Review into the investigations of the Asbestos Incident

26th June 2019

Date: November 2019
Version: 1.3

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Executive Summary

On 26th June 2019, Housing Caretakers picked up fly tipping on the Grange Farm Estate before eventually depositing it at the Civic Amenity Site. It was only at this point that it was identified by the Civic Amenity Site Staff that the items contained asbestos sheeting as well as plastic bags (which had then split) of needles, syringes and medical jars. As a result the items were cordoned off and management alerted that started a health and safety investigation process.

An internal health and safety investigation took place, led by [redacted], that concluded at the end of July 2019, as well as the initial Code of Conduct investigation conducted by [redacted]. Both these investigations were subject to critical analysis, mainly by the Union, leading to a senior management decision to bring in an independent external investigator. From the period of the end of July to start of November 2019, this investigator produced a total of 10 versions of the investigation report, each one being again critically analysed leading to constant changed.

The review finds that the investigations were subject to such analysis due to originating from a flawed investigation process from the setting of the terms of reference to the understanding of the purpose of such an investigation. The investigation became a reactive process, addressing the criticisms and errors that emerged, and never establishing a path to understand the root cause of the incident. It immediately failed to set a clear path forward, key personnel involved and key partners, and the next 4 months remained on the back foot to try and address early errors and issues. This led to an almost forgetting of the key aspects of such an investigation, being to ensure that such steps as necessary are taken without delay to prevent recurrence and remove risk, and that the root cause that led to the incident in the first place are highlighted to enable an effective action plan to be devised. Instead, this action plan was not finalised until November 2019, 5 months after the event, and the basis of it which should have been the root causes was never established.

The review has gone through each stage of the investigation, from the moment of the incident to the final correspondence of the external investigator, and identified key critical issues that require addressing to prevent recurrence of such mistakes in future health & safety investigation. As a result, clear learning outcomes have been set out, providing a path to a consistent and competent investigation going forward, including

- Setting out a clear H&S investigation process and procedure, including roles of individuals involved especially the commissioning and investigating officers
- Approval of external people to be tighter
- Involving the Trade Unions at an early stage of any such investigation
- Training of managers around identifying risks in a service, carrying out suitable and sufficient risk assessment and resulting documentation.

While there are many errors that are found with hindsight, and some highlighted at the time, the review also recognises that some good practice was seen. Of this, the recognition of the hazardous waste by the Civic Amenity Staff and the efficient and effective control of the risk is highlighted and shows that failures of training and procedures are not endemic across all the waste service, but clearly need to be more consistent going forward.

Review into the investigations of the health & safety incident regarding hazardous waste collection and disposal and subsequent learning outcomes

1 Remit:

[redacted] and [redacted] was commissioned by [redacted], to review both investigations as well as take into account comments and information provided by partners to establish key learning outcomes and define a clear action plan for future serious health & safety incidents due to numerous concerns raised by a number of parties, including the Unions, around the incident investigations.

It must be noted that this review does not look to conduct a further investigation into an incident that occurred 4 months ago, or attempt to rewrite what has been previously stated. It also does not write or set the action plan that specifically addresses the incident issues, which rests with Housing, but does provide information to assist them. The review does look at all issues highlighted throughout the process to allow a clear set of recommendations to go to the Housing Department to be addressed in their action plan.

2 Incident:

26th June 2019 hazardous waste, being asbestos and hypodermic needles, was found on the civic amenity site following the tipping of waste by a Housing Caretaker crew. The area was immediately sealed off and raised with relevant managers. Although there were no injuries occurred as a result of the incident, it did indicate a failure of procedures and an investigation was launched.

3 Methodology

The methodology for this review are in line with what the commissioning officer had stated, being:

1. To capture all the events, correspondence and evidence of what occurred during the investigations in direct relation to the asbestos incident of 26th June 2019
2. To set out all comments and correspondence by Unions, Corporate Health & Safety and Senior Management to understand failures of the investigations that took place and identify key learning outcomes to prevent recurrence of such failings in future health & safety investigations
3. To ensure Housing are provided with all necessary comments made during the incident investigation to enable to put in place a suitable and sufficient action plan to prevent such an incident occurring again.
4. To establish areas of learning from the process to identify key learning opportunities for future investigations
5. To set out a clear action plan from this review to address all identified learning outcomes
6. This review will not look to conduct a further investigation into an incident that occurred 4 months ago, or attempt to rewrite what has been previously stated.

4 Incident Investigation Overview:

- The initial investigation was undertaken by [redacted], a report was produced, from the initial investigation report it was realised that further investigation was needed due to the seriousness of this incident.
- It was agreed by [redacted], that an independent health and safety consultant would be better placed to deal with this asbestos incident, as this would provide impartial advice. [redacted] was asked by the [redacted] to procure a qualified health and safety consultant at Chartered Member Status (CMIOSH) as this demonstrated experience and competence,
- The consultant, [redacted], was procured through [redacted] who are health and safety organisation who provided various health and safety resources to organisations. The appointment was agreed by [redacted] and Terms of Reference were provided
- The Investigation centred on where the waste came from, the understanding of the waste, and its handling to the point where it was identified at the Civic Amenity Site
- Wider investigation looked at the policies and procedures around asbestos and hazardous waste in the Housing Service, as well as the training provided to staff

5 The facts surrounding the investigations

Time line and description

Date	Notes
26/6/19	Asbestos and Needles discovered in Civic Amenity Site following tipping of Rubbish by Housing Caretaking team. Asbestos and needles isolated and put in safe place. Alert raised.
	Key Senior Managers involved later in the investigations ([redacted]) off
28/6/19	Letter from Unison to [redacted] seeking information around the incident
28/6/19	Acknowledgement to Unison letter from [redacted]. Email states plan in place to address isolated incident
2/7/19	Email response from Unison to [redacted], highlighting concerns over lack of proactive approach to such waste
3/7/19	[redacted] email to [redacted], copying in others, stating need to be a code of conduct investigation and that [redacted] will instigate a health & safety investigation at the same time and work with [redacted]
	Email from [redacted] to [redacted], [redacted], [redacted], confirming he has asked [redacted] to carry out the investigation of the incident. [redacted] confirms health & safety template provided by [redacted].
4/7/19	Letter from [redacted] to Unison stating commissioning of the investigation, and role of [redacted]
19/7/19	Unison letter to [redacted] raising concerns over the competence and actions being taken by Council Housing with regards the incident
22/7/19	[redacted] emailed [redacted] and [redacted] stating read the investigation report and had feedback from Union. Stated [redacted] to review report as the commissioning manager
19/7/19	Internal Investigation Report Produced
23/7/19	Email from [redacted] to [redacted] and [redacted], thanking them for the work done and his decision to get an independent investigation carried out and the code of conduct investigation to be put on hold. Confirms [redacted] to commission this independent expert and confirm the timescales.
29/7/19	Independent health and safety consultant commissioned to conduct independent investigation into the incident.
5/8/19	First 2 versions of independent report produced

7/8/19	Asbestos Report produced by independent investigator shared by [redacted] with all parties including [redacted] and Unions. Instruction sent on back of this by [redacted] to [redacted] and [redacted], copying in [redacted] and [redacted].
9/8/19	Unison letter to [redacted] providing view of investigations carried out to date, highlighting concerns
29/8/19	3rd Version of Independent Investigation Report Produced
4/9/19	4th Version of Independent Investigation Report Produced
9/9/19	Unison Letter expressing concerns over report produced
10/9/19	5th Version of Independent Investigation Report Produced
20/9/19	6th Version of Independent Investigation Report Produced
22/9/19	7th Version of Independent Investigation Report Produced
20/9/19	8th Version of Independent Investigation Report Produced
7/10/19	9th Version of Independent Investigation Report Produced
8/10/19	10th Version of Independent Investigation Report Produced
11/10/19	Letter from Unison
18/10/19	Email from [redacted] to Unison in response to letter
25/10/19	Email response from Unison to [redacted] in response to his email
25/10/19	Matter reviewed by [redacted] to seek clarity around the investigations and issues since the initial incident and put in place learning outcomes for future investigations

6 Findings of the review

6.1 Investigation Standard

This review has seen that there was one investigation report produced by [redacted] and 10 draft versions produced by the Independent Health & Safety Investigator. The review has also seen numerous bits of correspondence between numerous parties raising, addressing

and adding to issues around these reports in terms of accuracy, content, style and approach. This includes around the investigations themselves that led to the reports.

While this review can do a deep analysis of each of these, this would only lead to an almost re-run of the investigations themselves to try and address the issues raised. This, in itself, presents risk as it would be an attempt by those not involved in the investigations trying to second guess those that were. Instead, a comprehensive list of issues that were raised between July and October 2019 has been produced in **APPENDIX 1**

The review has taken this list and set them out into 2 main categories:

a. Those that need to be addressed through the Incident Action Plan, directly relating to the investigation of the incident to stop this type of incident occurring again;
b. Those that are addressed through the Review Action Plan, that are linked to learning outcomes and aimed at ensuring future health & safety investigations

For the purposes of this report, the review broke down the investigation standard into the stages of the actual investigation:

1. Commissioning of the Investigation
2. Investigating Officer
    a. Internal Investigating Officer
    b. Independent Investigating Officer
3. Terms of Reference
4. Trade Union Involvement
5. Internal Investigation
6. Code of Conduct Investigation
7. Independent Investigation
8. Action Plan

6.1.1 Commissioning of the Investigation

There appears confusion over who exactly commissioned the investigation. On reviewing the correspondence available to the review, everyone from the Chief Executive, Corporate Director, Head of HR, Housing Director, Head of Housing and Corporate Health & Safety Compliance Manager had, sent or received correspondence about the incident. Additionally, it has been confirmed that the Terms of

Reference for the investigation conducted by both [redacted] were set by [redacted] and those for the independent investigator were drafted by the [redacted] on conversations with [redacted]

The Unison letter of 28th June 2019 was addressed to the [redacted] holding him to account due to the evidence showing housing staff were involved and the origin of the hazardous waste was from a Housing Estate (though not clear which bit). This copied in a number of other individuals, including the [redacted]

This appears to be collaborated by the email from [redacted], on 28th June 2019 to Unison stating "*He [redacted] is the Housing lead and one route of communication with regards to responses to Unison regarding this matter"* It would therefore be assumed that the Commissioning Officer at this point was [redacted]. There does seem to be some confusion taking in place, with an email from the Head of HR to the Director of Housing on the 3rd July 2019 stating [redacted] *will instigate a full Health and Safety investigation at the same time. He has asked* [redacted] *to do this and will give her any support she requires*" But the response from the [redacted] to [redacted] on 3rd July 2019 again indicates that it was the [redacted] who actually commissioned the investigation, stating "*I've asked for the investigation to be carried out in a thorough and timely manner and for* [redacted] *to make recommendations based on her findings which we will share"*

It is noted that the [redacted] did briefly get involved, on the back of the emails from the Union to a number of parties. The [redacted] appear to have sought an end to back and forth correspondence and move the matter on to addressing the actions needed. This can be seen in the email of 4th July 2019 from [redacted] to the Union, copying other parties in, stating "*I believe the emails on this can stop now as the actions are in hand*". This was met with a response from the Union who indicated their concern was over the fact this incident had occurred at all. This is appears to be the only involvement of [redacted], who attempted to find a clear way forward.

Verification of the commissioning was then done in the letter of 4th July 2019 from [redacted] to Unison stating "*investigation that I've commissioned to be conducted by* [redacted]" This also confirms that [redacted] was to support where necessary.

A further Unison letter of 19th July 2019 was addressed to the [redacted], asking him questions about the investigation. It is noted no Council Housing person was copied into this.

