS	**62**	**35**	56

App B

Risk Management Action Plan 2010/2011

In date order- Issued with Agenda for 6 January 2011 meeting.

Date required by	Action required to achieve objective	Responsibility	Report due Date	Progress to date
April 2010				
	2.7.3 Communication network of newsletters and reports to the Audit Committee etc.	CA/RW	April 2010 SRMG 07/05	Audit survey which includes an element on risk management is being analysed by internal audit. Report on findings made to SRMG 02/07/10.
May 2010				
	2.5.1 Review arrangements for major projects/ initiatives. E.g. BSF, Sports Academy, Waste Management, etc. • **Worksmart**	J.Tattersall	May 2010 SRMG 07/05	Jeff Tattersall gave presentation on Worksmart including associated risks. Worksmart Risk Register presented to SRMG 25/08/10.
June 2010				
	2.3.1 Procure risk management system capable of analysing strategic and operational risk and provide management information thereon.	RW	June 2010 SRMG 02/07	Project brief prepared, 3 systems looked at. All 3 to be invited to demonstrate their products with IT technical staff as well as Jon Conroy, deferred by IT until Jan.
	2.7.3 Communication network of newsletters and reports to the Audit Committee etc.	CA/RW	June 2010 SRMG 02/07	Sixth edition of RISKroundup issued in Sept 2010. Report to Audit Committee 28/09/10 discussed.
Sept 2010				
	2.1.2 Annual review of the strategic risk controls and achievement of the strategic plan ambitions. Review of strategic risks in the light of revised service plans.	Service Directors CA/RW/ALL	Sept 2010 Sept 2010 SRMG 02/09 SRMG 01/11	Report and new Strategic Risk Register (SRR) presented to SRMG 02/09/10. Copy of the revised SRR incorporating SRMG comments presented 01/11/10.
	2.2.1 Annual review of operational risk controls and achievement of service plan ambitions.	Service Directors	Sept 2010 SRMG 02/09 SRMG 01/11	Progress reported on 01/11/2010.-33% received. SRMG members to progress those outstanding through their SMTs
	2.7.3 Communication network of newsletters and reports to the Audit	CA/RW	Sept 2010 SRMG 02/09	Latest issue of RISKroundup had been posted to intralinc and staff informed via Comms group. Audit

	Committee etc.		SRMG 01/11	Committee - Risk Mgt. Progress' report 28/09/10 presented to SRMG.
	2.9.1 Update on risk management arrangements in procurement of key services, works contracts and projects.	Jason Whaler	Sept 2010 SRMG 01/11	Update provided 01/11/10
	2.10.1 Develop benchmarking data to measure performance on risk management both internally and externally and propose actions.	CA/RW	Sept 2010 SRMG 02/09 SRMG 01/11	CA verbally reported that early indications from the ALARM/CIPFA risk mgt. Benchmarking group were generally favourable. As a result of meaningful discussions some data had been clarified and resubmitted by several councils
	2.10.3 Develop SMART performance indicators for risk management	CA	Sept 2010 SRMG 02/09	CA reported once the results from the above were known, it was hoped to develop SMART PIs.
	2.5.1 Review arrangements for major projects/ initiatives. E.g. BSF, Sports Academy, Waste Management, etc. • **Baths Hall**	N. Bennett	Sept 2010 **SRMG 06/01**	**Deferred to 6 January 2011 meeting**
Nov 2010				
	2.3.2 Review Criminal Liability issues for officers arising from new legislation. (MLO, Corp Manslaughter).	JR (Health & Safety Manager)	Nov 2010 SRMG 01/11	JR issued handouts to SRMG and updated the group on the first corporate manslaughter case to come before the Courts. The trial continues in Jan. 2011.
	2.5.1 Review arrangements for major projects/ initiatives. E.g. BSF, Sports Academy, Waste Management, etc. • **Waste management**	John Coates	Nov 2010	**Deferred to 2 March 2011 meeting**
Dec 2010				
	2.1.3 Analysis of strategic risks and actions arising from Position Statements provided by Service Directors.	CA	Dec 2010 **SRMG 06/01**	Progress reported 06/02/11
	2.2.2 Analysis of operational risks.	RW/RK	Dec 2010 **SRMG 06/01**	
	2.3.3 Evaluate the risk of fraud and controls in place.	CA	Dec 2010 **SRMG 06/01**	Fraud risk profile and analysis work presented 06/01/11
	2.5.1 Review arrangements for major projects/ initiatives. E.g. BSF, Sports Academy, Waste Management, etc. • **BSF**	J. Galbraith	Dec2010	**Deferred to 26 April 2011 meeting**
Jan 2011				
	2.5.1 Review arrangements for major projects/ initiatives. E.g. BSF, Sports		Jan 2011	**Deferred to 26 April 2011 meeting**

