Investigating Accidents and Incidents Policy

	Name	Signature	Date
Prepared by:	Richard Lebrun & Gracious Chukwu		April 2020
Checked by:	John Griffiths & TUC		April 2020
Approved by:			
Document Title:	Investigating Accidents and Incidents Policy 2020		
Version Number:	01	Date of Next Review:	April 2021

Community Directorate
Harrow Council
Civic Centre
Station Road
Harrow
HA1 2XA

Tel: 020 8863 5611

CONTENTS

INTRODUCTION

This policy outlines the investigation procedures which are to be adopted when any accident, ill health, near miss or dangerous occurrence occurs on Council premises, on land the Council is responsible for or caused by the provision of a Council service.

It is the policy of the Council to ensure that, where practicable, accidents or incidence of work related ill health, dangerous occurrences and near misses will be investigated by suitably trained staff.

This policy is based on good practice and HSE HSG 245 “Investigating Accidents and Incidents: A workbook for employers, unions, safety representatives and safety professionals” ,and may be amended at any time in consultation through the Corporate Health & Safety Board.

1 Scope

The scope of any investigation is:

a. to ensure that all necessary information in respect of the accident or incident is collated
b. to understand the sequence of events that led to the accident or incident
c. to identify the unsafe acts and conditions that contributed to the cause of the accident or incident
d. to identify the underlying causes that may have contributed to the accident or incident
e. to ensure that effective remedial actions are taken to prevent any recurrence
f. to enable a full and comprehensive report of the accident or incident to be prepared and circulated to all interested parties
g. to enable all statutory requirements to be adhered to.

It is imperative that the root /underlying causes are identified as part of the investigation to seek to prevent recurrence. It is paramount to understand that such investigations are not a means to determine fault or apportion blame, and it is only after such an investigation is completed should consideration be given to whether any individuals acted inappropriately.

2 Immediate Response

Following any adverse event, the first course of action will always be to seek appropriate assistance for any person involved, and to make any area / situation safe if applicable.

It is important that the appropriate manager is informed of the situation without any unnecessary delay, and the following actions are taken:

- Preserve the scene;
- Note the names of the people, equipment involved and the names of any witnesses;
- Report the adverse event on the SHE software
- Notify the HSE if necessary

Should there be any confusion or assistance is needed, then contact Corporate Health & Safety (healthandsafety.healthandsafety@harrow.gov.uk)

3 Decision to Investigate

It is recognised that not all incidents require a full health & safety investigation, and a decision whether one is required must be based on the worst consequence of the adverse event and the likelihood of recurrence. The HSE have provided a table to determine this:

Likelihood of recurrence	Potential worst consequence of adverse event			
	Minor	Serious	Major	Fatal
Certain				
Likely				
Possible				
Unlikely				
Rare				

Risk		Minimal		Low		Medium		High
Investigation level		Minimal level		Low level		Medium level		High level

4 Investigation Level

Where it has been decided that a MINIMAL LEVEL is appropriate, the matter must still be reported on the SHE Assure software but it is left to the line manager to carry out an informal review to determine if any steps need to take place to prevent recurrence. Such findings are then articulated to the appropriate people, or necessary steps taken.

Where is has been decided that a LOW LEVEL is appropriate, the same approach will be taken as minimal but with a more in depth review, trying to identify the root cause and putting the findings on the SHE Assure software.

Where is has been decided that MEDIUM LEVEL is appropriate, the appropriately delegated Manager (MG1 or above) shall be the Commissioning Officer and appoint a suitably qualified and competent investigating officer, and an investigation will be conducted as set out below.

Where is has been decided that HIGH LEVEL is appropriate, the appropriate Director or above shall be the Commissioning Officer and appoint a suitably qualified and competent investigating officer, and an investigation will be conducted as set out below. The Head of HR, Corporate Director for the relevant Directorate, Head of Communication and Chief Executive shall be informed without delay of such an incident.

Trade Unions will be informed of any MEDIUM or HIGH investigation and encouraged to participate in the Investigation if suitable

5 The Investigation

5.1 The Investigator

Staff selected to carry out investigations must be competent to do so and will be required to attend any necessary training (**suitably approved course must be procured to ensure the level of competence)** and will be provided with the appropriate information and resources to enable them to carry out their respective roles. Corporate Health & Safety will act as lead investigators for any accident or incidents defined as **MEDIUM/**HIGH LEVEL.

To ensure that the objectives of the investigation are met, suitable and sufficient managers and supervisors will be selected and trained in investigation procedures, interview techniques, report writing skills and use of any equipment employed in the investigation process.