The Terms of Reference for the initial investigation by [redacted] also shows the confusion, stating:

TOR 1 The investigating officer [redacted] has been **appointed by** [redacted] to instigate the full health and safety investigation

TOR 2 The investigating officer has also been **appointed by** [redacted] & [redacted]) to investigate the Health and Safety aspects of the incident

It would appear at this stage a decision had been made to change the commissioning officer, as an email from the [redacted] to [redacted] and [redacted]

[redacted] on 22nd July 2019 stated "[redacted] *as commissioning manager please can you review the report and the process followed*" No correspondence was seen at this stage to show [redacted] had been informed. A further email of 23rd July 2019 from the [redacted] to [redacted] and [redacted], copying in the [redacted], [redacted] and [redacted], that "*I have decided that the Council needs the assurance of an independent expert examining this in more detail*", and confirming the code of conduct investigation was on hold and finally "*I have asked* [redacted] *to commission an independent expert and to confirm the timescales for the work*"

On 7th August 2019, an email from the [redacted] to Housing, HR, Chief Executive and Unions provided them with a copy of the independent investigation report. A response back from the [redacted] and [redacted] stated

It is not clear that this was communicated to the Unions at this point in terms of who was commissioning the investigations now, A Unison Letter of 9th August 2019 was then addressed to [redacted] addressing all the investigations to date. This was copied to [redacted] and [redacted] amongst others

A further Unison letter of 9th September 2019 was addressed to [redacted] again addressing the investigations to date. In this case [redacted] and [redacted] were not copied in.

Each of these letters were responded to by the individuals the letters were addressed to, but no clarification of who the actual commissioning officer who would be responsible for overseeing and receiving the investigation reports.

In line with other investigations, for example disciplinary and grievance, the Corporate Procedures and Policies put the emphasis on the line manager of those involved to assess and, if necessary, commission an investigation into the events (unless directly involved themselves). In this case it would appear the relevant person, considering the incident and the impacts around it, would therefore sit in the Housing directorate. This would appear backed up by the Unison letter of 9th September 2019 which stated "[redacted] too was happy with the investigation as it stood", but also then confusion as also stated "[redacted], a service manager in Housing division is on record in writing, as thanking [redacted] for such a thorough investigation"

The emails between [redacted] and [redacted] on 3rd July 2019 indicate that it was [redacted] who actually commissioned the investigation, stating "*I've asked for the investigation to be carried out in a thorough and timely manner and for* [redacted] *to make recommendations based on* [redacted] *findings which we will share"*

It has been confirmed that no terms of reference were set out as part of this commissioning and that the terms of reference set out in the [redacted] report of 19th July 2019 were set by the investigating officer themselves.

But the above does show confusion around who exactly was formally responsible for overseeing the investigation as went from the [redacted] to [redacted] to [redacted] in the space of a month. Due to mistakes made throughout, and further explained in the report, the role of the commissioning officer and the investigating officer also became blurred, with the independent investigating officer being directed about what changes and aspects to make in the report.

Learning Outcome:

Any health & safety incident / investigation procedure must set out clearly the role of the commissioning officer and who this should be. It does not preclude others assisting, but allows one port of call for issues

It is for the commissioning officer to set out clearly the terms of reference for any investigation to ensure that the investigation covers all aspects and the report provides the factual evidence necessary to allow the root causes to be identified and appropriate action plan to be put in place

6.1.2 Investigating Officers

There were investigating officers involved in the process, being [redacted] and [redacted] (Independent Investigating Officer). [redacted] involvement in investigating and producing a report were from the period 3rd July 2019 to 19th July 2019. [redacted] involvement in investigating a producing a number of reports were from the period 29th July 2019 to present.

6.1.2.1 Involvement of [redacted]

The initial investigation was given to [redacted]. While there is logic to the appointment, as [redacted], this did not take into account other factors that were then raised in the Unison letter of 19th July 2019 to [redacted].

This review does not comment on the competence of [redacted] to carry out such an investigation, or her qualifications, and the Union letter makes it clear that this has been looked at elsewhere.

It is accepted principal that any investigation into any aspect must not be involved or compromised by the incident being investigated. The Councils disciplinary procedure even highlights stating (depending on the nature of the allegation) "*it may be appropriate to bring in an external investigating officer with specialist skills and knowledge who brings with them an independent perspective*"

In this incident, a serious breach of health & safety had occurred that potentially put employees and others at risk. Point 2 of the Unison letter dated 19th July 2019 has foundation, in terms of the neutrality of those involved in the investigation. It must be noted this review does not and cannot judge whether any investigation carried out by [redacted] would be anything other than evidence based and accurate (though this is covered later in this review), it was remiss of the organisation to give any cause to question this and an independent person would have been best placed to carry out this investigation.

As stated within the report above, this matter was not helped by the fact that it had been left to [redacted] to determine the terms of reference for their own investigation. Additionally, that the advice of [redacted] in terms of setting out the investigation (Email of 3rd July 2019, providing an investigation template) appears not to have been taken up.

Learning Outcome:

In line with other formal investigation procedures, the investigating officer of any incident shall not be connected to any aspect that potentially led to it happening.

6.1.2.2 Involvement of an Independent Investigator

An email of 23rd July 2019 from [redacted] to [redacted] and [redacted], copying in [redacted], [redacted] and [redacted] stated ""*I have decided that the Council needs the assurance of an independent expert examining this in more detail*" This is in line with the recommendation above, for the reasons given. The email then goes on to say "stated ""*I have asked* [redacted] *to commission an independent expert and to confirm the timescales for the work*"

[redacted] was asked by the [redacted] to procure a qualified health and safety consultant at Chartered Member Status (CMIOSH) as this demonstrated experience and competence,

The consultant, [redacted] was procured through [redacted] who are health and safety organisation who provided various health and safety resources to organisations. The company is one [redacted] has used before to provide technical and expert assistance whilst in his previous role at [redacted] Council, and are an established company.

The appointment was agreed by [redacted] and Terms of Reference were provided by [redacted]. The framework of the investigation, including the Terms of Reference was set out in a document provided to [redacted] on 29th July 2019. It should be noted at no time has the terms of reference been challenged, though these are addressed later in this review.

A copy of [redacted] CV was provided on 1st August 2019 to [redacted]. The review identified from the CV that [redacted] held a number of health & safety qualification, including:

- Chartered Member of IOSH
- Member Institute of Industrial Accident Investigators
- Occupational Safety and Consultants Register

[redacted] CV also showed that he had completed the Lead Investigators qualification. He therefore met the requirements set out in the Terms of Reference document provided on 29th July 2019, where it specified "*Qualifications…CMIOSH*"

The statement from [redacted] also supported the reasons for employment, stating the activity as "*Health and Safety Investigation. Initial report and accident investigation for Harrow Council on August 2019*"

Therefore initial overview of [redacted] indicate he met the requirement of a person suitable for carrying out such an investigation, who had not worked for any party involved previously and was put forward by a company rather than specifically chosen by any Harrow person.

A Unison letter of 9th September 2019 (page 3) states "*The second investigation was conducted by* [redacted] *an independent H&S consultant appointed by* [redacted]*. So we have one consultant appointing another consultant?*" It also raised questions around the following of recruitment process in this matter.

The Harrow Council Agency Worker Policy (found on the Harrow Hub at https://harrowhub.harrow.gov.uk/info/200301/agency_recruitment/1242/agency_workers) stipulates when agency workers are to be used and includes "*To undertake a specific time-limited project where specialist skills, knowledge and experience are required and are not available within the council*"

The use of [redacted] in this case met this requirement in terms of it being a specific time-limited project where specialist skills, knowledge and experience are required. There is debate whether this is available in the Council but it is clear with the confusion over all those involved, the requirement stipulated around an "*independent expert*" ([redacted] email of 23rd July) the use of such a person outside of the Council can be seen as justified.

The matter of a consultant employing a consultant is noted, but it was not a decision made by the Harrow consultant (being [redacted]) to employ another consultant but to just source one. While the Union raises the matter of 9th September 2019, the review shows that the individual employed to conduct the investigation is one that was not known previously by [redacted] or Harrow Council, and therefore the element of independence was in place.

Therefore the review finds that the use of an independent investigator was, in principal, a sensible option to take to try and establish the facts around the incident and put forward clear recommendations to prevent recurrence. The use of a suitable company who specialise in health and safety is understood, putting the emphasis on them to provide a person that is fit for purpose to carry out the task set.

The review did find though that there was a potential issue that may have led to some of the issues raised during the investigation, including the way the investigation was conducted and the recommendations from it by the independent person.

A review of the CV of the independent investigator indicated tha[redacted] was more of an auditor than an investigator, with his work history centring on management and auditing in health and safety. While this may appear pedantics, the two are different in approaches to incidents.

An accident investigation is defined as "*An **investigation** is conducted to identify the root cause of an **accident** in an effort to make recommendations or take corrective actions to prevent the future occurrence of the same or a similar event*." A health & safety audit is defined as "*an expert assessment of an organisation's health and safety policies, systems and procedures*"

While the standard of investigation and resulting reports is covered below in more details, this aspect is worth raising. An auditor will carry out an investigation with a system review based approach to determine if the systems put in place will achieve the outcome desired. This will focus more on policies, procedures, systems etc. and less on the specifics of an incident. This will produce a different way of investigating and the subsequent report from it. It is therefore important that when choosing a person to carry out a specific role that their qualifications and experience match what is needed.

Learning Outcome:

In line with other formal investigation procedures, the investigating officer of any incident shall not be connected to any aspect that potentially led to it happening.

Any person brought in to carry out a specific project requiring specialist expert skills undertake an interview process to ensure that their CV / Qualifications are backed up by their experience to carry out the specific role being tasked

6.1.3 Terms of Reference

HSG 245 Guidance around accident investigations states "*An effective investigation requires a methodical, structured approach to information gathering, collation and analysis. The findings of the investigation will form the basis of an action plan to prevent the accident or incident from happening again and for improving your overall management of risk. Your findings will also point to areas of your risk assessments that need to be reviewed*."

The terms of reference are the means to ensure the framework is in place to conduct such an investigation. These set out what the investigation sets out to achieve. HSG 245 sets out the key aim as "*…to establish not only how the adverse event happened, but more importantly, what allowed it to happen*." What this means is establishing the cause which the guidance sets out as:

These causes can be classified as:

- ***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 (eg failure to identify training needs and assess competence, low priority given to risk assessment etc).*

The root causes of adverse events are almost inevitably management, organisational or planning failures, and is the purpose of a health & safety investigation to then allow an "*action plan to prevent the accident or incident from happening again and for improving your overall management of risk.*"

Any Terms of Reference therefore needs to stem from this aim, setting out clearly the stages of the investigation that ultimately will lead to the identification of the root cause. Unfortunately neither sets of terms of reference (Internal Investigation or Independent Investigation) did this, and almost relied on the person carrying out the investigation to understand what was required.

The Terms of Reference set out in the internal report were actually set by the investigator themselves, and were:

TOR 1 The investigating officer [redacted] has been appointed by [redacted] to instigate the full health and safety investigation

TOR 2 The investigating officer has also been appointed by [redacted] & [redacted] to investigate the Health and Safety aspects of the incident

This actually gives no framework with regards what the investigation is trying to achieve, the outcome required, or any guidance from the commissioning officer.

The Terms of Reference set out in the independent report were accompanied by an explanatory document, but still only gave details of the areas to look at in terms of the collection and transportation of hazardous waste, being:

- Terms of Reference 1: The handling of suspected hazardous material on the site of origin

- Terms of Reference 2: Transportation of suspected hazardous material including means of transportation
- Terms of Reference 3: The handling and disposal of the hazardous material at the depot
- Terms of Reference 4: The local management of the activities relating to the incident and the interdependencies involved
- Terms of Reference 5: Asbestos training, H&S Training, organisational policies and procedures, and any other relating documentation . materials, to include risk assessments, method statements and other relevant documentation and records

These were set by [redacted], and did provide a framework but again assumed that the person taking these forward would understand the principles of a health & safety investigation as set out in HSG245.

Further details around this are found in the relevant investigation sections below.

Learning Outcome:

That the terms of reference for any health and safety investigation are directly linked to understanding how the adverse event happened and what allowed it to happen (underlying and root causes)

6.1.4 Trade Union Involvement in the Investigation

There was a failing in both investigations that the trade unions were not consulted with, or invited to be involved in the investigation. This should have occurred at the time of commissioning.

Section 2(6) of Health and Safety at Work etc Act 1974 states:

"*It shall be the duty of every employer to consult any such representatives with a view to the making and maintenance of arrangements which will enable him and his employees to co-operate effectively in promoting and developing measures to ensure the health and safety at work of the employees, and in checking the effectiveness of such measures*."