	Academy, Waste Management, etc. • **The Pods**	CR		
	2.7.3 Communication network of newsletters and reports to the Audit Committee etc.	CA/RW	Jan 2011 **SRMG 06/01**	
March 2011				
	2.1.1 Annual review of SRMG membership, terms of ref., risk management strategy & action plan, and framework for 2011/2012 and approval thereof.	CA/RW/ALL	March 2011	
	2.6.1 Report on last three years accident statistics for trends, showing direction of travel. Ensure action is taken by management to minimise costs/ service disruption	JR	March 2011	
	2.6.2 Report on last three years insurance claims data for trends, showing direction of travel. Ensure action taken by management to minimise costs/ service disruption	RW	March 2011	
	2.9.2 Annual review of governance arrangements for partnership and collaborative working	LSP Manager	March 2011	
	2.10.1 Develop benchmarking data to measure performance on risk management both internally and externally and propose actions.	CA/RW	March 2011	02/07/10: CIPFA/ALARM benchmarking exercise completed, awaiting results. Progress will be reported to Audit Committee in September.
	2.10.2 Review the effectiveness of risk mgt. arrangements against current best practice e.g. CAA Key Lines of Enquiry recommendations	CA	March 2011	
	2.10.3 Develop SMART performance indicators for risk management	CA	March 2011	
	2.10.4 Capture outcomes resulting from risk management actions.	CA/RW	March 2011	
Items with no date agreed/published for action as required.				
	2.4.1 Develop a programme of targeted operational risk mgt. actions arising from changes in legislation, government	ALL	As req'd	

	guidance/initiatives, etc.			
	2.7.1 Additional training and development programme in response to emerging risks for the year not met through the corporate programme.	ALL	As req'd	
	2.7.2 Provision of risk management training identified through Leadership and Management Competencies, generic competencies and revised induction programme delivered through the corporate training plan.	HR corporate training plan	As req'd	Risk Management for Managers training delivered by RW on: • 25/06/10 • 23/11/10

RISK roundup

Issue 6
October 2010

A quarterly digest of risk management issues

Wheelie bin injury page 7

No failure by education authority

ASSAULT OF TEACHER BY PUPIL – EMPLOYER'S LIABILITY
Vaile v London Borough of Havering, 31.03.10, High Court

The claimant was a teacher at a school in the defendant's local education authority area. The school had only 65 pupils, some of who were autistic.

In July 2003 the claimant was assaulted by a teenage pupil, P. The claimant had taught at the school for 14 years and had considerable experience of teaching children with learning difficulties. She sought damages from the defendant in respect of her injuries, alleging, among other things, that the assault took place due to the defendant's failure to provide her with a safe working environment and to protect her from P's aggressive behaviour.

It was alleged that P was autistic but he had not been diagnosed as such. He had been made the subject of a statement of special educational needs in 1994 when he was aged five. P had several difficulties with learning and coordination and all ten pupils in his class had learning difficulties. The claimant was their class teacher at the time of the incident.

The incident for which the claimant claimed damages involved P stabbing the claimant's hand with a pencil, lunging at her and violently shaking her head. This happened after she had said to P, "No, [P]", asking him to put his work where the other children had put theirs instead of on her desk. A colleague shouted at P to stop attacking the claimant and P stopped and left the classroom. P had once previously assaulted the claimant some weeks before this incident. The claimant eventually retired due to ill health.

The defendant argued that the claimant knew that P had challenging behaviour and that she had received appropriate training. They also alleged contributory negligence, saying that advice and guidance to the teachers teaching the children was that they should not say "no" to them. The claimant denied being told this, saying that children needed to know that "yes" and "no" were part of everyday language.

Expert evidence indicated that a more structured approach to P's teaching would have been preferable but his education was adequate. The claimant was not working in an unsafe environment and before the first assault P had been a passive, non-violent pupil.

The judge held that the assault for which the claimant sought damages was sudden and unexpected, following a reasonable request by the claimant for P to leave his work at the correct place. It was not caused by any failures by the defendant. The claim was dismissed.

Teachers teaching pupils with learning difficulties have to manage pupils' challenging behaviour but sudden, unexpected and out-of-character assaults cannot necessarily be reasonably foreseeable. Experienced teachers will be aware of the range of challenging behaviours they might encounter in schools. Where, however, an otherwise passive pupil suddenly becomes violent, a causative link between that unexpected behaviour and any alleged failing by the local education authority has to be demonstrated for a subsequent claim to succeed.

NORTH LINCOLNSHIRE COUNCIL
www.northlincs.gov.uk

School exclusion a disciplinary matter

EXCLUSION – HUMAN RIGHTS – RIGHT TO A FAIR TRIAL
R (application of LG) v Independent Appeal Panel for Tom Hood School (Respondent) and Secretary of State for the Department for Children, Schools and Families (Interested Parties), 26.02.10, Court of Appeal

The Court of Appeal has confirmed that article 6 of the European Convention on Human Rights is not applicable to a hearing before independent appeal panel concerning whether a pupil should be permanently excluded from school. This was a disciplinary matter. Where a head teacher, governing body or appeal panel is considering whether a pupil should be excluded, the facts are to be decided on the balance of probabilities under regulation 7A of the Education (pupil Exclusions and Appeals) (Maintained Schools) (England) Regulations 2002.

"The decision to exclude V was a preventative not a punitive measure, despite involving matters that had a criminal law element."

The applicant is the mother of V who was excluded from school after a fight in which he was accused of having a knife. At the hearing in the High Court in March 2009, the judge held that the respondent's role was regulatory and the decision to exclude V was a preventative not a punitive measure, despite involving matters that had a criminal law element. The court also held that V's civil rights were not infringed by the exclusion – this was a disciplinary matter rather than one concerning his civil rights under the ECHr. V could be educated elsewhere, he did not wish to return to the school and he enrolled elsewhere.

The questions for the Court were, first, where a child is excluded from school, does that child have a right to a fair hearing under article 6 of the European Convention on Human rights? Second, if there is a right to a fair hearing, is that right infringed by the decision to exclude the pupil being made after the evidence was assessed on the balance of probabilities rather than on the basis of beyond reasonable doubt?Article 6 states that, when considering a person's civil rights and obligations, or a criminal charge, a person is entitled to a fair and public hearing.