Other staff will be required to co-operate and participate in any investigation if the organisation feels that they have specific knowledge, understanding, experience or skills that may assist in the investigation.

5.2 Safety Representatives and Employees

The organisation encourages the involvement of employees in the investigation process.

Recognised trade union safety representatives or other employee representatives will be given access to any necessary information and workplaces to enable them to fulfil their duties in strict compliance with the SRSC1977 Regulations. Safety representatives will also be encouraged/entitled to fully participate in any investigation and Make representations to management on matters arising from the investigations.

All employees will be required to co-operate with the organisation in any investigation.

5.3 Process of Investigation

There are four main steps to the investigation that shall be conducted under MEDIUM and HIGH levels:

Step One: Gathering the Information

Step Two: Analysing the information

Step Three: Identifying suitable risk control measures

Step Four: The action plan and its implementation

These areas are expanded under HSE guidance and, for consistency, replicated below for ease of use.

5.3.1 Gathering the information

This stage requires all relevant information to be gathered, ensuring all reasonable lines of enquiry are made. In line with Council policies, if another matter of concern is detected during the investigation, for instance a matter that indicates a disciplinary matter, this should be recorded as part of the investigation, and linked to any recommendations or conclusions as appropriate.

This information gathering stage is vital as underpins any evidence base used to make conclusions and determine root cause of any incident. Therefore it is important that the information is gathered in a timely manner, and also recognises what is not known as well as what is.

A number of key areas of information are therefore vital:

- Where and when did the adverse event happen? (This sets the context)
- Who was injured / became ill / involved in the adverse event? (witnesses that hold vital information)
- How did the adverse event happen?
- What activities were being carried out at the time?

- Was there anything unusual or different about the working conditions?
- Where there adequate safe working procedures and were they followed?
- What injuries or ill health effects, if any, were caused?
- If there was any injury, how did it occur and what caused it?
- Was the risk known? If so, why wasn't it controlled? If not, why not?
- Did the organisation and arrangement of the work influence the adverse event?
- Was maintenance and cleaning sufficient? If not, explain why not.
- Were the people involved competent and suitable?
- Did the workplace layout influence the adverse event?
- Did the nature or shape of the materials influence the adverse event?
- Did difficulties using the plant and equipment influence the adverse event?
- Was the safety equipment sufficient?
- Did other conditions influence the adverse event?

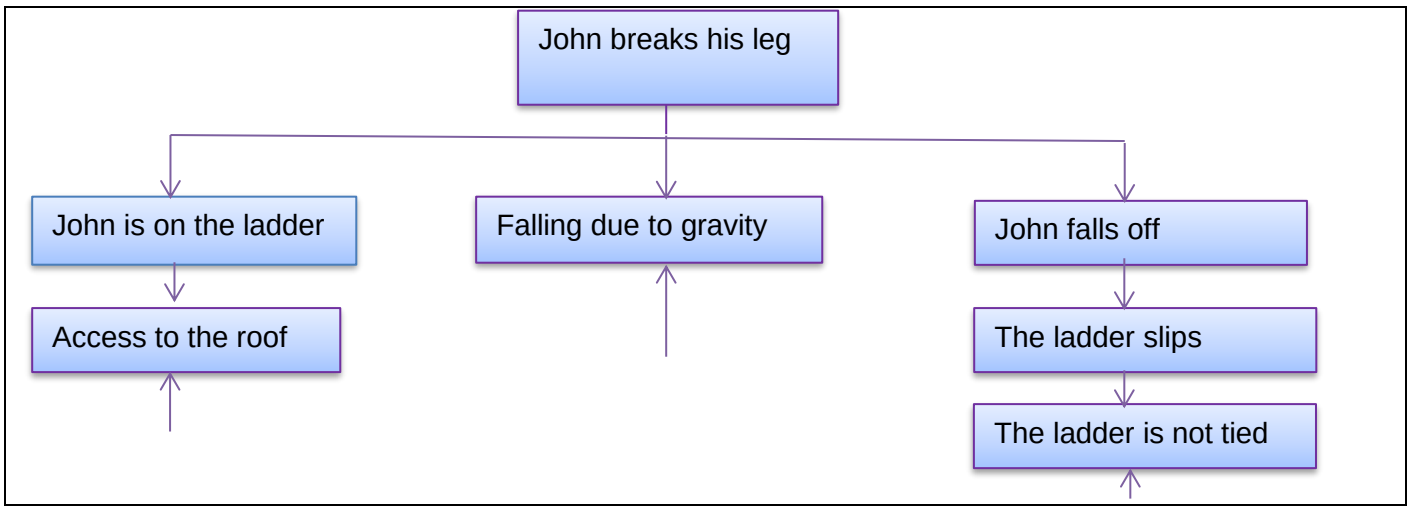
5.3.2 Analysing the information

The purpose of the investigation is to identify the immediate, underlying and root causes of the incident and setting it out in a clear and structured manner to ensure the sequence of events is captured.