Section 4(1)(a) of the Safety Representatives and Safety Committees Regulations 1977 states:

"*to investigate potential hazards and dangerous occurrences at the workplace (whether or not they are drawn to his attention by employees he represents) and to examine the causes of accidents at the workplace*"

Section 6(1) of the same Regulations state:

"Where there has been a notifiable accident or dangerous occurrence in a workplace or a notifiable disease has been contracted there and—

(a)it is safe for an inspection to be carried out; and

(b)the interests of employees in the group or groups which safety representatives are appointed to represent might be involved.

those safety representatives may carry out an inspection of the part of the workplace concerned and so far as is necessary for the purpose of determining the cause they may inspect any other part of the workplace; where it is reasonably practicable to do so they shall notify the employer or his representative of their intention to carry out the inspection."

In addition to the above, the Health and Safety Executive (HSE) have produced guidance HSG245 "Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals". This guidance states "*For an investigation to be worthwhile, it is essential that the management and the workforce are fully involved. Depending on the level of the investigation …supervisors, line managers, health & safety professionals, union safety representatives, employee representatives and senior management / directors may be involved*"

This guidance also states "*As well as being a legal duty, it has been found that where there is full cooperation and consultation with union representatives and employees, the number of accidents is half that of workplaces where there is no such employee involvement."*

It's worth noting that both the internal and independent investigations requested information from trade unions, but neither sought a joint investigation. Unisons letter of 19th July 2019 (page 2, final paragraph) stated that Unison had even been told "*The time for Unison to Challenge the investigation is when the investigation has been completed*". The review has found that these words were actually those stated by [redacted] in an email of 19th July 2019 to [redacted] and Head of Human Resources, where he stated:

"*Without any other evidence, there are no grounds for any further action on this email from Unison. The time for Unison to challenge the investigation is when the investigation has been completed. Unless there are specific requirements for a H&S investigation that I am not aware of the process is clear, an investigator has been identified and the investigation is being completed, There is no trade union involvement as this is a management activity. The unions will be made aware of the outcome of the investigation but that is it.*"

Unfortunately this advice, based on the reasons set out above in this review, was incorrect as there are clear requirements. It was also noted that this advice was provided on the back of the Unions raising concerns over the investigation and procedures. As a result of this advice, the involvement of the Unions was restricted leading to future issues and involvement during the course of the investigations. This was immediately seen with the Unions response in writing with their letter of 19th July 2019

Learning Outcome:

Any investigation process around health & safety must include initial contact with the Unions to allow the opportunity for joint working to meet legal requirements as well as a partnership approach

That any external person involved in advising an investigation must provide accurate and evidenced information to allow the investigation to meet all statutory and policy requirements

6.1.5 Internal Investigation

The review recognised that two investigations took place, being the initial one conducted [redacted] and the later ones being conducted by an independent investigator.

The initial investigation established that incident occurred on 26th June 2019, and the internal investigation report was presented to all parties (except the Unions) on 19th July 2019, 23 days afterwards. A copy of the report is provided in **APPENDIX 2**

6.1.5.1 Terms of Reference

While details around terms of reference have been stipulated above, it is worth reiterating here as they fundamentally affected the manner of the investigation and the resulting report. The Terms of Reference set out in the report were:

- TOR 1 The investigating officer [redacted] has been appointed [redacted] to instigate the full health and safety investigation
- TOR 2 The investigating officer has also been appointed by [redacted] & [redacted] to investigate the Health and Safety aspects of the incident

These terms of reference were set by the investigating officer and did not clearly set out the outcome to be achieved, the areas being looked at, or provide a clear framework around the investigation. HSG 245 sets out the key aim as "*…to establish not only how the adverse event happened, but more importantly, what allowed it to happen*." None of these Terms of Reference aim at this. This was recognised by the [redacted] in an email of 22nd July 2019 stating "*I thought the terms of reference needed to be more precise and specific*". This naturally led on to his second comment being "*the actual findings need to be more detailed and importantly factual covering the incident from start to finish*".

The Union, in their letter of 9th August 2019, stated "*No monitoring of the inadequately qualified investigators performance at all during the process to see if* [redacted] *was on the right track*" Again, this review reiterates that the matter of qualification and competence is not one that has been asked to be reviewed, and has been subject to a separate discussion between all relevant parties. But the review takes this statement as important, as it recognises that the investigation had issues as it was not clearly set out what it was intended to achieve, therefore the "*right track*" at the start.

It also did not set out the extent of the hazard, and therefore the risk, with the report focusing on the asbestos and not taking into account the other hazardous waste in place.

6.1.5.2 Establishing the Hazard

It is worth noting at the point the investigation had been concluded that it had not even been established if the sheets in question were asbestos, as a sample was only sent to a laboratory for testing on 30th July 2019 (see Asbestos Identification Report) and therefore the investigation report and subsequent code of conduct investigation (conducted by [redacted]) were based on a belief not a fact, including the statement of [redacted] on 22nd July 2019 in an email stating "*There is no evidence that the suspected asbestos is in fact asbestos as no sample testing took place to confirm this*" means any conclusion about potential hazard and effect is limited at this point. There appears no reason why there was a month delay in establishing a key fact of the incident. It is noted that the report does indicate the conclusion that the default position of the investigation was that the product contained asbestos until such time shown otherwise.

The investigation report stated "*The hazardous material included the suspected asbestos cement sheet, hypodermic syringes with needles and some small medically labelled jars*". The investigation report itself concentrates on the asbestos solely, not the other hazards. This may be due to the other hazards not being obvious at the time of the items being collected, but they should still form an important aspect as the risk was actually higher from not knowing they were there to allow proper handling. For an investigation report to be of true benefit, all facts must be considered to allow conclusions to be drawn and recommendations provided to implement corrective actions

In this case, the investigation would have been expected to look at the collection of waste in general to take into account that waste may contain hazardous material – the same default position taken with the asbestos – and therefore any procedures and policies based on protecting such a risk.

6.1.5.3 Location of the Incident

[redacted] raised issues in a follow up email of 22nd July 2019 including "*First the incident is not at Harrow depot, its Grange Farm Estate".*

There is also no confirmation where exactly the asbestos (and other hazardous waste) actually came from. The investigation report states "*Grange Farm Estate*" (page 3 and page 4) but no precise details. The statement of [redacted] stated "It was picked up from Grange Farm Close". This in itself is a vague description, as the close is quite long with quite a few residential premises fronting on to it, with the only other description being "*The sheet was leaning against the fence*". Further clarification was then made in the statement of [redacted], stating "*The location described was on the Grange Farm Estate, opposite block 55-67, near the parking*".

There is no indication that any party visited the site as part of the investigation, but would have been good practice at the start of the investigation as soon as hazardous waste was identified to ensure no further waste of this type was still in place, or it could be established where it came from. This again comes back to the comment made above by Unison in their letter of 9th August 2019.

This is quite a substantive hazard, and would be expected to be something that the precise location would be established to try and find the origin of such items to prevent recurrence. It also forms part of the "..*how the adverse event happened*" element of HSG245 as the collection was not the start of the story around these products, but actually where they came from.

There seems little emphasis put on this in the report. While appearing minor, as the investigation concentrates on the "what went wrong" and clarifying if anyone was at fault, it misses out a fundamental element of any investigation being how did asbestos and other hazardous material came to be in this area in the first place. The Unison letter of 9th August 2019 picked this up stating "*No immediate follow up to the site of the incident to ensure that all waste had been removed and to determine if there were any contributory factors or evidence as to how the asbestos got there in the first place*".

6.1.5.4 The Investigation

The investigation did follow a logical process in terms of asking the relevant persons involved in picking up the waste and disposing of it. This is recognised in their statements. But the initial page of the investigation report immediately showed an area of concern stating "*Where sufficient proof of evidence has not been obtained due to short H&S investigation time, the more detailed records should be obtained via the Management incident investigation*".

This immediately sets out that the investigation is incomplete, and raises concern over the extent of the investigation and any conclusions drawn from it. It also does not assist stating "*Issuing the report has been delayed due to circulation of the supporting evidence being delayed and / or non-supplied*". This raises the question that if something is to be used as evidence, then it must be viewed to ensure it is collaborated.

The review does not intend to relive the investigation, but look at it in terms of learning outcomes. To this extent, this review examines the principles of the HSE HSG245 and applies them to the investigation to show potential learning outcomes. It also takes into account general principles of investigation reporting, including the basic facts that must be set out including:

- When and where did the accident / incident happen
- Who was involved
- Injuries sustained
- How did it happen
- What was the sequence of events
- What was the cause
- What are the recommendations

The first principle of HSG245 in carrying out an investigation is that "***In general adverse events should be investigated and analysed as soon as possible*".** It has not been possible to establish beyond doubt when the investigation actually started, but [redacted] letter to the Union confirming appointment of an investigator was on 4th July 2019 (less than a week after the incident) and the first person interviewed was on the 5th July 2019. Therefore minimal delay took place from the incident to the investigation starting. But it does raise concerns that this left the "scene" of the incident unchecked for nearly a week, and therefore any evidence from this would likely have been lost.

6.1.5.5 When and where the incident happened

There is evidence in the statements about the precise location of the incident, being opposite block 55-67 on Grange Farm Estate. But this is not conveyed into the body of the report, and the report actually attributes the incident location to Harrow Depot. The report stated the rubbish was picked up at 11am, but it is not clear where this time came from, especially as the report then contradicts itself on page 4 stating "…*believed to be on site between 9:00 to 10:00 hours*". [redacted] statement stated, when asked how long he had spent at Grange Farm, "*About 1 hour, approximately between 9-10am*". [redacted] statement supports the length of time, but not the precise time. The Objective set out at the top of each of the statements provided as part of the report stated "*to investigate the asbestos related accidents that took place on Wednesday the 26th June 2019 at Depot, CA site between 10:30 and 11:00 AM*". This adds to the confusion as it is not clear where this timeline came from, and should have referred to Grange Farm for this time period. Therefore there are doubts the incident did happen at 11am.

6.1.5.6 Who was involved

The report covers this by interviewing those involved, being the two caretakers [redacted] and [redacted]. It also mentions [redacted], who was involved from the CA site. But the report did not set out clearly the people involved, who they were, and their part in the investigation. This was only established by reading the statements and by the review having knowledge of their positions. This would have been better laid out so the report was clear.

6.1.5.7 Injuries sustained

There is confusion around this as the first page set out "*No injuries reported and / or recorded via email / but injuries noted on the SHE assure Report form. Unclear what injuries have been received, if any. No additional information provided*". The incident record report provided to the investigation on 11th October states "*Injury Details Yes……Was any treatment given Yes*". This does cause confusion but it would have been expected that the investigation would have sought to clarify. The investigation report states on page 3 "*Incident logged on SHE assure: Yes. By* [redacted] *on 26/06/2019*" and page 1 states next to persons to be interviewed "[redacted] *– 9th July 2019*". This would appear to give the opportunity for clarification but no copy of any statement from [redacted] was found. Therefore injuries sustained was never clarified.

It should also be noted that one of the items of hazardous waste was later identified as asbestos, though recognised that the investigation assumed this fact despite no analysis taking place until after the investigation. The risk of asbestos is through inhalation, as well as potential contamination of clothing, that can lead to health issues at a later date. This was not recognised directly, though throughout the investigation report mention is made of limited risk, though wording such as "*unlikely that the concentration release of suspected asbestos fibre would exceed the clearance indicator….*" was stated without any tests of the actual material itself.

6.1.5.8 How did it happen

This element sets out the background of the actual incident, which in part is covered in page 3 of the investigation report under the summary of incident. It provides a brief summary of the event and transportation and discovery to the depot. HSG245 sets out guidance around this aspect of the investigation, stating "*Discovering what happened can involve quite a bit of detective work. Be precise and establish the facts as best you can*." The investigation does breakdown the stages of the event into four categories (page 4 of investigation report) and goes through the details, but would have been useful to have in one area to cover the collection to discovery aspects.