The appellant argued that the court was either considering her son's civil rights and obligations within the meaning of article 6, or a criminal charge against him. The Court of Appeal held that V did not have a civil right to be educated at a particular school.

The Court referred to case law on this point including Ali v Lord Grey School, a House of Lords decision. There had therefore been no infringement of V's civil rights.The Court rejected the claim that, as the respondent had considered a criminal charge against V, the evidence had to be proven beyond reasonable doubt. The respondent had been deciding a disciplinary, not a criminal, matter. Permanent exclusion was not a sufficiently severe sanction that could lead the allegation against him to be regarded as criminal. Further, article 6 does not expressly state which standard of proof was to be used. The appeal was dismissed.

Park marker was 'obvious danger'

PUBLIC PARKS – ORIENTEERING MARKERS – INJURY
Young v Plymouth City Council, 26.02.10, Exeter County Court

In July 2006 the claimant was walking with her dogs in Central Park, Plymouth. She injured her foot when she caught it on a 12 inch-high wooden marker. The marker had been in situ for several years, as part of an orienteering course. The claimant sought damages from the defendant council, alleging negligence and breach of duty under the Occupiers' Liability Act 1957. She alleged that the area was not reasonably safe for visitors because the marker was partially concealed by grass, it was difficult to see due to its colour and it created a trap for walkers.The defendant denied liability. It relied on evidence from its employees who cut the grass in the park, as well as evidence from the person who redesigned the course in 2008. The defendant argued that the claimant, knowing of the marker, should have looked where she was going.At trial the court heard from the claimant that she was probably aware of the marker at the time of her accident and had known of it on her previous visits to the park. Evidence showed that, other than the claimant's accident, there had been no other accidents or any complaints involving the marker in the preceding 10 years. The judge disagreed that the marker presented a danger to visitors, ruling that the marker was an obvious danger for which no warning signs were necessary. The claim was dismissed.

This is another claim in which the court applied the principles in the now well-known judgment of Congleton v Tomlinson Borough Council. The judge also applied s.1 of the Compensation Act 2006 regarding alleged negligence and liability for injury when engaging in "desirable" activities.

Drivers need to be highly vigilant

ROAD TRAFFIC ACCIDENTS – CHILDREN – DRIVING WITH REASONABLE CARE
Richardson (by his mother, M Allen) v Butcher, 12.02.10, High court

One evening in December 2000 at about 7.45pm the claimant ran out into a road in Bedlington, Northumberland, and was struck by an Audi 80 car driven by the defendant.

The road was an urban B road with houses either side. It was usually busy but quiet at that time of the evening. The claimant, aged almost nine at the time, was seriously injured.The claimant, through his mother, claimed damages from the defendant, alleging negligence.

Both parties instructed road traffic accident experts. The judge acknowledged that the test to establish whether the defendant was negligent was to decide if her actions matched those of a reasonable driver, taking into account the realities of the situation at the time.

The defendant said that the child appeared suddenly out of nowhere, he was crouched or bent over and, although she braked hard, her car struck him. The judge held that the defendant was travelling at 25mph at the time of impact. There was no oncoming vehicle that could have dazzled her with its lights or obscure her view. A car in front of her had turned left shortly before the incident and her counsel contended that it was not unreasonable for her to have been paying attention to this vehicle until it had cleared her path immediately before seeing the claimant. Her counsel argued that she could not reasonably have had time to react sooner than she had.

However, the defendant herself did not say that she had been concentrating on the car in front turning left before suddenly seeing the claimant in the road in front of her. She said that, after the car in front had turned off, she changed up a gear and accelerated slightly.

The judge held that the defendant failed to pay attention to the road in front of her. Had she been paying attention she would have seen the claimant at least two seconds before she did actually see him. The expert evidence showed that, had she seen the claimant in those two seconds she could have braked 0.75 of a second earlier and avoided hitting him.

Her failure amounted to failure to take reasonable care and to keep a proper lookout. The claim succeeded in full, no allegation of contributory negligence due to the claimant's age. The judge said that, had the same accident involved an adult at the time, contributory negligence would have been about 75%.

Although the judge accepted that it would be a "counsel of perfection" to expect drivers not to be distracted from time to time, this judgment cautions drivers of the need for a high degree of vigilance and to be aware of the potential for the unexpected, particularly in residential areas, even when travelling relatively slowly. Here, the driver was driving at about 25mph at a quiet time along a mainly residential street. However, it was dark and there were sweet shops in the area, one of which the claimant child was intending to visit. The defendant did not see the claimant poised in the road in front of her but she was held, following expert evidence, to have required just 0.75 of a second in which to have braked to avoid hitting him.

Yards must be managed properly

FATAL ACCIDENT – WHEELED SHOVEL LOADER
Dudley Metropolitan Borough Council, Wolverhampton court, 08.02.10

In October 2006 a manager with the council was struck and killed by a wheeled shovel loader in a depot. The manager, P, was wearing a high visibility jacket at the time. The site had a one-way system and P was facing oncoming traffic in the yard. At the same time, L, an employee, was driving the loader against the one-way system, at about 8mph, with the loading shovel raised, effectively obscuring his view.

Other staff tried to warn P and alert L but L continued driving. P was struck by the blade of the shovel's bucket. The loader only stopped after the front wheel had run him over. The Health and Safety Executive (HSE) prosecuted the council under s.2(1) of the Health and Safety at Work etc Act 1974. L was prosecuted under s.7. Both pleaded guilty. The council was fined £30,000 and ordered to pay £20,000 costs, and L was fined £750 and £500 costs.The HSE emphasised the importance of depots and loading yards being managed properly with set routes that ensured pedestrians and vehicles were kept safely apart. Employers should also check that site rules and systems of work were appropriate and adequately enforced.