- **Immediate causes**: the agent of injury or ill health (the blade, the substance, the dust etc.);
- **Underlying causes**: unsafe acts and unsafe conditions (the guard removed, the ventilation switched off etc.);
- **Root causes**: the failure from which all other failings grow, often remote in time and space from the adverse event (e.g. failure to identify training needs and assess competence, low priority given to risk assessment etc.).

Failure to do this means that recommendations are not certain to prevent recurrence of the incident going forward

Figure 1



What happened and why

Use the simple technique of asking 'Why' over and over, until the answer is no longer meaningful(See Figure 1).The starting point is the 'event', e.g. John has broken his leg. On the line below, set out the reasons why this happened. The first line should identify;

- the vulnerable person e.g. John on a ladder
- The hazard, e.g. falling due to gravity
- The circumstances that brought them together e.g. John fell off the ladder

Ask 'Why' for each of the reasons identified and set down the answers. Some lines of enquiry will end quickly e.g. 'Why was the hazard of falling present?' Answer: 'Gravity'

Having collected the relevant information and determined what happened and why, you can now determine the causes of the adverse event

Checklist /question analysis of the causes

Use the adverse event analysis work sheet and checklist (see Appendix A for checklist) to analyse the possible immediate causes of the adverse event (place, plant, people, process).An example can be found here. Record the immediate causes identified and risk control measures. Consider the underlying/root causes suggested by the immediate causes. Record the relevant ones and note the measures needed to remedy them.

The final step in analysis is to consider the environment in which health and safety organisation and planning was carried out.

The management section must be carried out by people within the organisation who have both the overall responsibility for health and safety and the authority to make changes to the management system.

What if 'human failings (errors and violations)' are identified as a contributory factor?

If your investigation concludes that errors and violations contributed to the adverse event, speak to those involved and explain how you believe their action(s) contributed to the adverse event. Invite them to explain why they did what they did. This may not only help you identify immediate causes but may offer pointers to root /underlying causes.

Unless you discover a deliberate and malicious violation or sabotage of workplace safety precautions, it will be counterproductive to take disciplinary action against those involved.

Human failings can be divided into 3 broad categories and the action needed to prevent further failings will depend on which type of human failing is involved.

