SAFETY INFORMATION SHEET

ACCIDENT INVESTIGATION

This Information Sheet is one of a series produced by the LEIA Safety and Environment Committee on topics relevant to the lift and escalator industry. Whilst every effort has been taken in the production of these sheets, it must be acknowledged that they should be read in conjunction with the relevant legislation, codes of practice etc. They should not be taken as an authoritative interpretation of the law but guidance to it.

Introduction

At present, it is not a legal requirement for employers to investigate accidents. However, it is implied by the Management of Health and Safety at Work Regulations 1999 (MHSWR) and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Investigating accidents feeds into the risk assessment and review required by MHSWR, and the RIDDOR reporting forms imply that some basic investigation should have taken place, at least for reportable incidents.

All accidents, dangerous occurrences, 'near misses' and reports of workplace violence should be investigated to learn from the incident.

The initial aim of any accident or near miss investigation is to establish the facts of what actually happened. This information sheet reviews the logical sequence of an investigation and considers what recommendations and remedial actions may be necessary to prevent a recurrence, which should be the ultimate goal of any investigation.

When any accident occurs, causing injury, the first response should be to ensure the safety of those assisting, to help the injured and take further action to minimise the effects of any injuries sustained. Subsequent activity must then secure the area and prevent injuries to others.

Consideration should be given in providing support for employees who have been witness to a serious accident and may be suffering trauma as a result of this.

In many cases the constraints of time and finance mean that often only serious accidents, dangerous occurrences and workplace violence such as those reportable to the Health and Safety Executive (HSE) under RIDDOR prompt a full investigation. However it is worthwhile investigating all minor accidents, near misses and dangerous occurrences as similar incidents in the future may have more serious consequences.

Routine accident reports detail the circumstances around an incident (the events that comes before an injury) e.g., tripping over rubbish on the machine room floor whilst gaining access to the control equipment and its outcome, a fall on an outstretched hand that results in a sprained wrist. Such reports may be used to compile statistics to measure the seriousness of accidents and to monitor the company's safety performance. Reports should also be discussed and analysed and the findings shared with all relevant parties in order to increase awareness.

Beware of allowing employee witnesses involved with the accident to discuss it between themselves before a formal interview. This could be prejudicial in any prosecution which may follow.

Those investigating an accident need access to information such as the injured party's background, including qualifications and training, site activities, type of work being carried out and the type of equipment used.

Reasons for an accident investigation

- To ascertain immediate and underlying causes of the accident and to introduce measures to prevent a recurrence.
- To establish the facts of the accident; whether work followed the risk assessment/ method statement.
- To review existing risk assessments and identify any improvements that may need to be made.
- To establish any further training needs.
- To comply with MHSWR in planning your health and safety arrangements.
- To satisfy the requirement in the event of a civil claim, that you make a full disclosure of the circumstances of an accident to the injured parties.
- Improvement in employee morale; if action is seen to be taken after an accident, to improve employee safety.

It is beneficial to investigate near misses and dangerous occurrences as well as accidents resulting in damage or injury. A near miss, such as a stumble and recovery, if not reported would result in no remedial action and the potential for an accident would remain. If reported and investigated, an action - such as clearing away rubbish - could be taken to prevent an accident. This is the proactive aspect of examining near misses.

Accidents have many causes. What may appear to be bad luck (being in the wrong place at the wrong time) can, on analysis, be seen as a chain of failures and errors that lead almost inevitably to the adverse event. (This is often known as the Domino effect.)

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).

To prevent accidents, you need to provide effective risk control measures which address the immediate, underlying and root causes.

Discussing the actual accident scenario in a group after the investigation may help employees develop a positive attitude towards accident prevention. The discussion may encourage them to ask questions and draw out the facts of the original investigation, learning in greater depth than would result from merely reading about the accident. But beware of allowing employee witnesses involved with the accident to discuss it between themselves before being interviewed. This could be prejudicial in any prosecution which follows.

To encourage openness in reporting it is important that an accident investigation should **not** be used to apportion blame.

Accident investigations should examine all the reasons for the behaviour associated with the accident, as accidents can seldom be attributed to a single cause. Were the correct procedures followed? Has some new information become available which may require assessments and controls to be reviewed?

Investigation

A company investigation should be undertaken as soon as possible. A serious or unusual accident may warrant investigation by the HSE or other enforcement agency. Ideally, the site should be secured and left untouched after the accident. This may not always be possible, but a telephone call to those likely to be involved in any investigation should indicate what needs to be left for the HSE. However if immediate investigation is not possible then photographs of the scene immediately after the incident can aid the investigation considerably.