This tragic but avoidable incident warns all businesses that run loading depots of the importance of having and adhering to proper site safety systems. The HSE said that signs and instructions in the workplace need to be obeyed "just as closely as they would obey them on a public highway". Such incidents, with the possibility of subsequent related civil claims, are avoidable.

Pothole accident claim failed

TRIP – S.58 DEFENCE
Stephen v Warrington Borough Council, 01.02.10, Salford county court

During an early evening in May 2008, the claimant, a postman, was collecting mail from a post box on a lane in Warrington. As he stepped out of his van his left foot was caught in a pothole and he broke his ankle.

The claimant claimed damages from the defendant highway authority, alleging negligence and breach of s.41 of the Highways Act 1980 (the Act).The defendant denied liability. It defended the claim under s.58 of the Act, relying on the adequacy of its inspection system. The area was subject to an annual inspection with ad hoc inspections if complaints were received from the public. Its highways inspector inspected the area after a complaint and found a defect with a depth of 45mm. He ordered a repair in line with the policy to intervene where defects are more than 40mm deep. The inspector carried out an inspection of the accident site three months beforehand. He did not find any defect at that time.

The judge accepted that the claimant fell and injured himself and that the defect, as described by the inspector, was dangerous. However, the defendant's inspection system was reasonable and adequate and there was no defect during the inspection carried out three months before the accident. The judge accepted that defects of this kind can develop very quickly, referring to how many such potholes had appeared during the cold weather earlier this year. The defence was accepted and the claim failed.

Although only a county court decision, this judgment indicates a judge taking a common sense approach to the common problem of potholes. He acknowledged, in particular, how they can quickly develop in extreme and well-documented weather conditions such as during the early months of this year. This ruling could be a useful, though of course not binding, reference for similar cases if a highway authority can also demonstrate the operation of an adequate inspection and maintenance system on which to base a s 58 defence.

"The judge accepted that defects of this kind can develop very quickly"

No liability for playground injury

PLAYGROUNDS – PLAYGROUND EQUIPMENT – ADULT INJURY
Butt v Walsall Metropolitan Borough Council, 05.02.10, croydon county court

In May 2005 the claimant, then aged 41, went to a playground with her children and her sister. She was playing with the children on monkey bars and, when hanging from them, she released her grip to drop to the safety matting about one and a half to two feet below her feet. As she landed she suffered broken leg bones. She claimed damages, alleging her injuries and loss were caused by the defendant's negligence and/or breach of duty under either the 1957 or 1984 Occupiers' Liability Acts. She alleged, among other things, that the defendant had failed to ensure she was reasonably safe in the playground, that trespassers, if she were one, were reasonably safe at the site and that the matting was unsafe due to holes exposing the underlying concrete. The claimant also relied on the maxim, res ipsa loquitur: the facts speak for themselves.

The defendant denied liability. It argued that the equipment was for children – the claimant was not a lawful visitor when using the monkey bars and the 1984 Act applied. The safety matting was not defective, daily inspections took place, and it denied that it should have offered the claimant protection against the risk of using children's equipment. Had the claimant been a lawful visitor under the 1957 Act, it said it had taken all reasonable care to ensure she was safe at the site.

The defendant said that if the accident occurred as alleged it was caused wholly or in part by the claimant failing to take care for her own safety. She should have known she was "too big" to use the monkey bars. She also failed to avoid alleged defects in the matting. The judge regarded some of the claimant's evidence as inconsistent and sometimes unclear and that she was convincing herself of facts after the event. By contrast, the defendant's witness gave clear and precise evidence of the area not being defective. The claim was dismissed.

This is a good example of the importance of persuasive evidence and the perils of conflicting evidence. The claimant's evidence was inconsistent and unclear but the defendant, though its inspection regime was "not flawless", could give accurate and credible evidence of the area not being defective. The judge did not concentrate on whether the claimant should, as an adult, have been using the equipment but rather on the general safety of the area. He held that there was no causal link between the alleged fall and any alleged defect.

FIRE PROTECTION

Water mist systems – Zurich advises caution for full building protection

"Sprinklers continue to provide the most appropriate method of protection to public buildings."

Zurich is issuing a fire protection technical guidance note on the use of water mist systems in place of sprinklers in public buildings. The insurance company remains unconvinced that water mist systems, originally developed for use in the marine environment and for local applications, such as industrial fryers, are a suitable substitute for tried and tested sprinklers in property protection.