Figure 2

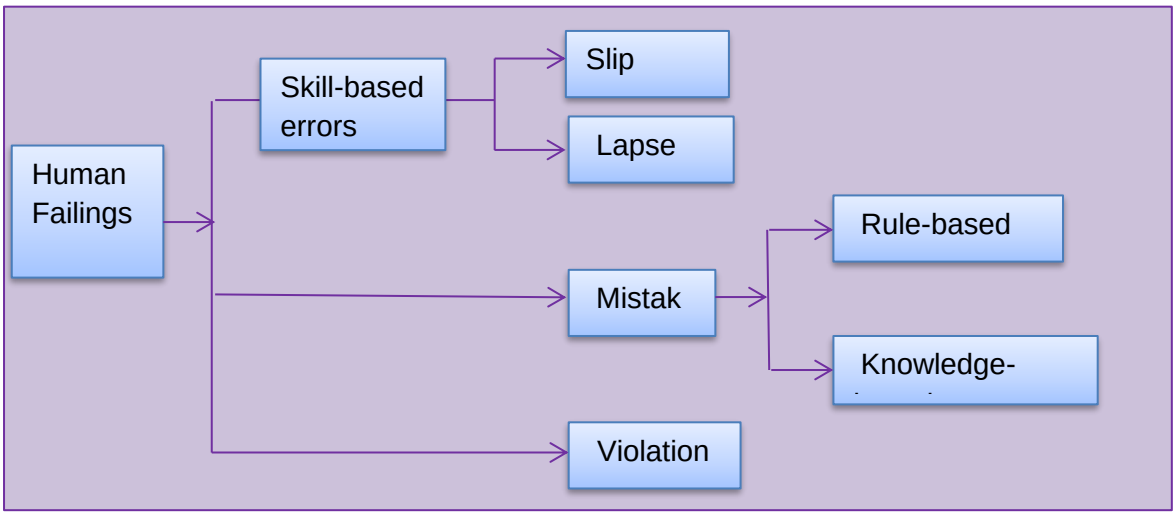


Figure 3

	Failure Types	Examples	Control Measures
Carrying out familiar tasks that require little conscious attention and the resulting action is not as planned	Slips	• Operating the wrong switch on a control panel	• Human centred designs(UP always means off • Colour coding • Checklists and reminders
Omit to perform a required action	Lapse	• Drive road tanker off before delivery is complete(hose still attached)	
A person has a set of rules on what to do in certain situations and applies the wrong rule	Rule-Based Mistake	• Ignore alarm in real emergency, due to history of spurious alarms	• Trainings • Comprehensive safe working procedures • Equipment Design
A person, faced with an unfamiliar situation without rules, applies his or her knowledge but comes to a wrong conclusion	Knowledge-Based Mistake	• Misdiagnose process and take inappropriate corrective action	
Deliberate deviations from rules	Violation (rule breaking)	• Operating a circular saw with the guard removed	• Training • Simple practical rules • Routine supervision • Performance monitoring

Human Failures do not happen in isolation. The following factors can influence human behaviour.

- Job Factors
- Human Factors
- Organisational Factors
- Plant and Equipment Factors

6.3.3 Identifying suitable risk control measures

If several risk control measures are identified, they should be carefully prioritised as a risk control action plan, which sets out what needs to be done, when and by whom.

What risk control measures are recommended?

Evaluate each of the possible risk control measures on the basis of their ability to prevent reoccurrences and whether or not they can be successfully implemented.

In deciding which risk control measure to recommend and their priority, you should choose measures in the following order, where possible:

- Measures which eliminate the risk e.g. Use water-based product rather than hydrocarbon-based solvent
- Measures which combat the risk at source e.g. provision of guarding
- Measures which minimise the risk by relying on human behaviour e.g. Use of Personal Protective Equipment

Do similar risk exist elsewhere, if so, what and where?

Having concluded your investigations, consider if a similar event can happen elsewhere in the organisation and the steps that can be taken to avoid this.

Have similar adverse events happened before? Give details

If yes, the fact that such adverse events are still occurring should be a spur to ensure that actions are taken quickly.

Remember that there is value in investigating near misses and undesired circumstances.

6.3.4 Action Plan and Implementation

The organisation will, so far as is reasonably practicable, implement any recommendations made as part of the investigation. In the event of any remedial action taken, staff will be fully involved and provided with the necessary information, instruction and training.

7 Records and Reports

All necessary staff will be issued with an accident report as soon as is reasonably practicable. Employees or their representatives will be given access to any report in so far as it is applicable to do so.

Records of any accident will be kept in accordance with the company's policy on record keeping.

Any records kept will be done so in accordance with the Data Protection Act 2018.

APPENDIX A

Adverse event analysis and Checklist: Rooting out risk

Using the information gathered during your investigation, go through each of the four sections on the immediate causes (the Place, the Plant, the Process and the People). If the answer to any of the questions is 'no', then this is an immediate cause of the adverse event under investigation. After identifying the immediate causes, direct your attention to the potential underlying causes (which are set out to the right of the immediate causes identified) and consider the questions under the relevant headings. For example if the answer to the first question below 'Were the access and egress adequate?' is 'no', you should consider whether the design of the workplace and the risk assessment for workplace access / egress were adequate.

Immediate Causes

1	**The place or premises where the incident happened**							
The place or premises where the incident happened. If there was anything about the condition of the workplace that contributed to the adverse event, answer the following question, which will suggest other areas to consider. If not, go to 'Plant, equipment and substances'.		Control	Co-operation	Communication	Competence	Design	Implementation	Risk assessment
1.Were the access and egress adequate?								
2.Were the access and egress points being used?								
3.Was the workplace suitable for the task in hand?								
4.Was there sufficient space for the task in hand?								
5.Was the workplace being used as intended?								
6.Were people segregated from hazardous areas/processes/machinery?								
7.Was the work environment (lighting, temperature and ventilation) suitable?								

8.Did the ergonomics of the workstation suit the person using it?							
9.Was the work area clean and tidy? (Routine cleaning programme and dealing with spills.)							
10 Were weather conditions a factor?							
11Were the noise levels within acceptable levels?							
12.Were the appropriate warning signs in place?							
13 Were contractors provided with adequate information on access/egress and the hazards within the premises?							