6.1.5.9 What was the sequence of events

A lot of this is covered in "how did it happen", but again would have been best laid out in a timeline to aid in understanding events and also allow for clarity of facts (e.g. around the times the waste was collected)

6.1.5.10 What was the cause

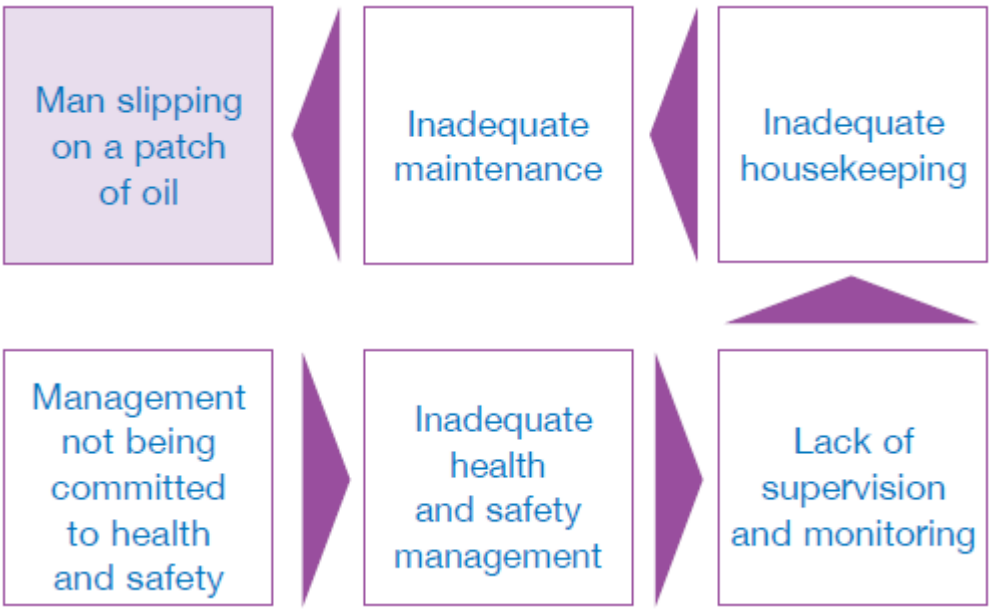
This is a fundamental aspect, and links directly to HSG245 key aim as "*…to establish not only how the adverse event happened, but more importantly, what allowed it to happen*." This is related to the immediate, underlying and root causes that any investigation aims to establish to allow proper recommendation to stop the event occurring again. Unfortunately this is lacking in the report, instead there are general observations including:

- "*there was non-compliance with ACOP 143 and non-conformity with the evidential documents especially with the Housing Standard Operating Procedure…..*"
- *(transportation) "No evidence was provided and / or might not be available for this section"*
- *"The caretakers confirmed that they had completed an asbestos awareness training in 2018)*

Fundamentally the concluding finding on page 9 stated "*Sufficient evidence has not been provided. Further investigation is required to ascertain whether deficiencies are related to processes, management, and/or other breaches of combination of all*". This is an admission that the investigation did not achieve the core aim needed of identifying the cause. HSG245 clearly states "*it is only be identifying all causes, and the root causes in particular, that you can learn from past failures and prevent future repetition*". This investigation did neither.

While reasons are stated in the report, based around lack of evidence and the timescale imposed, neither seem valid. All parties involved were available to be interviewed and, in the majority, were. CCTV was available for the CA site. And all paperwork relating to the incident in terms of policies and procedures sat within the Housing Department, where the investigator themselves sat. This was clear in the Appendices set out in the report.

HSG245 clearly sets out how causation is established from an incident to the root cause, with the example below.



Unfortunately the internal investigation conducted only established the initial stages of the causation route, in that hazardous waste was collected and certain key policies and procedures were not followed, despite demonstration of training being shown.

This is a key criticism highlighted a number of times by the Union, including their letter of 9th August 2019, stating "*No root cause evident from the report*". Unfortunately, as set out under [redacted] section (Section 2a), it has led to a concern that the failure to establish or even address the route cause was linked to the fact there was a vested interest in the service area, and in particular the health & safety advice and guidance, of the person conducting the investigation. The Union in the same letter mentioned "*no mention that the investigating officer* [redacted] *is response for the compliance advice*". This insinuates the potential for conflict of interest, though there is no evidence to demonstrate the *mens rea* being insinuated.

6.1.5.11 What are the recommendations

It is worth remembering that the HSE guidance is very clear in terms of what should come from a health & safety investigation, being an "*action plan to prevent the accident or incident from happening again and for improving your overall management of risk.*" But this is built upon the investigation establishing causation, which it has been established this investigation did not.

The investigation report did set out recommendations, being 5 in total, but these were based on the underlying and immediate causes in part. Such aspects as Rec (1)a and Rec (1)b around training builds upon the training that the investigation established the caretakers had undergone in 2018. While it was a sensible approach, the investigation had not established why the training had not been successful previously, especially as it showed that the caretakers involved in the incident had undergone it. This may well be in part due to not obtaining a copy of the specific training that had been conducted, or it could even be due to the length of time from initial training to the incident (c18months) without any indication of refresher training. Without establishing this, it would not be guaranteed that the training recommended, which again appears to be a "one off", would show any more success in preventing a recurrence of this incident. Rec (3) aims to address this but again lacks detail about what this entails, what is meant by regular, and what is meant by "*all their employees liable to be exposed to asbestos*" as this could technically be any Housing Officer.

The recommendations do mention Housing documentation "*to be aligned with the waste CA site operational documentation",* yet the only CA site document that seemed to accompany the report was around general site use. Therefore the review cannot conclude what documentation is referred to. The only other reference to documentation is in Rec (2) about "*frequency and distribution*" of relevant documents to operational staff. Yet the investigation report, while mentioning standard operating procedures (e.g. Page 5), no reference is made to whether they were found to be suitable and sufficient. It is noted that SOP was dated 2010, the needles policy 2015 and the other two documents were general corporate documents rather than specific housing operational documents.

While on the face of them, the recommendations seem sensible, they are in themselves limited in effect as they stand alone from any conclusion over causation. The HSE guidance clearly sets out that "*The root causes of adverse events are almost inevitably management, organisational or planning failures*". None of these had been identified, but a failure of any of these undermines any documentation or training as it cannot be guaranteed they will be embedded or followed.

6.1.5.12 Conclusion

Ultimately any investigation must link back to HSG 245 Guidance in that "*An effective investigation requires a methodical, structured approach to information gathering, collation and analysis. The findings of the investigation will form the basis of an action plan to prevent the accident or incident from happening again and for improving your overall management of risk. Your findings will also point to areas of your risk assessments that need to be reviewed*."

The internal investigation conducted unfortunately did not follow this approach. The review noted that an investigation template was provided by [redacted] on 3rd July 2019 to [redacted]. It is also noted that [redacted] confirmed to [redacted] in an email on 3rd July 2019 that "[redacted] *Workplace Accident / Incident Investigation template is helpful and I will ask her to use it*", and further confirmed in a letter to Unison on 3rd July 2019 stating "*….providing* [redacted] *with a suitable template to use for the investigation*". It is unfortunate that this template was then not used, as it does a step guide to meeting that which is set out in HSE Guidance, including causation, and would have resulted in the necessary investigation taking place.

The overall investigation and resulting report seems to be incomplete, lacking evidence, setting out basic conclusions and is inconsistent in approach and accuracy. It states failures in following certain documents without evidencing how, and references them without drawing any conclusion whether they were suitable and sufficient. It is also noted that the investigation did not mention any risk assessment(s), whether because none existed or looked at it is not possible to determine. It would appear from the report that potential statutory breaches occurred, but these are not clear, and gives no indication of council breaches in terms of policies or procedures. It also was noted that the age of the Housing Documents referenced indicate potential concern around whether they have been updated or are even relevant to the processes years after they were produced. It must be noted that these are areas of concern that the Housing Action plan as a result of the incident need to address and provide reassurance.

The Union concluded in their letter of 9th August 2019 that this internal investigation was "*totally flawed from start to finish*". It is, unfortunately, not hard to disagree based on the evidence presented. While the review does make any conclusion about the competence of the investigator in terms of knowledge of the legislation, it does find deficiencies that suggest that they are either inexperience in, or lacking knowledge of, carrying out a health and safety investigation of this nature and the fundamentals behind it.

Learning Outcome:

The Council would benefit from having a clear health & safety investigation procedure / policy that take on board the process set out in HSG245

That managers within the organisation would benefit from having investigation training to understand how to carry out an investigation. This would probably provide universal benefit in conducting any investigation

It is for the commissioning officer to set out clearly the terms of reference for any investigation to ensure that the investigation covers all aspects and the report provides the factual evidence necessary to allow the root causes to be identified and appropriate action plan to be put in place

That standard templates related to health & safety investigations are put in place, as is the case with any other council investigation (e.g. disciplinary or grievance) to ensure consistency of approach and that key aspects are therefore addressed. This would include an investigation report template

6.1.6 Code of Conduct Investigation

It is noted that in the report reference is made to an additional investigation being conducted around the code of conduct, led by [redacted]. This is further emphasised in an email from [redacted] on 22nd July 2019 to [redacted], [redacted] and [redacted] stating "*The report also needs to be read with the result of the management / conduct code investigation which [redacted] will circulate today*"

6.1.6.1 Commissioning

An email from the [redacted] to [redacted] on 3rd July 2019 set out two actions being "*There needs to be a conduct code investigation into what has taken place*" and "[redacted] *will instigate a full Health & Safety investigation at the same time. He has asked [redacted] to do this*". [redacted] confirmed to [redacted] in an email on 3rd July 2019 "*FYI [redacted] has been asked to look at whether there has been any conduct breach by any individual as part of her investigation*". It would therefore appear that [redacted] commissioned initially one overarching investigation to be conducted by [redacted], before [redacted] replied stating "*We do need the two investigations*". This was acknowledged on 3rd July 2019 by [redacted] stating "*I fully understand the need for both. The advice we have received from [redacted] is that the two shouldn't be done in parallel and that one needs to follow the other*". It is noted that this does not necessarily seem to have followed as the code of conduct report relies mainly on the health & safety investigation report, being produced on the Thursday and the code of conduct on the following Monday. This raises doubts about their timings.

The review does not have sight of anything stating when the [redacted] was asked to conduct the code of conduct review. As a result, there is no direct evidence of what the code of conduct was initiated to look at, whether it was directly the two operatives involved or any person involved in the incident. It is noted that in the email of 22nd July 2019 from [redacted] that the Code of Conduct investigation was done under Section 5 being:

> ***5. HEALTH AND SAFETY***
> *The Council accepts and will meet its statutory obligations by making every reasonable effort to provide a safe and healthy working environment and to ensure that all reasonable steps are taken to protect the health and safety of its service users.*
>
> *All employees are expected to know and to follow all appropriate health and safety requirements. It is the responsibility of managers to arrange appropriate training*.

It is noted that [redacted] first involvement in the incident appears to be on 28th June 2019 when they acknowledged Unisons letter of the same date. Of interest is the sentence in this acknowledgement stating "*There is a plan in place as to how this isolated matter is being addressed by Housing. The plan includes collaboration with Waste Management colleagues*". The review can only conclude that discussions had happened between 14:45 when Housing received the incident report (as confirmed in the Investigation Report) and 16:15 when the acknowledgement to Unison was sent. This appears confirmed from the email from [redacted] to [redacted] on 3rd July 2019, copying in Senior Managers and HR Officers, stating "*As requested last Friday, can you investigate the incident as a priority*". Unfortunately this review does not have sight of any records from any discussions, or who was involved in them, only to assume all those within the email chain were party to them and thus copied in. The review also notes that the incident was being treated as an isolated incident prior to any investigation taking place, which then became the theme throughout all the investigations.