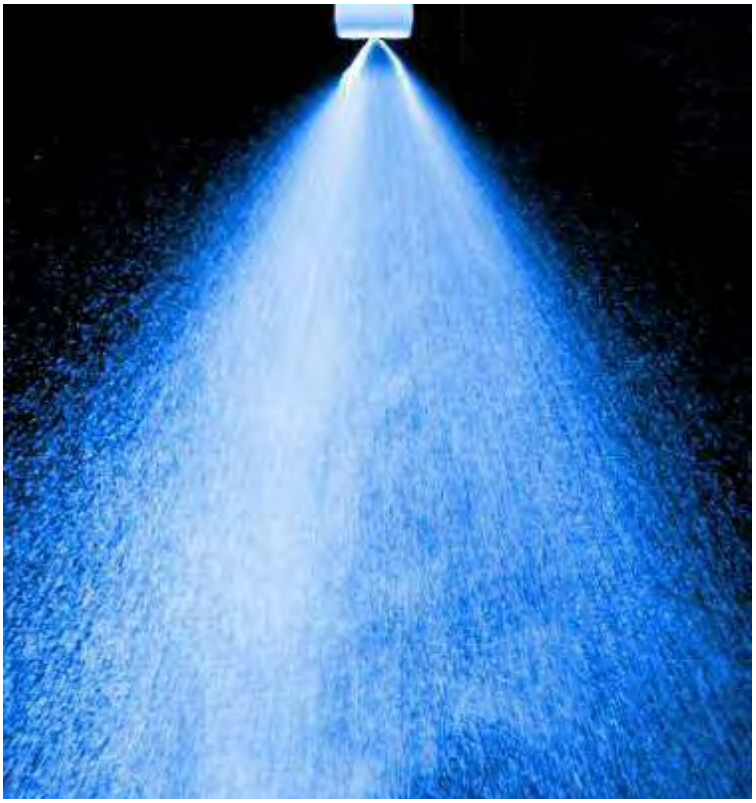
"We feel that sprinklers continue to provide the most appropriate method of protection to public buildings," explains Graham Page, Practice Leader, Zurich Risk Engineering. "Water mist is an unknown quantity," he continues.

Over the past year, installers have heavily promoted water mist systems as an alternative to conventional sprinklers for complete building protection, particularly in schools, hospitals and offices.

"These systems haven't gone through the stringent testing processes and assessments sprinklers have. Zurich's view is that they do not provide suitable protection, for instance for large areas or volumes, for buildings with high ceilings or changing fire loads," says Graham.

Zurich does not consider water mist systems to have been proven to provide an equivalent level of fire protection to that of a conventional sprinkler system because of:

- Lack of appropriate design standards.
- Lack of third party certification of water mist companies and equipment.
- Limited fire test data and relevance of tests compared with premises to be protected.
- Ability to protect all areas of premises, like stockrooms, gym stores, external canopies, kitchens and plant rooms, is not proven.
- Ability to provide protection for different methods of construction, or products used in construction, is not proven.
- Ability to deal with design features of premises, which may affect performance of systems, like atriums, areas with ceilings over 5m high, open cell ceilings and plenums, is not proven.



There is currently no UK third party certification scheme, which controls and supervises the installation of water mist systems or the installing companies and staff. This means the industry is largely unregulated. "End users and stakeholders have no peace of mind regarding the quality of the installation or the equipment," says Graham.

Zurich's view is: 'Water mist is an effective means of fire suppression in the correct application and its worth has been proved for marine-based and local application uses. However, until such time as there are extensive design standards, supported by appropriate fire testing carried out by approved third party research laboratories and third party approval of installers and systems, we consider that the use of water mist, for the fire protection of entire buildings, remains unproven.

'Water mist systems are not (as yet) accepted by Zurich as comparable alternatives to conventional sprinkler systems and therefore do not qualify for the same preferential insurance terms. The fire protection technical guidance note was produced in summer 2010.

To find out more about fire protection, go to www.zurichmunicipal.com or email info@zurichmunicipal.com

Trip claim appeal dismissed

TRIP – REPAIRS TO FOOTPATH – INTERVENTION LEVELS
Esdale v Dover District Council, 15.03.10, Court of Appeal

The claimant lived in a flat in a block owned and occupied by the defendant. She tripped and injured herself on the footpath outside her home. She claimed damages from the defendant, alleging negligence and/or breach of duty under the Occupiers' Liability Act 1957. The footpath was constructed partly of tarmac and partly of concrete. Where these materials meet there was a small change in the level which ran across the width of the path. The claimant was familiar with the area, had considered the entire path dangerous but had not reported her concerns to the defendant until after her accident.

The defendant's highways inspector said that, as a general rule, he would report differences in level of more than three quarters of an inch as needing repair although other factors would be taken into account. He had not previously regarded the area as needing attention and maintained this view on his post-accident inspection. However, he later arranged for a concrete fillet to create a sloping surface between the two levels.

At trial the judge held the difference in height between the levels was between three quarters of an inch and one inch. The only record of a complaint about the path was 25 years earlier. The trial judge considered whether the area was reasonably safe, referring to Mills v Barnsley MBC (1992, Court of Appeal). Although Mills concerned a highway claim, the judge regarded it as relevant because the Court of Appeal held that such defects were a danger if the reasonable person considered harm as reasonably foreseeable. The claim was dismissed.

This is a useful Court of Appeal reminder of the reasonableness of intervening to repair defects in footpaths, whether under highways or occupiers' law. All circumstances of the area will be taken into account. The occupier's or highway authority's policy on intervention levels is not a factor that can indicate whether there has been a breach of duty but it could be relevant. Not all defects are dangerous, not all differences of height in a footpath above an inch are dangerous nor all those below, not dangerous. A breach of duty is decided objectively by the judge based on what is considered reasonable in the particular circumstances of the case.

The claimant appealed, contending that the height difference exceeded the defendant's intervention level and the trial judge had failed to consider this fully.

The Court of Appeal held that the test for whether there has been a breach of duty was the view of the reasonable person. The trial judge, as the reasonable person, had considered the defect only minor and it had been in situ for years. The defendant's inspection system was reasonable. The trial judge had not erred in regarding three quarters of an inch as a reasonable general intervention level. The appeal was dismissed.