2	**The plant, equipment and substances (used or generated)**						
The plant, equipment and substances (used or generated). If the equipment being used, or the substances/materials used or generated, contributed to the adverse event, answer the following questions, which will suggest other areas to consider. If not, go to 'Process/procedures'.	Control	Co-operation	Communication	Competence	Design	Implementation	Risk assessment
1 Were the most suitable plant and equipment available for the job?							
2 Were the plant and equipment used suitable for the person using them?							
3 Were the plant and equipment used suitable for the job?							
4 Had the plant and equipment been chosen, or modified, so that its health and safety efficiency could not be improved?							
5 Were plant and equipment in working order and adequately maintained? Was there a routine maintenance programme? Was there a procedure for repair when a defect was discovered?							

6 Were the plant and equipment being properly used?							
7 Were there adequate controls or guards for the safe use of the equipment?							
8 Were the controls or guards fitted, maintained and properly used?							
9 Were the controls well laid out and easy to understand?							
10 Were the most suitable materials or substances available for the job?							
11 Were the correct materials being used?							
12 Were the materials as specified?							
13 Were the materials or substances used suitable for the job and person?							
14 Were the materials or substances being properly used?							
15 Was exposure to hazardous materials and by-products adequately controlled?							
16 If the need for personal protective equipment (PPE) had not been identified, was it safe to do the job without PPE?							
17 If necessary, was suitable PPE available?							
18 If necessary, was the correct PPE used?							
19 If the correct PPE was used, was it used correctly?							

3	The process/procedures							
The process/procedures. If the procedures, instructions or information (or the lack of them), contributed to the adverse event, answer the following questions, which will suggest other areas to consider. If not, go to 'People'.		Control	Co-operation	Communication	Competence	Design	Implementation	Risk assessment
1 Were there safe working procedures and instructions for the tasks under consideration?								
2 If there were safe working procedures and instructions, were they up to date?								
3 If there were safe working procedures and instructions, were they realistic, accurate and adequate?								
4 If there were safe working procedures and instructions, did they deal with the circumstances of the adverse event?								
5 If there were safe working procedures and instructions, were the correct ones followed?								
6 If there were safe working procedures and instructions, were they provided or readily available to those carrying out the work? Include contractors.								
7 If there were safe working procedures, were they policed?								
8 Was the level of supervision adequate? Include contractors.								
9 Were the training needs for this activity identified?								
10 If there were safe working procedures and instructions, were they used as part of training?								
11 Were contractors working in accordance with agreed method statements and safe systems of work?								
12 Were contractors informed of the safe working procedures they should adopt?								

4	The people involved							
The people involved. If there was anything about the people involved that contributed to the adverse event, answer the following questions which will suggest other areas to consider		Control	Co-operation	Communication	Competence	Design	Implementation	Risk assessment
1 Were the people involved suited for their job? Physically and emotionally (young people need special consideration)? Competence (skilled, knowledgeable and experienced)?								
2 Was the health of people who could be affected monitored?								
3 Were the people performing their work as expected?								
4 Were workers employed by contractors suitable and competent?								
5 Was the event free of human failings?								
Was it a mistake? If it was a mistake consider:								
Was it a slip or lapse caused by:								
• Fatigue – not enough rest breaks, working excessive hours, already tired? • Lack of motivation or boredom? • Being distracted? • Being preoccupied, e.g. angry, or excited? • Being under too much pressure, i.e. too much or too many things to do? Too little time? • Taking substances, such as alcohol, medicines or drugs?								
If it was a violation, i.e. breaking the rules or taking short cuts, consider:								

Underlying and Root Causes

If your answers to the Place, Plant, Procedures and People sections identified any immediate cause, consider the relevant 'Underlying and Root Causes' section.

ORGANISATION – how we do things and how we make sure they are done correctly.

Control

1 Were the workplace and work activities adequately supervised and monitored in order to ensure that risk control measures were effective and implemented as intended?
2 Did the supervisors have adequate resources to carry out their duties?
3 Were people held accountable for their performance in carrying out their duties with regard to Health and Safety?
4 Were there adequate arrangements for overseeing and controlling contractors?

Co-operation

1 Were trade unions, employees and their representatives involved in determining workplace arrangements, preparing risk assessments and safe working procedures?
2 Did the individuals involved in the incident share information?
3 Were there arrangements for cooperation with, and co-ordination of, contractors?