On 12th July 2019, concerns were raised about the Code of Conduct Investigator and the Health & Safety Investigator meeting with [redacted] (email 12th July 2019 to [redacted])

6.1.6.2 Code of Conduct Report

This code of conduct investigation was sent on 22nd July 2019 at 16:27 to all those mentioned as well as [redacted]. Unfortunately this adds nothing more to the investigation report, and instead just highlights the gaps further. This is not surprising as seems to have been reliant on the health and safety investigation report, with the above email stating "*The investigation report…..has provided substantial evidence to make a decision regarding any breach of the Code of Conduct*"

It recognises that at this stage, nearly a month after the incident, they are no nearer knowing if it was asbestos, stating "*There is no evidence that the suspected asbestos is in fact asbestos as no sample testing took place to confirm this*". The fact it then goes on to state any exposure is minimal is irrelevant, as

Unfortunately the code of conduct investigation is limited in approach, purely looking at [redacted] to understand if they were in breach of the code of conduct for Harrow Council. This in part seems contrary to the instructions given on 3rd July 2019, when the investigation was to look at any individual.

In line with the above, the code of conduct investigation appears to set out to emphasis the aspect that this was an isolated case, mentioning it three times in the one page email summary of 22nd July 2019. It does recognise there are gaps, being:

- No evidence that Site User Guide been circulated to all staff using the (CA) site
- No copies of training to understand content
- No evidence to suggest when the SOP was last issued
- No end to end process between collecting waste and tipping at the CA site

The conclusion indicated "*it is clear that procedures, processes and training have to be addressed together with lessons learnt from this incident*", and this was to be achieved through "*Housing and waste meet with their respective staff, review procedures and processes in order to prevent a repeat of such an incident*".

It is of concern to the review that a SOP was written in 2010, but no evidence of when this was actually circulated to [redacted] or even if [redacted] had even seen it. In fact the code of conduct review appears to highlight serious concerns over the lack of evidence to show suitable and sufficient steps were taken to ensure staff are aware of what is expected of them.

It also notes that no risk assessment was again mentioned or highlighted, but instead emphasis put on a nearly decade old standard operating procedure.

No further action or movement was made on the Code of Conduct investigation , because on 23rd July 2019 [redacted] wrote to [redacted] and [redacted], copying in a number of people, stating "*I propose to place on hold the conduct investigation that was undertaken until the independent investigation has been completed*." This made sense as the underlying cause of the incident was not realised at this point and could fundamentally affect the code of conduct investigation.

6.1.6.3 Code of Conduct Section 5

Referring to Section 5 of the code of conduct, it clearly states "*All employees are expected to know and to follow all appropriate health and safety requirements. It is the responsibility of managers to arrange appropriate training*." As will be seen in this review, there are highlighted issues that emerge from the independent investigation as well as the review that the health & safety requirements were outdated (note above in terms of date and apparent lack of review) and that appropriate training was not conducted (note training did take place but seems a one off with no refresher, and no evidence to show training around hazardous waste in general and COSHH). Therefore a later code of conduct investigation may want to explore this, but would need to be independent as evidence may show that [redacted] may be involved in what is being looked at

Learning Outcome:

That code of conduct investigations in such incidents should also explore all elements under Section 5, including management

That in such cases, the code of conduct investigation must be independent of those being investigated

That in such cases, the code of conduct investigation must take place after the health & safety investigation has been completed and root cause and underlying causes recognised.

6.1.7 Independent Investigation

The review then looked at the independent investigation that was commissioned after 19th July 2019, with [redacted] informed of this on 23rd July 2019 by email from [redacted]. This also paused the code of conduct investigation.

The independent investigator received a copy of the Terms of Reference from the [redacted] on 29th July 2019. Two days later, on the 31st July 2019, the sample result also came back confirmed asbestos, and was passed to [redacted], the independent investigator. By the 7th August 2019, the first copy of [redacted] report was produced and circulated to Senior Management and the Unions by [redacted]. This showed that a total of 9 days had passed from moment [redacted] had been told the basis of the investigation to the first report. A copy of all the reports provided by the independent investigator is provided in **APPENDIX 3**

A breakdown of each stage is presented below, as between August 2019 and October 2019 a total of 10 versions of this report were produced.

6.1.7.1 Terms of Reference

While details around terms of reference have been stipulated above, it is worth reiterating here as they fundamentally affected the manner of the investigation and the resulting report. The Terms of Reference set out in the report were:

- Terms of Reference 1: The handling of suspected hazardous material on the site of origin
- Terms of Reference 2: Transportation of suspected hazardous material including means of transportation
- Terms of Reference 3: The handling and disposal of the hazardous material at the depot
- Terms of Reference 4: The local management of the activities relating to the incident and the interdependencies involved
- Terms of Reference 5: Asbestos training, H&S Training, organisational policies and procedures, and any other relating documentation . materials, to include risk assessments, method statements and other relevant documentation and records

There terms of reference were more detailed and reflective of the incident then previous ones, but were based on the stages set out in the Internal investigation Report with only the addition of Terms of Reference 4 and a slight expansion to Terms of Reference 5 (though it should be noted risk assessments were mentioned for the first time)

The Terms of Reference define the purpose of the investigation but these ones presented set the areas to be looked at. Again HSG 245 is referred to around this, with the investigation being"*…to establish not only how the adverse event happened, but more importantly, what allowed it to happen*." None of these Terms of Reference aim at this. Terms of Reference should include the 3 "Rs" being Reason (why the investigation being carried out), Remit (who and how the investigation is to be carried out) and Report (what is expected from the investigation).

In this case, the Terms of Reference set out the areas to be explored as part of the investigation, but not the why, how and who aspects. The review concludes that these again did not set the framework necessary to direct the investigation. In simple terms, the sentence above from HSG 245 ("*…to establish not only how the adverse event happened, but more importantly, what allowed it to happen*.") is recommended to be included at the start of any terms of reference, of which the terms of reference then define how this is to be done.

6.1.7.2 Establishing the Hazard

This remains the same as per the internal investigation, which showed "*The hazardous material included the suspected asbestos cement sheet, hypodermic syringes with needles and some small medically labelled jars*".

The investigation report itself concentrates on the asbestos, with the syringes and medical jars mentioned only in passing. Again, as with the internal investigation, this may be due to the other hazards not being obvious at the time of the items being collected, but they should still form an important aspect as the risk was actually higher from not knowing they were there to allow proper handling. This would have then identified necessary SOPs, Risk Assessments and training to be looked at. For instance, by looking at the asbestos as the main waste, training around hazardous waste in general was missed. For example, no training records around COSHH, PPE or needlestick injuries was mentioned or appear asked for in either of the two investigations.

As with the internal investigation, the investigation would have been expected to look at the collection of waste in general to take into account that waste may contain hazardous material – the same default

position taken with the asbestos – and therefore any procedures and policies based on protecting such a risk.

6.1.7.3 Location of the Incident

The Union letter of 9th August 2019 set out "*The incident occurred at Grange Farm (the actual site of the incident stated by the operatives, everything else flows from this*)". The statements from the operatives that formed part of the internal investigation confirmed this. The statement of [redacted], stated "It was picked up from Grange Farm Close". This in itself is a vague description, as the close is quite long with quite a few residential premises fronting on to it, with the only other description being "*The sheet was leaning against the fence*". Further clarification was then made in the statement of [redacted], stating "*The location described was on the Grange Farm Estate, opposite block 55-67, near the parking*".

Version 1 of the independent investigation is headed "Grange Farm Estate" and mentions "*I have been able to speak with both [redacted] and [redacted] regarding their recollection……"* and *"….sought clarification of points raised in the original interviews…"* None of these aspects change in any of the 10 versions of the investigation.

It is unclear to the investigation why therefore the location suddenly changed in the body of the report in version 3 produced on 29th August 2019 when a sentence was added "*The material in question was collected from a garage area of Shaftsbury Circle in South Harrow on…."* . This sentence remained in all future versions, but the review could not identify why this was added when the facts did not change and had been established since the interviews from the operatives in July 2019. It is quite surprising this fact was not picked up at the time or future versions, especially considering the Union comment above on 9th August 2019.

Again, as with the internal investigation, there is no indication that the investigator visited the site as part of the investigation, but would have been good practice.

This is quite a substantive hazard, and would be expected to be something that the precise location would be established to try and find the origin of such items to prevent recurrence, so a statement of fact at a later date that still did not do this in Versions 3 to 10 is of concern. It also forms part of the "..*how the adverse event happened*" element of HSG245 as the collection was not the start of the story around these products, but actually where they came from.

There seems little emphasis or accuracy put on this in the report. While appearing minor, as the investigation concentrates on the "what went wrong" and clarifying if anyone was at fault, it misses out a fundamental element of any investigation being how did asbestos and other hazardous material came to be in this area in the first place. The Unison letter of 9th August 2019 picked this up stating "*No immediate follow up to the site of the incident to ensure that all waste had been removed and to determine if there were any contributory factors or evidence as to how the asbestos got there in the first place*".

6.1.7.4 The Investigation

The investigation did follow a logical process in terms of asking the relevant persons involved in picking up the waste and disposing of it. It also showed it spoke to members of the Housing Department and the Civic Amenity Site.

As with the internal investigation, the review does not intend to relive the investigation, but look at it in terms of learning outcomes. To this extent, this review examines the principles of the HSE HSG245 and applies them to the investigation to show potential learning outcomes. It also takes into account general principles of investigation reporting, including the basic facts that must be set out including:

- When and where did the accident / incident happen
- Who was involved
- Injuries sustained
- How did it happen
- What was the sequence of events
- What was the cause
- What are the recommendations

The first principle of HSG245 in carrying out an investigation is that "***In general adverse events should be investigated and analysed as soon as possible***". As can be seen, the independent investigation did not initially take place for over a month after the incident. This in itself impacts the investigation as facts are not as fresh to recall, and the investigation will move naturally from a clear new investigation to an overview of the previous investigation with seeking to clarify certain aspects. This is clear from the contents of the reports produced.

6.1.7.5 When and where the incident happened

The matter of where the incident occurred is covered above. In terms of facts and timings around the incident, these are not mentioned in any of the versions of the investigation reports. Instead it mentions Grange Farm and the date as a heading, with little further reference.

6.1.7.6 Who was involved

The reports don't set out a specific section showing all persons interviewed per se, though the a general overview is given on the front page. Certain names are mentioned in the report, being the two operatives, [redacted] and [redacted]. The report doesn't set out their specific roles in the incident in all cases.

6.1.7.7 Injuries sustained

No mention of any injuries is mentioned. The early versions of the report raise concerns over contamination of clothing, but it is not until version 6 (20th September 2019) is Occupational Health referral mentioned. Again, the review does not know where this aspect originated as no mention in any of the documents available. But it can be hypothesised that the referral came off the back of the initial reports concerns over contamination

6.1.7.8 How did it happen

This element sets out the background of the actual incident, which in part is covered in aspects throughout the report. The investigation does breakdown the stages of the event into four categories as set out in the terms of reference given and goes through the details.