Investigation Purpose

The purpose of conducting an accident/ near miss investigation is to provide the answers to the questions:

- What was the immediate cause of the accident/ injury/ near miss?
- What were the contributory causes (root causes)?
- What is the necessary corrective action to avoid similar events in the future?
- What system changes are necessary to prevent recurrence?
- Is there a need to review policies and procedures or introduce new ones?
- Is there a need to review training?

Statutory and other notifications

Various individuals and organisations will need to be informed of an accident. A check list may be used to ensure that the necessary notifications are made to appropriate bodies/ people:

- HSE or other appropriate enforcement body,
- Company safety officer,
- Next of kin,
- Line manager,
- Employee representative
- Company insurer,
- Company lawyer,
- LEIA
- Others who may be identified in the company's health and safety policy
- Others who may be identified as a result of the investigation

Notifications will not necessarily to all of these, or be in the above order, this will vary depending on circumstances.

Interviews

To establish the facts it is of fundamental importance that any interviews should be conducted early and should be conducted on a factual basis and without becoming an interrogation. It is essential to establish the trust of the interviewees, who may be suffering trauma as well as physical injury. A key element in this procedure is to enable people to talk freely. Interviews should be conducted on an individual basis and not collectively. The reason for the investigation should be explained, stressing that the purpose of the investigation is not to apportion blame, but to prevent a recurrence. Any interview should cover details of what happened, going over the events chronologically.

Advice on how to conduct interviews is given in the Code of Practice to the Police and Criminal Evidence Act 1984 (see Further Reading).

It is very important to try to establish from witnesses exactly what they saw, rather than their interpretation of what they saw.

Witnesses should be interviewed as soon as possible after the accident. If there is an injured person they should also be seen promptly.

The complete sequence of events should be established before asking others why a particular event may have happened. An accident may result from existing custom and practice if, say, a shortcut on safe systems of work has developed over a period of time.

Key points to consider during an investigation

- The employer organisation; what policies, standards, procedures, and rules are in place.
- The job; what site activity was being undertaken, substances used, procedures followed, tools, equipment, and what was the condition of the client's premises.
- Personal factors - including the injured party's behaviour, suitability, qualification, training and competence to carry out the work.
- Documents such as accident reports and investigations are discoverable by a court and could be used in later cases. With this in mind keep reports to factual information, and keep comments, blame or advice to management out of such reports.
- The amount of detail will depend on the severity of the outcome and the use to be made of the investigation and the report.
- If an employee representative (safety representative) is involved in the investigation they are also entitled to write a report of findings.
- As time passes, witness recollections may become less reliable.
- Those conducting the investigation should not make prejudgments about events.
- Make a clear distinction between what is established fact and what is opinion or hearsay
- Reliance should not be placed on any one source of evidence

Investigation Procedure

- Secure the scene of the accident, especially if the HSE/ Local Authority or other enforcement agency are likely to be involved.
- Commence the investigation and interviewing as soon as possible after the event.
- Take photographs and measurements
- Focus initially on the what, when, where and to whom, and the outcome the event.
- Then focus on how and why; seek the immediate cause of injury or loss and then the secondary or contributory causes
- Consider any contradictory or missing evidence, and how this affects the identification of root causes.

<u>Accident Investigation Report</u>

This should ideally follow a standard process:

i. Draft the report, including specified remedial actions.

ii. Circulate draft report for comments and to check the accuracy of the findings.

iii. Publish the Final Report and circulate to all relevant parties.

iv. Monitor closure and effectiveness of remedial action.

v. Obtain feedback from relevant parties.

When considering remedial actions to avoid future recurrences, the hierarchy of controls should be taken into account: elimination, substitution, engineering controls, administrative controls and provision of PPE, in that order. See Further Reading for additional information.

Primary remedial actions are actions to prevent the recurrence of the accident - such as education and training. Secondary remedial actions are designed to prevent or reduce the seriousness of the outcome of accident behaviour - such as wearing personal protective equipment.

For any clarification of this information sheet contact your company Safety Advisor or the LEIA Safety and Training Manager.

Further Reading:

Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals
http://www.hse.gov.uk/pubns/books/hsg245.htm

Revised Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers Police and Criminal Evidence Act 1984 (PACE) – Code C (Section 11 Interviews General)
https://www.gov.uk/government/publications/pace-code-c-2014

HSE Leadership and worker involvement toolkit; Management of risk when planning work: The right priorities (Hierarchy of controls)
http://www.hse.gov.uk/construction/lwit/assets/downloads/hierarchy-risk-controls.pdf