Council not liable for skate park slip

PUBLIC LEISURE CENTRES – SKATE PARKS
Breheney v Chistchurch Borough Council, 06.05.10, Bournemouth County Court

The claimant sought damages after he said he slipped on a patch of fluid and fractured his elbow while roller skating at the defendant's leisure centre.The claimant alleged that the defendant had breached its duty under the Occupiers' Liability Act 1957 by failing to take reasonable care for his safety. His allegations included failing to display notices prohibiting bringing drinks on to the skate area, failing to notice or clear up the fluid and failing to operate its system for inspecting and maintaining the floor in a safe condition.

The claimant was aged 39 at the time.The defendant denied liability. It said that a risk assessment before the accident resulted in food and drink being prohibited from the skating hall as stated on signs at the entrance. Any food or drink in the hall would be confiscated or the person would be asked to take it outside. The hall was checked almost hourly by its staff and any spillage would be promptly cleared up.

No spillages were found or accidents reported of the claimant's type on the day of the alleged accident. If a spillage were present, the defendant argued that it had taken all reasonable steps to ensure the safety of the claimant and others skating.

The defendant also argued that if the accident was caused as alleged it was due either wholly or partly to the claimant's negligence by his knowingly taking part in a risky activity. He had also, it argued, failed either to notice fluid on the floor or to take reasonable care for his own safety. Further, he did not report the spillage to the skate guards and the defendant was

Continued on next page

Continued from page 6

unaware of the incident until about 10 months later when it received a letter of claim. The defendant denied that the claimant fell on fluid.

The court heard evidence of witnesses who said there were signs on the doors forbidding food and drinks to be taken into the hall. Previous reports of accidents showed that none of those who had fallen had done so due to any spillage. Roller skating is a potentially hazardous exercise. The court noted that the claimant had not told anyone at the hall or even at the hospital that he had slipped on a wet patch while skating. Two of his witnesses stated at trial that he had but this was not included in their witness statements. However, the court held that the claimant probably did slip on a wet patch but the defendant operated a reasonable inspection and maintenance system and therefore the claim failed.

This illustrates how an occupier of public leisure facilities can be held to have complied with its duty to ensure its visitors are reasonably safe by demonstrating the operation of a reasonable maintenance and inspection system in addition, there was no evidence that the claimant reported the alleged hazard that caused his accident to any relevant member of staff or even to those treating him in hospital This again highlights the importance of not only operating, but keeping records of the operation of a reasonable maintenance and inspection system – the system does not have to be perfect or foolproof, but reasonable.

Wheelie bin claim succeeds

MANUAL HANDLING – WORK EQUIPMENT – REFUSE COLLECTORS
Reynolds v Gwynedd Council, 09.12.09, Caernarfon County Court

"There was no specific training as to handling wheelie bins and the defendant had failed to take steps to reduce the chance of the bin being overloaded."

The claimant worked for the defendant as a refuse collection driver and loader. One morning in January 2006 he was moving a heavy wheelie bin at commercial premises so that it could be emptied. He slipped and fell and the bin fell on his back which he said caused a sprain or strain of his spine and aggravated a pre-existing back condition.

The claimant claimed damages against the defendant alleging negligence and/or breach of statutory duty. He alleged breaches of the Manual Handling Operations regulations 1992, the Provision and Use of Work Equipment regulations 1998, the Management of Health and Safety at Work regulations 1999 and The Highways Act 1980. His numerous allegations included failure to provide proper training on how to handle loads correctly, failure to provide information about the weight of the bin and that the pavement on which he fell was potholed.

The claimant also alleged that complaints had been made by his colleagues to their line manager before the accident about the owners at the property concerned over-loading their bin. He said that after the accident he received manual handling training and that the defendant wrote to the owners about the weight of their bin.

The defendant denied liability but admitted to having written to the relevant owners after the accident. They said that the claimant received manual handling training and the task was risk-assessed before the accident. They argued that the accident was caused at least in part by the claimant's own fault because amongst other things, he ignored his training, tried to move a heavy bin without asking for help and failed to look where he was going. The claimant had occasionally acted as supervisor and had very considerable experience of handling wheelie bins. At trial, the court focused strongly on training. The defendant's trainer and other witness could not remember attending a training session outside involving an actual wheelie bin, but confirmed indoor training took place.

No record of the training given could be produced. The judge concluded that there was no specific training as to handling wheelie bins and the defendant had failed to take steps to reduce the chance of the bin being overloaded. The claim succeeded and the claimant was awarded damages of £2,000 in total. The claimant's costs were assessed at approximately only 50% of the amount claimed.

This claim succeeded largely because there was no record of the defendant's argument that proper training, involving actual bins, had taken place, nor any record of what action had been taken on previous complaints of these commercial bins being overloaded. These issues have since been addressed but they remind employers of the importance of keeping clear records of training given and of steps taken on complaints received.

Broken bottle not council's fault

PUBLIC PARKS – LITTER – INJURY FROM BROKEN BOTTLE
White v Cardiff City Council, 10.02.10, Cardiff County Court

The claimant alleged that, when playing football with friends in a park in Cardiff, he fell and cut his calf on a broken bottle. He was aged 15 at the time. He claimed damages for his injury from the defendant council, alleging breach of the Occupiers' Liability Act 1957 and/or negligence. His allegations included that the defendant had failed to operate a system to clear up litter and failed to deal with complaints from the public and from the police about the condition of the park. He said that the defendant knew that under-age drinking and anti-social behaviour were prevalent in the park and that they should have operated a system to ensure the resulting litter was regularly cleared.