6.1.7.9 What was the sequence of events

A lot of this is covered in "how did it happen", but again would have been best laid out in a timeline to aid in understanding events and also allow for clarity of facts (e.g. around the times the waste was collected)

6.1.7.10 What was the cause

This is a fundamental aspect, and links directly to HSG245 key aim as "*…to establish not only how the adverse event happened, but more importantly, what allowed it to happen*." This is related to the immediate, underlying and root causes that any investigation aims to establish to allow proper recommendation to stop the event occurring again. Unfortunately this is lacking in the report, instead there are general observations including:

- "*the processes and protocols for waste removal…..appear to be suitable and sufficient"*
- *"…there is no formal or informal knowledge sharing / lessons learned taking place."*

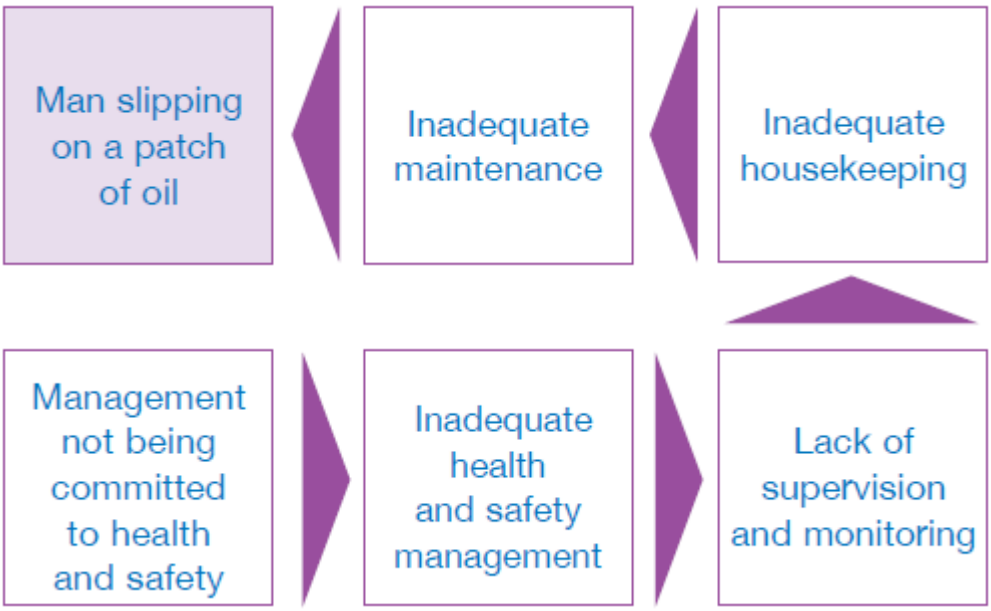
While it is accepted that the terms of reference don't specifically set out the outcome needed, it is assumed that any person competent in carrying out such investigations seek to find causation. . HSG245 clearly states "*it is only be identifying all causes, and the root causes in particular, that you can learn from past failures and prevent future repetition*". This investigation did neither. It is noted that the Union letter of 9th September 2019 page 6 states "*There have been three other documented asbestos waste related incidents that have occurred under your tenure"* , indicating past failures around asbestos, it is not clear if any of this had been relayed to the investigator, or if they were linked to Housing. But it should also be noted that there were 6 further versions of the independent investigation report after this date, so this information could have been conveyed to the investigator to look into.

There does not seem to be any reason why causation could not be established, as with the internal report. All parties involved were interviewed and, in the majority, were. CCTV was available for the CA site. And all paperwork relating to the incident in terms of policies and procedures sat within the Housing Department, and was made available according to the reports. It should be noted that the "Activity Based Risk Assessment" mentioned in the reports was not available to the review and doubts remain if such a document is in place or this was a heading of another document. This is important, as any standard operating procedure, training, procedures and work flows would be based on, or refer to, the initial risk assessment that would have identified the main risks associated with the activity and the controls necessary. It would also include the monitoring and review procedure, which are important as the investigations recommendations actually seek to put a review process in place. It is also not clear what activity this risk assessment that is reported to have been shown refers to (asbestos, hazardous waste, fly tipping collection etc.).

While the investigation cannot prove beyond reasonable doubt, it did see evidence (e.g. initial Housing Action Plan) where the SOP and the Risk Assessment are treated as one and the same. The initial action plan stated "*Risk Assessment incorporated in SOP*". This shows a lack of understanding in that the two are completely different, with a Risk Assessment being the initial sage to understand if there is a safe method, controls that can be incorporate etc. From this a SOP may be required, that then is given to operatives to carry out the task.

Regardless of what it was and what was seen, no causation was established or highlighted and the recommendations made therefore stand alone and do not ensure that the causes of the incident will not occur again.

HSG245 clearly sets out how causation is established from an incident to the root cause, with the example below.



Unfortunately the independent investigation, as with the internal investigation, only established the initial stages of the causation route, in that hazardous waste was collected. The internal investigation went further by stating certain key policies and procedures were not followed, despite demonstration of training being shown. The independent investigation did establish there is a lack of a fly tipping procedure, which could well be an underlying cause but, in itself, is not a root cause (root cause would establish why there is not, and work back to establish if Management were aware of the need)

This is a key criticism highlighted a number of times by the Union, including their letter of 9th August 2019, stating "*No root cause evident from the report*". And again on 9th September 2019 the Union raised the matter of root causation, and demonstrated concerns over gaps that could have established this as well as setting out, in their opinion, what the root causes were. Again, despite this being a running theme from the Unions, a total of 10 versions of the report (8 after 9th August 2019, and after 9th September Union Letters)

It is worth noting that a number of gaps highlighted by the Union letter of 9th September 2019 were never addressed or covered by any report, including:

- COSHH Training
- Lack of asbestos training in line with the SOP
- SOP stating annual review in 2009 and not done until 2019
- No risk assessments covering any other area of hazardous waste
- Manual Handling

Some of these have been mentioned in the review previously, but such gaps highlight a lack of methodical and analytical investigation to determine the cause of the issue, or to give confidence such an issue will not recur. If anything, the report and recommendations will improve matters but not necessarily address the presence and handling of hazardous waste in general. It should also be noted that a risk assessment was mentioned in the reports but none were seen or been able to be provided.

6.1.7.11 What are the recommendations

It is worth remembering that the HSE guidance is very clear in terms of what should come from a health & safety investigation, being an "*action plan to prevent the accident or incident from happening again and for improving your overall management of risk.*" But this is built upon the investigation establishing causation, which it has been established this investigation did not.

The investigation report did set out recommendations, being 8 in total, but these were based on the underlying and immediate causes only in part. It is also worth noting that the number of recommendations varied as the report versions went on, starting at 4, going to 8, then to 7 before settling on 8.

While on the face of them, the recommendations seem sensible, they are in themselves limited in effect as they stand alone from any conclusion over causation. The HSE guidance clearly sets out that "*The root causes of adverse events are almost inevitably management, organisational or planning failures*". None of these had been identified, but a failure of any of these undermines any documentation or training as it cannot be guaranteed they will be embedded or followed.

It is also noted that some of the recommendations are not based on any evidence seen in the report of failures per se, but more about learning opportunities. This includes recommending an internal audit of waste collection across the services. Some are more around housekeeping and best practice, for example review of documentation, removal of old documents and using competent and experienced providers. Again, these are not directly linked to any failures that caused the incident. It is actually of concern to the review that one of the recommendations actually appears to lead to an increased risk of hazardous waste exposure:

"(Recommentation) 2….Where the waste is clearly non domestic (e.g. industrial / commercial) then a more in depth inspection of the bags should be undertaken as the risk of contaminated / hazardous contents may be greater and need to be passed immediately to a specialist waste carrier".

This would appear to recommend opening bags, exposing operatives to more risks. For example, opening a bag to then find syringes and needles increases the risk of needlestick injuries.

6.1.7.12 Rewriting of the Incident Reports

As mentioned, there were a total of 10 versions of the independent investigation report from August to October 2019. A breakdown of the changes is found below, as well as what appears to cause the next version to be required (in red).

Version 1 5/8/19

1st Draft version provided by [redacted], with four recommendations included

Comments from Unison around training identified

Version 2 5/8/19

2nd Draft version provided by [redacted] including details from Unison within TOR 5, no further amendments to the report

Comments from Unison about unlicensed waste collection 7/8/19

Letter from Unison raising concerns over aspect of training, PPE and documents 9/8/19

Version 3 29/8/19

3rd Draft version provided by [redacted].

Addition of "*The material in question was collected from a garage area of Shaftsbury Circle in South Harrow on 26th June 2019 which had been left by person's unknown, a practice referred to as 'fly tipping'*".

Addition of PPE information and fly tipping collection to TOR 1

TOR 5 reverted back to Version 1 wording but paragraph about [redacted] recollection of training, paragraph about attempts to meet [redacted] and an expansion of the final paragraph around SOPS and risk assessments. Concern over no sharing of best practice about all those involved in waste collection

Recommendation 4 added to, and a further 3 recommendations added around clothing, liaison between departments and review of all licenses

Version 4 4/9/19

4th Draft version provided by [redacted].

TOR 5 [redacted] recollection of training paragraph removed

Recommendation 2 wording changed from "properly sources and interrogated" to "properly sourced and verified"

Recommendation 6 had addition of wording ",possibly by other family members"

Recommendation 7 expanded to show uncertainty about licences held by the Council around waste

Addition of a paragraph around the need for an internal audit around waste, including potentially with the Trade Unions

Letter from Unison raising multiple concerns over the report and investigation 9/9/19

Version 5 10/9/19

5th Draft version provided by [redacted]

TOR 2 The disposal of clothing paragraph removed

TOR 5 Removal of paragraphs about training and meeting [redacted] replaced with addition of sentence stating would have been useful to meet with [redacted]

Additional Recommendation added around differentiating of waste

Recommendation 2 becomes Recommendation 3 and add sentence about need to identify documents within 3 months of review date

Expansion of final paragraph to state no unlawful act and comment around positive safety culture

Email from [redacted] to [redacted] stating doesn't feel picks up Unison feedback

Version 6 20/9/19

6th Draft version provided by [redacted]

TOR 1 expansion of fly tipping paragraph to state no formal process appears to be in place

TOR 2 Addition of referral of [redacted] to OH

TOR 4 Addition of paragraph around documentation outlining processes and protocols for waste removal Seems to contradict TOR 1? Additional paragraph to say spoken to [redacted]

TOR 5 Complete reduction of paragraphs to bare facts around training carried out by qualified person

Recommendation about checks on H&S Trainers removed

Recommendation around review of licences reduced down to one paragraph

Paragraph about carrying out an internal audit has become a recommendation

Added word “conclusion” above final paragraphs, and addition of sentence “From the evidence I was presented with and the conversation that took place I have seen no evidence of statutory breaches”

Email provided to [redacted] about the training provided by the Training Academy

Version 7 22/9/19

7th Draft version provided by [redacted]

Recommendation 7 removed, about not clear what licences and permissions are in place

Email from [redacted] to [redacted] stating areas that still need to be picked up on

Version 8 29/9/19

8th Draft version provided by [redacted]

TOR 4 Addition of “that documented systems are in place and clearly understood by staff”

TOR 5 Replaced “I have been unable to verify this” with “I have seen no evidence of this”

Removal of [redacted] information to SOP and Risk Assessment paragraph

Addition of Recommendation of [redacted] confirming all necessary licences held

Email from [redacted] to [redacted] stating further amendments to be picked up on, and including Union letter of 9th August 2019

Version 9 7/10/19

9th Draft version provided by [redacted]

TOR 5 “I have seen no evidence of this” replaced with “as well as environmental qualifications and professional memberships”

Email from [redacted] suggesting further tweaks

Version 10 8/10/19

10th Draft version provided by [redacted]

Takes recommendation regarding [redacted] and licences, and adds it to TOR 2 section with OH

Changes “Top Management” to “Senior Management” under TOR4

SOP and Risk Assessment paragraph condensed, removing last sentence

Last recommendation wording changed

Unison Letter of 11th October raising issues with the report

[redacted] Stops Further Work 4th November 19 emailing [redacted] stating "You agreed the contents of this report before I submitted it to you formally and over various iterations I have taken out some things that I was not comfortable with so what you have now is the final report and delays you refer to are of your making, not mine." It is noted that this email is the first reference to root cause by the independent investigator stating "When we look at root cause analysis, as I'm sure you are aware, we look at organisational issues, top management and culture and I'm sure if you are honest with yourself you'll see how this is a major issue, but perhaps not something you'd want in a formal report."

What appears apparent from the review of each of these versions is that the reports and the work around them moved away from the actual investigation of the incident, and the establishment of the causation, but more towards addressing concerns raised mainly by the Unions and appeasement of these concerns. It would appear from the evidence presented, a lot of this came about due to what was perceived criticism by the investigator around the training provided by [redacted], and this became the focus.

The Union letter of 9th September 2019 from the Union, page 3, stated "*Instead, without any proof or corroborative evidence it (the report) attempted to apportion blame on the training mentioned above…."* Again, this appears a consistent theme highlighted in the Union letter and accompanying statement of 9th August 2019. Unfortunately there are over 1000 pages of emails, reports and documents associated to this time period, and therefore the review presents a synopsis of what occurred but it is telling that the majority of documents provided throughout all the investigations relate directly to the training carried out. Ultimately any training is linked back to the initial risk assessment and identification of training as a control, and there appears to be no risk assessments provided.

Unfortunately while the reports tried to address the matters being raised, they did not address fundamental errors that ran through them (location, using documentation in a training course ran before the documentation written, accuracy around waste licences etc.). Therefore the report maintained its flaws and unfortunately only built upon them with each passing version, as it adapted from information being provided to the investigator rather than by the investigator investigating the incident. This does signal a fundamental failure of the investigation and the report.