Communication

1 Were responsibilities and duties clearly set out?
2 Were they clearly understood by those involved?
3 Did everyone involved know who they report to and who reports to them?
4 Was there sufficient, up-to-date information to enable good decisions to be made?
5 Were there adequate arrangements for passing on information at shift changes?
6 Were written instructions, safe working procedures and product information sheets practical and clear?
7 Were the instructions and procedures available to all who needed them?
8 Was communication between workers and supervisors effective?
9 Was the communication between different departments effective?
10 Were there effective communications with contractors?

Competence: Training and suitability

1 Were the people involved assessed as suitable for the work in terms of health and physical ability?
2 Were the health and safety training needs of people identified?
- on recruitment;
- on changing jobs;
- when changes in the work are proposed;
- periodically as part of refresher training?

3 Were the training requirements for particular jobs identified

4Was the training effectively delivered?
- with adequate resources?
- effectively?
- and assessed?
- were training records kept?

5 Was the competence of contractors, employees and agency workers checked?

Planning and Implementation: How we prepare to do things effectively and efficiently

Design

1 Were the workplace and equipment layouts designed considering health and safety?
2 Were the controls, displays etc of plant and equipment designed to reduce the risk of, or prevent, human error? For example mis-reading dials or operating the wrong switch

Implementation

1 Were there arrangements for ensuring that sufficient, and suitable, plant, equipment and materials were available?
2 Were there arrangements for ensuring that sufficient and suitable labour was available?
3 Was there adequate cover for leave or sickness absence?
4 Were suitable contractors appointed?
5 Were there adequate arrangements for cleaning?
6 Were there adequate arrangements for reporting defects in plant and equipment?
7 Were there adequate arrangements for carrying out maintenance work?
8 Were there adequate arrangements for reporting health and safety concerns?
9 Were there adequate arrangements for reporting near-misses and undesired circumstances?
10 Were there adequate arrangements for carrying out health surveillance?
11 Were there adequate arrangements for carrying out air monitoring/sampling? (If required)
12 Did production targets take account of health and safety?
13 Were there adequate arrangements for appointing and controlling contractors?

Risk assessment

Risk assessments involve identifying the hazards, identifying who may be affected and putting in place suitable arrangements to eliminate or reduce the risks to an acceptable level.
1 Were there risk assessments for the work in question?
2 Were they adequate?

- did they correctly identify the risks?
- were they up-to-date and reviewed as necessary?
- were correct technical standards used?
- were adequate risk control measures identified?
- were safe working procedures developed?
- were there clear conclusions and recommendations?

3 Did the risk assessments result in a risk control action plan with SMART (Specific, Measurable, Agreed, Realistic and Timescaled) objectives?
4 Were responsibilities for implementing the risk control action plan set out?
5 Had the risk control action plan been implemented?
6 If there had been similar adverse events in the past, had they been investigated?
7 Were adverse events recorded, investigated and the findings fed back into the risk assessments?
8 Did the risk assessments include the risks from work carried out by contractors?

A 'no' answer to any of the questions in the underlying or root cause section identifies an underlying or root cause.

These underlying or root causes in turn point to failings in the health and safety management system. Senior management should consider all the questions in the following 'Management' section to identify weaknesses in the overall risk control management of the organisation.

Management: How we create the environment and set the standards under which all other health and safety activities take place

- Was there a written health and safety policy statement?
- Did all employees know and understand the health and safety policy statement?
- Were named partners, directors and senior managers made responsible for health and safety arrangements?
- Was there an adequate commitment to health and safety at a senior level?
- Was this commitment reflected in the actions of directors, partners and managers?
- Were sufficient people appointed to assist with health and safety measures?
- Were the people appointed to assist with health and safety measures adequately trained and competent?
- Did the health and safety assistants have sufficient authority to carry out their duties?
- Were the tasks of carrying out risk assessments and preparing safe working practices given to competent persons?
- Was the carrying out of risk assessments a high priority?
- Were adequate resources allocated to health and safety?
- Was it your policy to learn from adverse event investigations and improve your health and safety performance?
- Were the recommendations and findings of the health and safety team acted on?
- Was the work of the health and safety team (including managers, safety officers, safety assistants, supervisors and safety representatives) monitored?
- Were the health and safety team held to account for their performance?

- Were there clear and integrated lines of communication and control?
- Was there a conflict between production and health and safety?
- Was health and safety performance measured and monitored?
- Did you seek to improve your health and safety performance as a result of your dealings with the regulatory authorities and other health and safety