The defendant denied liability. It provided evidence of its system to clear litter. A driven inspection would take place two or three times each week, the bins would be emptied and litter would be manually picked up if seen on the ground. However, the inspection route did not include the playing field area that was the site of the alleged accident. The defendant said this was due to the lack of resources – funds able to be allocated to its obligations to clear this and other parks in Cardiff did not allow for more painstaking litter clearing.

The defendant's grass-cutter also gave oral evidence of its grass-cutting regime but was unable to provide documentary evidence. He said if he saw broken bottles likely to obstruct his mower, he would pick them up but would leave undamaged bottles to one side for litter collection.The defendant said that it did not keep documentary records of complaints about litter although complaints of broken glass would be attended to immediately. Complaints made to the defendant's main complaints telephone number were documented and these did not show any complaints about litter in this particular park.

The defendant admitted there were problems with anti-social behaviour and an officer was delegated to address this, but the defendant only knew this behaviour occurred in the city's car parks.The judge held that there was insufficient evidence of complaints to the defendant about litter in the area of the incident. There was no evidence that the broken bottle had been present for any specific length of time and there was no evidence that the defendant had failed to keep the park sufficiently safe. The claim was dismissed.

Although the defendant council was unable to provide documentary evidence of some elements of its defence, the judge accepted the evidence it was able to give of its inspection system The judge also accepted that, given limited resources, the system for clearing litter was reasonable and sufficient Although the defendant knew of anti-social behaviour in its car parks and it had an officer designated to deal with that, there was no sufficiently clear evidence of complaints of this behaviour in other areas and the defendant could not reasonably have known of the alleged problem.

No council liability for classroom fall

SCHOOLS – TEACHERS – INJURY IN CLASSROOM
Bromby v Kingston-upon-Hull City Council, 19.05.10, Hull County Court

The claimant was a teaching assistant and had been employed by the defendant for 15 years. When collecting exam papers from Year 5 children in a classroom, one of the children leant forward on his chair and the claimant tripped over the chair's legs. She fell, injuring herself. The claimant said that the teacher whose class had taken the exam did not witness the incident but the teacher said he did. The claimant alleged that the desks had been arranged in a haphazard way but this was disputed.

The claimant claimed damages from the defendant, the local education authority for the school, alleging negligence and/or breach of statutory duty relating to health and safety in the workplace. She succeeded at trial and the defendant appealed.The trial judge had held that when children were seated at their desks, space was so limited that teachers would have to squeeze past. He also held that it was foreseeable that children would tip up their chairs and that, if they did, protruding chair legs would create a tripping hazard. He also held there had not been a risk assessment that identified this hazard and, had there been one, the desks would have been positioned to allow access at their sides, so avoiding the need for teachers to walk behind the children's chairs.The defendant argued that the trial judge had made no findings of fact about the two key areas of dispute – whether the teacher witnessed the incident and how the furniture in the room had been set out. The defendant also contended that

Continued on next page

Continued from page 8

any restrictions on space in the classroom did not cause the accident. There had not been any similar incident before or since and the defendant argued it was not foreseeable. There is no directive requiring staff to keep their distance from behind seated children.On appeal, the judge held that the trial judge had not adequately considered causation. He held that the cause of the accident was the child suddenly tipping forward in his chair. The accident was not caused by any breach of duty of the defendant and the appeal was allowed.

This illustrates the importance of considering the real cause of an accident even if an employer has not risk assessed the possibility of the incident that occurred, that does not automatically indicate any particular breach of duty An employer has a duty to consider risks that are reasonably foreseeable and to take reasonably practicable steps to address them. It is not a duty to eliminate the risk of all accidents that might possibly occur.

Trip claim fails

TRIPPING ACCIDENT – PAVING STONE – EVIDENCE
Stockell v Regenda Group, 02.02.10, Blackpool County Court

The claimant was the defendant's tenant. She alleged that, when returning from a shopping on Christmas Eve 2007, she tripped on a defective flagstone on a footpath outside her home, straining her left shoulder and exacerbating a pre-existing condition. She was aged 62 at the time.

She sought damages, alleging breach of the Defective Premises Act 1972 and/or the Occupiers' Liability Act 1957. She alleged, among other things, that the defendant had failed to operate an adequate maintenance and inspection system.

The defendant denied liability, arguing that the injury was not caused as alleged. The claimant's medical records suggested a clearly different cause of her injury: her Accident and Emergency records described her as being a casualty of Christmas shopping, that she had sustained an injury to her left shoulder when she had been carrying several bags of shopping. Other medical records referred to the injury having been caused by her losing her balance when carrying a shopping bag.

The defendant also denied it was an occupier under the 1957 Act but admitted owing a duty under the 1972 Act. It denied breach of that duty, contending that it took such care as was reasonable to ensure the claimant's safety.

At trial, the court found the claimant's evidence unconvincing and unsatisfactory. The court held that the hospital notes were correct on the balance of probabilities. The claim was dismissed and the claimant was also ordered to pay the defendant's costs of £6595.00.

In this case the medical notes taken on the claimant's attendance at hospital provided a stark contradiction of her own account of how she sustained her injury. This again highlights the need to cross-check evidence supplied in support of a claim, particularly in high-volume claims such as trips and slips.

The council gratefully acknowledges the contribution made by its insurers, Zurich Municipal, in providing articles for this publication.

Any employee intending to take action arising out of these articles should, if in any doubt, contact the council's legal section for advice before doing so.