This brings the review back to the original point made under 2a Independent Investigator:

"*A review of the CV of the independent investigator indicated that [redacted] was more of an auditor than an investigator, with his work history centring on management and auditing in health and safety. While this may appear pedantics, the two are different in approaches to incidents*"

The independent investigator report highlighted this, and again it is worth repeating the reasons why being:

"*While the standard of investigation and resulting reports is covered below in more details, this aspect is worth raising. An auditor will carry out an investigation with a system review based approach to determine if the systems put in place will achieve the outcome desired. This will focus more on policies, procedures, systems etc. and less on the specifics of an incident. This will produce a different way of investigating and the subsequent report from it*."

It is the reviews view that the independent investigator did a top skim audit of the systems and procedures around the incident rather than the incident itself, thus showing the accuracies around the incident were circumstantial to what was trying to be achieved. It also would explain why the fundamentals of an investigation, being the root cause, are not shown or discovered.

Either way, the independent review did not add much more than what was established in the initial internal investigation and failed to address the fundamentals of a health and safety investigation.

6.1.7.13 Conclusion

Ultimately, as previously stated with the internal investigation conclusion, any investigation must link back to HSG 245 Guidance in that "*An effective investigation requires a methodical, structured approach to information gathering, collation and analysis. The findings of the investigation will form the basis of an action plan to prevent the accident or incident from happening again and for improving your overall management of risk. Your findings will also point to areas of your risk assessments that need to be reviewed*."

The independent investigation conducted unfortunately did not follow this approach. The overall investigation and resulting report is the same as the internal investigation in that it seems to be incomplete, lacking evidence, setting out basic conclusions and is inconsistent in approach and accuracy. It references documents without drawing any conclusion whether they were suitable and sufficient especially as it is noted that the age of the Housing Documents referenced indicate potential concern around whether they have been updated or are even relevant to the processes years after they were produced.

It is also noted that the investigation did mention a risk assessment, but the review has found no evidence of one even existing and can only surmise this was an accidental reference to an operational procedure document.

Again while the review does make any conclusion about the competence of the investigator in terms of knowledge of the legislation, it does find deficiencies that suggest that they are either inexperience in, or lacking knowledge of, carrying out a health and safety investigation of this nature and the fundamentals behind it. It is noted though that the independent investigator may have a different view on that judging from his final email of 4th November 2019

Learning Outcome:

The Council would benefit from having a clear health & safety investigation procedure / policy that take on board the process set out in HSG245

That managers within the organisation would benefit from having investigation training to understand how to carry out an investigation. This would probably provide universal benefit in conducting any investigation

It is for the commissioning officer to set out clearly the terms of reference for any investigation to ensure that the investigation covers all aspects and the report provides the factual evidence necessary to allow the root causes to be identified and appropriate action plan to be put in place

That standard templates related to health & safety investigations are put in place, as is the case with any other council investigation (e.g. disciplinary or grievance) to ensure consistency of approach and that key aspects are therefore addressed. This would include an investigation report template

That training is required for all managers to understand the risk assessment process to allow suitable and sufficient operational documents to be produced

That an audit of all risk assessments should be conducted across the Council to ensure all risks are controlled

6.1.8 Action Plan

In any health and safety investigation there are two points when an action plan is needed, being:

a. Immediately after an event to prevent recurrence while an investigation takes place and

b. Once the investigation is concluded, providing recommendations and identifying root cause to enable clear actions to take place to address them

On 28th June 2019 [redacted] responded to a Union letter by email stating "*There is a plan in place as to how this isolated matter is being addressed by Housing. The plan includes collaboration with Waste Management colleagues*". This would appear to suggest that within the first two days a plan had been put in place. Unfortunately no explanation of this plan or details of it can be found by the review. The next reference to a plan is on conclusion of the internal investigation and the report produced including an action plan on 19th July 2019, 24 days after the incident. Unfortunately this action plan is a result of a limited investigation and only seems to seek to update what is already in place with regards the SOP and training. But unfortunately there is no explanation why these failed in the first place, therefore providing limited confidence that such actions would directly prevent such an incident again. For example, there is no mention of any waste assessment prior to collection to try and identify hazardous waste, but instead an generic action to ensure SOP is reviewed. Again, no risk assessment is mentioned, so any action around these are not based on the basic health & safety requirement and identification of all risks and controls.

The subsequent action plans from the Independent investigation build upon these and are directed in part by issues raised by the Union so provide more confidence, but again are built upon an investigation that fails to identify root causation and having basic documents in place such as a risk assessment

HSG245 clearly sets out the requirements around a Risk Control Action Plan, stating "*An action plan for the implementation of additional risk control measures is the desired outcome of a thorough investigation*" It also sets out the need for SMART actions, and clearly defining high risk areas and immediate actions needed. Unfortunately neither investigation achieved this.

Due to the investigations not being conducted in a timely manner or identifying the root cause, it was not possible for clear actions to be identified and implemented to prevent recurrence at an early stage.

In conclusion, the review found that while some actions appear to have been taken (e.g. updating of the Standard Operating Procedure) it is not clear of any actions that were actually implemented to prevent such an incident occurring while the investigations took place. It is also clear that no investigation report identified clear underlying or root causes which are fundamental to ensuring the correct actions are taken to address them. The review has summarised all the issues highlighted during the investigation (Appendix 1) and provided these to the Housing Service to ensure they are addressed in the action plan that is produced to prevent recurrence of such incidents. The Housing Action Plan (Appendix 3) is attached.

Learning Outcome:

Any Action Plan must identify immediate risk and take action to address to prevent recurrence

Any Action Plan must be based on SMART objectives clearly linked to causation

Senior Management must be involved in the action plan as they have the authority to make decisions and to act on the recommendations

6.1.8 Historic Issues

The Unison letter of 9th September 2019 stated "There have been three other documented asbestos waste related incidents that have occurred under your tenure" and yet this was never addressed in any of the investigations.

The review understands that the independent investigator may not have access to such information and is reliant on others bringing it to their attention, but then this occurred on the 9th September without any resulting change or comment in the subsequent reports.

The review does find that such information is important as can show a trend in an area that needs to be addressed. It would appear that such information would be stored on the SHE Assured database, as any such incident around asbestos should be reported through the internal health & safety database. But no reference to this system is seen in any report.

Additionally, the review notes that the Corporate Health & Safety Board has such incidents raised and, while this Board has only been running properly for 18 months, is a source of information as all meetings are minuted.

The review understands that finding historic issues can be hard, and therefore recommends a means to capture them to allow easy checks by an investigator to understand trends and therefore whether past actions have been successful or not, and aid in understanding root causation.

Learning Outcome:

A serious incident log should be set up, either on or with the aid of SHE Assure software to enable historic trends to be identified.

7 Review Conclusion

Ultimately any investigation must link back to HSG 245 Guidance in that "*An effective investigation requires a methodical, structured approach to information gathering, collation and analysis. The findings of the investigation will form the basis of an action plan to prevent the accident or incident from happening again and for improving your overall management of risk. Your findings will also point to areas of your risk assessments that need to be reviewed*."

The internal investigation conducted unfortunately did not follow this approach. The review noted that an investigation template was provided by [redacted] on 3rd July 2019 to [redacted]. It is unfortunate that this template appears to have been ignored, as it does a step guide to meeting that which is set out in HSE Guidance, including causation.

The overall investigation and resulting report seems to be incomplete, lacking evidence, setting out basic conclusions and is inconsistent in approach and accuracy. It states failures in following certain documents without evidencing how, and references them without drawing any conclusion whether they were suitable and sufficient. It is also noted that the investigation did not mention any risk assessment(s), whether because none existed or looked at it is not possible to determine. It would appear from the report that potential statutory breaches occurred, but these are not clear, and gives no indication of council breaches in terms of policies or procedures. It also was noted that the age of the Housing Documents referenced indicate potential concern around whether they have been updated or are even relevant to the processes years after they were produced. It must be noted that these are areas of concern that the Housing Action plan as a result of the incident need to address and provide reassurance.

The Union concluded in their letter of 9th August 2019 that this internal investigation was "*totally flawed from start to finish*". It is, unfortunately, not hard to disagree based on the evidence presented. While the review does not make any conclusion about the competence of the investigators in terms of knowledge of the legislation, it does find deficiencies that suggest that they are either inexperience in, or lacking knowledge of, carrying out a health and safety investigation of this nature and the fundamentals behind it.

The review also found that the same faults ran true throughout the independent investigation, with more concentration on training then causation.

The amount of documentation provided by the review, as well as recognitions there are gaps in information due to conversations and other aspects not being provided, means that not all elements are covered but instead the fundamentals linked directly to the conducting of a successful health & safety investigation.

It is accepted that further correspondence has been on going since the start of the review, but it is felt that these are covered in the body of this report anyway so do not need further clarification

Ultimately the investigation process failed as it was not set out clearly from the start what the outcome was (e.g. root cause) and what roles people took in this. This in turn led to the investigator, especially the independent investigator, ending up being led rather than leading on the investigation. This resulted in a chronology of then trying to cover gaps and correcting mistakes, each time not moving nearer towards establishing the root cause of the incident. While in principle the recommendations from the reports were sound and logical, they then became generic and not directly correlated to cause.

One fundamental flaw that was highlighted is any proactive approach to prevent recurrence of the incident while the investigations took place, and failure of the investigations to identify causation which is fundamental to ensuring they are addressed in any action plan. The review did find that the collation of all

issues highlighted during the investigation does lead to some tangible conclusions around causation that do assist the action plan.

Ultimately the failure to set a clear steer on the health & safety investigation at the early stages led to a flawed process that extended beyond what was reasonable and focusing on addressing the flaws of the investigation rather than the causation of the incident.

The review concludes that these same issues can be potentially seen in other key incident investigations over the last two years, where lessons learnt have not been established and steps taken to prevent recurrence. Without a clear process addressing these and setting out each stage, this is likely to occur again going forward.

As with the actual investigations itself, it is important that the lessons learnt from this incident are heeded and that a partnership approach is adopted in their implementation, allowing full and inclusive involvement including from the Trade Unions who contributed throughout the incident investigation to attempt to highlight areas of concern.

APPENDIX 1 – ISSUES RAISED WITH REGARDS THE INVESTIGATION PROCESS

	Comment	Review Category
TRAINING AND KNOWLEDGE	Asbestos course advertised as being appropriate for those 'carrying out minor works and those with management responsibilities', not refuse collections	Incident Action Plan
	Need appropriate asbestos training for caretakers that carry out fly tipping operations and that the trainer is qualified to deliver the training.	Incident Action Plan
	Should asbestos training not have taken place more regularly and what is the opinion on refresher training for front line staff through to senior management.	Incident Action Plan
	Confirm qualification of trainers	Incident Action Plan
	It appears that there is no record of due diligence checks undertaken by Harrow council to ascertain the suitability of this training and that of the trainer.	Incident Action Plan
	Course content not being confirmation of what was discussed and therefore not including in the report.	Incident Action Plan
	Asbestos awareness training was provided to 23 members of the housing operations team on 27th Feb 2018. The training was provided by [redacted], on behalf of the council.	Incident Action Plan
	The brochure is a description of what the course could cover, but not confirmed what was actually delivered which may well be different. The course content for the actual course deliver has been requested and thus far nothing has been received.	Incident Action Plan
	Asbestos awareness in a formal letter to [redacted] from [redacted], which helpfully included a statement from [redacted] to support the investigation and confirming that the training course he delivered on behalf of corporate health and safety was designed to comply with CAR 2012, HSE and Academy stipulations. The course was 3 hours in duration and was supported by handouts and DVD's	Incident Action Plan
	The DVD used on the course was 'How are we Today' produced by the HSE. Part 1 being aimed at staff and highlights the dangers and medical effects of asbestos. Part 2 is aimed at management and outlines their responsibilities. Part 1 was shown to the group attending the course.	Incident Action Plan