If you want further information or advice, please contact the insurance and risk management team:

Rob Walters Insurance & Risk Manager **01724 296072**
Maureen Lyons Senior Insurance Officer **01724 296075**
Katy Shipp Insurance Officer **01724 296073**

NOTICEBOARD

Fraud Focus

The second 'fraud focus' newsletter was issued by internal audit in July 2010. This contains articles on the National Fraud initiative (NFI). How to be safe online. What to do if you suspect a fraud. Frauds at cashpoint machines/ATMs. Lotto scams and more.

To view a copy, simply type in the words 'fraud focus' on the council's intralinc site and view, or download a copy.

If anyone suspects that fraud is being committed, trained audit staff will respond to the allegations in a confidential manner. You can report suspicions of fraud by ringing the council's confidential hotline on 01724 296666.

The third 'fraud focus' newsletter will be issued mid to end October 2010. This will include articles on bogus government employees attempting to gain entry to properties and/or bank details, fraud alerts from the National Anti Fraud Network, the work of trading standards and more.

Strategic Risk Register

The council's Strategic Risk Register (SRR) has been substantially revised to reflect the risks facing the council in these difficult times.

New strategic risks have been identified through analysis of service plans. Other strategic risks have been reworded or extended to include significant issues for the council such as: Transformation Plan reduced financial settlement, workforce planning, challenges.

The SRR was approved by the Strategic Risk Management Group on 2 September 2010 and by the Audit Committee on 28 September 2010. The SRR can be viewed on the SRMG intralinc site.

SRMG Intralinc site

There is a wealth of risk management information on the council's intralinc site. Access the site via: councilwide issues, groups, strategic risk management group.

Operational Risk Registers

Three questions by way of prompts:

Have all services reviewed their Operational Risk Registers (ORRs) for the financial year 2010 -2011?

Have you remembered to change the date to 1 April 2010 or later? This may sound simple but it's surprising how many services review their registers but forget to change the date to the new reviewed date.

Finally, have you remembered to send a copy to Rob Walters?

Designed by North Lincolnshire Council Publications Unit. Ref 8337

	Leadership & Management	Strategy & Policy	People	Partnership, Shared Risk& Resources Processes	Processes	Risk Handling & Assurance	Outcomes & Delivery
Level 5 Driving	Senior Management uses consideration of risk to drive excellence through the business, with strong support with reward for well-managed risk taking.	**Risk management capability in policy and strategy making helps to drive organizational excellence.**	**All staff are empowered to be responsible for risk management** **The organization has a good record of innovation and well managed risk taking** **Absence of a blame culture**	Clear evidence of improved partnership delivery through risk management and that key risks to the community are being effectively managed.	**Management of risk and uncertainty is well-integrated with all key business processes and shown to be in key driver in business success**	**Clear evidence that risks are being effectively managed throughout the organization.** **Considered risk-taking part of the organizational culture**	Risk management arrangements clearly acting as a driver for change and linked for plans and planning cycles
Level 4 Embedded & Working	**Risk management is championed by the CEO** **The Board and senior managers challenge the risks to the organization and understand their risk appetite** **Management leads risk management by example**	Risk handling I an inherent feature of policy and strategy making processes Risk management system is benchmarked and best practices identified and shared across the organisation	People are encouraged and supported to take managed risks through innovation Regular training and clear communication of risk is in place	**Sound governance arrangements are established** **Partners support one another's risk management capability and capacity**	A framework of risk management processes in place and used to support service delivery Robust business continuity management system in place	Evidence that risk management is being effective and useful for the organization and producing clear benefits Evidence of innovation risk-taking	**Very clear evidence of very significant improved delivery of all relevant outcomes and showing positive and sustained improvement**
Level 3 Working	Senior managers take the lead to apply risk management thoroughly across the organization They own and	Risk management principles are reflected in the organisation's strategies and policies Risk framework is	A core group of people have the skills and knowledge to manage risk effectively and implement the risk management	Risk with partners and suppliers is well managed across organizational boundaries Appropriate resources in place to manage	Risk management processes used to support key business processes Early warning indicators and lessons learned and reported	Clear evidence that risk management is being effective in all key areas Capability assessed within a formal assurance	Clear evidence that risk management is supporting delivery of key outcomes in all relevant areas

	manage a register of key strategic risks and set the risk appetite	reviewed, refined and communicated	framework Staff are aware of key risks and responsibilities	risk	 Critical services supported through continuity plans	framework and against best practice standards	
Level 2 Happening	Board/ Councilors and senior managers take the lead to ensure that approaches for addressing risk are being developed and implemented	Risk management strategy and policies drawn up, communicated and being acted upon Roles and responsibilities established, key stakeholders engaged	Suitable guidance available and a training programme has been implemented to develop risk capability	Approaches for addressing risk with partners are being developed and implemented Appropriate tools are developed and resources for risk identified	Risk management processes are being implemented and reported upon in key areas Service continually arrangements are being developed in key service areas	Some evidence that risk management I being effective Performance monitoring and assurance reporting being developed	Limited evidence that risk management is being effective in, at least, the most relevant areas
Level 1 Engaging	Senior management are aware of the need to manage uncertainty and risk and have made resources available to improve	The need for a risk strategy and risk-related policies has been identified and accepted The risk management system may be undocumented with few formal procedures present	Key people are aware of the need to understand risk principles and increase capacity and competency in risk management techniques though appropriate training	Key people are aware of areas of potential risk in partnerships and the need to allocate resources to manage risk	Some stand-alone risk processes have been identified and are being developed The need for service continuity arrangements has been identified	No clear evidence that risk management is being effective	No clear evidence of improved outcomes