	[redacted] has also included confirmation of his professional qualifications held at the time	Incident Action Plan
	From the letter the course content, I would be grateful if this could be included in the report.	Incident Action Plan
	A report that does not mention the lack of health and safety training within your own management team	Incident Action Plan
MANAGEMENT COMMITMENT	What is the responsibility of housing senior management	Incident Action Plan
	Not interviewed members of senior management in housing	Incident Action Plan
	No interviews conducted with senior departmental managers.	Incident Action Plan
	No mention that the investigating officer [redacted] is responsible for compliance advice	Incident Action Plan
OPERATIONAL DELIVERY	There is no formal system in place in housing were fly-tipped industrial/domestic waste is assessed by suitably qualified staff before housing staff are instructed to collect, therefore preventing similar events happening again	Incident Action Plan
	Is this type of waste usually gets collected by caretakers or is this one off incident.	Incident Action Plan
	Reinforce that systems and processes are in place for caretakers collecting waste	Incident Action Plan
	Review of documentation, that they meet best practice or not, that the ACM document had not been reviewed since 2010 and how learning for management investigation is best used to improve the documentation	Incident Action Plan
	Not clear what licences are held by the council in respect of waste removal. Whether the council as an entity hold the licence or whether individual departments hold such licences is unclear.	Incident Action Plan
	Reinforce if this type of waste was what usually gets collected by caretakers or is this one off incident? This is not known, there may have been other incidents which have gone undetected but there is no evidence or suggestions of this.	Incident Action Plan
	Comment	**Review Category**
	No evidence of any risk assessment for the task in question	Incident Action Plan

	The vehicle used was not sufficient to carry hazardous waste	Incident Action Plan
	no question why the head of service failed to enact legal compliance for carriage of waste	Incident Action Plan
	No mention of cross contamination of load which identifies all waste would need to be classified as hazardous.	Incident Action Plan
	Failure to comply with transportation of waste itemised under the duty of care notice blunder after blunder	Incident Action Plan
	No mention of the risks posed by the sharps and medical waste	Incident Action Plan
	Information received from [redacted] reveals a consistency of approach from within the council when dealing with hazardous waste, not just asbestos- statement is confusing and not sure what it adds	Incident Action Plan
INVESTIGATION STANDARD	Root causes	Review Action Plan
	Union comments- I am sure you will agree that this investigation report is inadequate and inaccurate on a number of fronts	Review Action Plan
	The incident occurred at Grange farm actual site of the incident as stated by the operatives	Review Action Plan
	No incident form has been completed to accurately record this nor have either of the investigators visited the science of the crime	Review Action Plan
	No analysis of the waste was conducted at the time	Review Action Plan
	No immediate follow up visit to the site of the incident to ensure that all waste had been removed and to determine if there were any contributory factors or evidence as to how the asbestos got there in the first place.	Review Action Plan
	The analysis of the suspect waste was only conducted at the end of the process.	Review Action Plan
INVESTIGTION	No root cause was evident from report, no legal documentation duty of care notice to transport waste	Review Action Plan
	Failure to determine the root cause	Review Action Plan
	Investigative process since the investigator has viewed this incident in isolation and has not taken the trouble to look into detail or at historical events that may have led to the organisations failure to implement robust control measures to	Review Action Plan

	prevent similar events recurring	
	No monitoring of the inadequately qualified investigators performance at all during the process to see if she was on the right track	Review Action Plan
	Investigation fails to identify the underlying causes which led to the incident no risk assessment, an out of date 2009 SOP document that doesn't even get the legislation right and fails to provide any details advice regarding correct PPE or contingency action in the event of an emergency	Review Action Plan
	Lack of knowledge and competent advice within the housing department, the extensive breach of legislative requirements throughout the whole process.	Review Action Plan
	Instead this investigation attempts to shift the focus away from poor management practices and cites the asbestos training as a sort of get out jail card	Review Action Plan
	Terms of reference for this investigation have not been met so far as activity involving the union in the investigation process	Review Action Plan
	One minute he was talking about grange farm estate and next minute the location has changed to a garage area of Shaftsbury circle in south harrow.	Review Action Plan
	A so called technical report has no appendices or supporting documentation attached to it and relies solely on the considered opinion of a so called investigator	Review Action Plan
	A report that is unable to cite the root cause of the incident	Review Action Plan
	Report that is full of contradictions a report that relies on unqualified statements from individuals	Review Action Plan
	Would be good to say that [redacted] opinion that no statutory breach was identified.	Review Action Plan

NOTE: All issues related to the Housing Incident Action Plan have been passed to Housing Management Directly

APPENDIX 2 – LEARNING OUTCOMES ACTION PLAN

Action Point	Learning Outcome	Report Section (To show reasoning)	Action	Lead Person	To Be Completed By	Review Date
1	Any health & safety incident / investigation procedure must set out clearly the role of the commissioning officer and who this should be. It does not preclude others assisting, but allows one port of call for issues	**Section 6.1.1**	**Ensure set out in the Health & Safety Investigation Procedure**	**J Griffiths / R Le-Brun**	**End of January 2020**	
2	It is for the commissioning officer to set out clearly the terms of reference for any investigation to ensure that the investigation covers all aspects and the report provides the factual evidence necessary to allow the root causes to be identified and appropriate action plan to be put in place	**Section 6.1.1, 6.1.5 and 6.1.7**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
3	In line with other formal investigation procedures, the investigating officer of any incident shall not be connected to any aspect that potentially led to it happening.	**Section 6.1.2a and 6.1.2b**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
4	Any person brought in to carry out a specific project requiring specialist expert skills undertake an interview process to ensure that their CV / Qualifications are backed up by their experience to carry out the specific role being tasked	**Section 6.1.2b**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	

5	That the terms of reference for any health and safety investigation are directly linked to understanding how the adverse event happened and what allowed it to happen (underlying and root causes)	**Section 6.1.3**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
6	Any investigation process around health & safety must include initial contact with the Unions to allow the opportunity for joint working to meet legal requirements as well as a partnership approach	**Section 6.1.4**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
7	That any external person involved in advising an investigation must provide accurate and evidenced information to allow the investigation to meet all statutory and policy requirements	**Section 6.1.4**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
8	The Council would benefit from having a clear health & safety investigation procedure / policy that take on board the process set out in HSG245	**Section 6.1.5 and 6.1.7**	**Put in place a Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	

9	That standard templates related to health and safety investigations are put in place, as in the case with any other Council investigation (e.g. disciplinary or grievance) to ensure consistency of approach and that key aspects are therefore addressed. This would include an investigation report template.	**Section 6.1.5 and 6.1.7**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
10	That code of conduct investigations in such incidents should also explore all elements under Section 5, including management	**Section 6.1.6**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
11	That in such cases, the code of conduct investigation must be independent of those being investigated	**Section 6.1.6**	**Ensure set out in the Health & Safety Investigation Procedure**	**All**	**End of January 2020**	
12	That in such cases, the code of conduct investigation must take place after the health & safety investigation has been completed and root cause and underlying causes recognised	**Section 6.1.6**	**Ensure set out in the Health & Safety Investigation Procedure**	**All**	**End of January 2020**	
13	That managers within the organisation would benefit from having investigation training to understand how to carry out an investigation. This would probably provide universal benefit in conducting any investigation	**Section 6.1.5 and 6.1.7**	**Training to be arranged for Managers in line with the procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**September 2020 (Part of line manager training)**	

14	That training is required for all managers to understand the risk assessment process to allow suitable and sufficient operational documents to be produced	**Section 6.1.7**	**Training to be arranged for Managers to carry out risk assessment**	**All**	**September 2020 (Part of line manager training)**	
15	That an audit of all risk assessments should be conducted across the Council to ensure all risks are controlled	**Section 6.1.7**	**Corporate Audit to be conducted to ensure all suitable and sufficient risk assessments in place**	**All**	**May 2020**	
16	Any Action Plan must identify immediate risk and take action to address to prevent recurrence	**Section 6.1.6**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
17	Any Action Plan must be based on SMART objectives clearly linked to causation	**Section 6.1.6**	**Ensure set out in the Health & Safety Investigation Procedure**	**All** **J Griffiths / R Le-Brun to ensure in process for H&S investigation**	**End of January 2020**	
18	Senior Management must be involved in the action plan as they have the authority to make decisions and to act on the recommendations	**Section 6.1.6**	**Ensure set out in the Health & Safety Investigation**	**All** **J Griffiths / R Le-Brun to ensure in process for**	**End of January 2020**	

			Procedure	**H&S investigation**		
19	A serious incident log should be set up, either on or with the aid of SHE Assure software to enable historic trends to be identified.	**Section 6.1.6**	**Serious Incident Log established on the SHE Software and all informed of the need to update it, with what and how**	**All** **Corporate H&S**	**March 2020**	
20	That the implementation of these actions are managed and monitored transparently through the Corporate Health & Safety Board, and especially in conjunction with the Unions	**Section 6.1.7**	**As per the learning outcome**	**Corporate Health & Safety Board**	**On Going**	

APPENDIX 3 - HOUSING INCIDENT ACTION PLAN

Housing Incident Action Plan

No.	Issue Related to the root or underlying cause of the incident initially	Action Point	Areas to be addressed Break down of specific areas that need to be addressed as highlighted from the investigations	Action Specific Action needed to address issue	Outcome to be achieved Setting out what will need to be in place to	Owner Responsible person to take forward the action and ensure completed	Timescale Target date for completion of the action.	Update Monthly update on progress	RAG Status
1	Management Commitment	1A	No Suitable and Sufficient Risk Assessments in place for identifying and controlling hazardous waste (asbestos, chemicals, sharps) by caretakers	Carry out suitable and sufficient risk assessment of this activity taking into account the Asbestos Regulations, COSSH Regulations and associated guidance		Head of Resident Services	February 2020		

		1B	Standard Operating Procedures not linked to any risk assessment or updated to reflect good practice	Put in place a standard operating procedure for staff that takes into account the controls identified within the risk assessment and in line with HSE guidance https://www.hse.gov.uk/pubns/guidance/a38.pdf					
		1C	No clear asbestos or other hazardous waste arrangements covering all activities and issues						
		1D	Unclear on the governance within the Housing Department around health & safety and putting in place / ensuring in place correct procedures and risk assessments in place						

		1E	No monitoring or audits of activities to understand whether any process / procedure is adequate and working					
		1F	No link in with other similar services to ensure best practice is adopted and consistent in approach					
		1G	No set review dates / process for documentation including SOP and Risk Assessment	Ensure all risk assessments across Housing are reviewed and a clear review date is then assigned and recorded going forward				

		1H	No document control in place with processes / procedures to ensure only the current version available						
2	Training and Knowledge	2A	Concerns over competence of those carrying out the risk assessment and SOP at management level						
		2B	Training around hazardous waste (asbestos, chemicals, sharps) not linked to any clear risk assessment or SOP						
		2C	Training not specific to the task and staff involved						

		2D	Refresher training frequency inconsistent and does not take into account any changes to the risk assessment or SOP					
		2E	Confusion over competence and procurement of trainers to carry out identified training					
		2F	No copies of training carried out held by service					

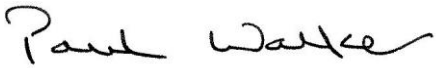
		2G	No process in place to train staff that are new to the service and not been party to formal training / refresher training						
		2F	No clear training matrix to ensure that all relevant staff receive necessary up to date training and refresher training						
		2G	No toolbox talks in place to keep staff updated or aware of requirements or changes to procedures, or to reinforce training						

3	Operational Delivery	3A	No formal system in place to assess any waste prior to removal / instructions to remove to identity any hazardous waste						
		3B	Not clear what waste licences are in place to allow caretakers to collect and remove waste						
		3C	Waste Transfer Note not incorporated into the work carried out by caretakers						
		3D	Staff do not differentiate between commercial and domestic waste						

		3E	No process for what action to take if staff become contaminated or affected by hazardous waste						

SIGN OFF

The undersigned confirm that the review and action plans resulting from it are accurate and to be carried out by the suitably nominated person.

CORPORATE DIRECTOR (COMMUNITY)  DATE: 19th January 2021

DIRECTOR OF HOUSING SERVICES  DATE: 19 January 2021

CORPORATE H&S COMPLIANCE MANAGER  DATE: 19th January 2021