

HEALTH & SAFETY

ACCIDENT INVESTIGATION PROCEDURES

APRIL 2012

ACCIDENT INVESTIGATION PROCEDURES

It is important that when an accident occurs, a true and accurate account becomes a matter of record.

The purpose of accident investigation is to:

1. Establish the facts with the aim of preventing a recurrence (not to apportion blame).
2. To comply with the legal requirement to report major injuries and dangerous occurrences to the Health and Safety Executive (RIDDOR).
3. To record them for future reference and analysis.

An accident must be investigated whether injury has been sustained or not.

Distinction should be made between cause and effects of the accident.

The cause will include the unplanned events, sequence of events, unsafe acts, unsafe conditions etc.

The effects cover injury, damage, near miss and loss.

The aim of the investigation should be to remove the cause of the accident thereby removing the need to protect against the effect.

When an accident has occurred particularly when involving a major injury, the first duty is to ensure that medical treatment is obtained immediately.

Never attempt to question an injured employee/pupil about the accident before medical assistance has been given.

General Points

1. All accidents should be investigated as soon as possible.
2. When eventually interviewing an injured person, make sure that he/she is in a fit state, e.g. he/she might still be in shock or confused about the situation.

It is generally better to keep eye witnesses apart during an investigation and question them separately. These persons may not necessarily supply you with reliable information.

Differentiate between those who actually saw the accident and those who only saw the result, e.g. *"I turned round and saw him on the floor"*.

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3. Differentiate between 'opinion and fact'.
4. Note exact positions, visibility conditions etc., as soon as possible.

When time elapses between accident and investigation, accurate details may be forgotten and details may be mentioned that never occurred.

5. Keep evidence that is available, e.g. damaged equipment or clothing. If, for safety reasons, you are unable to retain the evidence, e.g. damaged fence, pot hole, then take a photograph, date, mark and sign it, then attach it to the accident report for safekeeping.

Cause Analysis When an accident has occurred, the first step is to prevent recurrence.

Determine the actual causes (this is not always a simple matter). There are always two sides to every accident. The human element and the job itself.

There are 5 principles to work to:

1. Who?
2. When?
3. Where?
4. How?
5. Why?

and finally, the conclusion, i.e. recommendations to prevent a recurrence.

There are 3 questions to be asked:

1. What did the person do or fail to do that contributed to the accident?
2. How did surrounding physical conditions contribute to the accident?
3. What factors under the control of other persons contributed to the accident?

These questions bring us to the Unsafe Act and/or Unsafe Condition.

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Unsafe Act

Unsafe acts can be described as things people do that can result in accidents causing injury, damage to equipment (or both) or a near miss situation.

Some examples are:

1. Misuse of equipment.
2. Using defective or worn equipment.
3. Failing to follow correct work procedure.
4. Negligence and horseplay.
5. Failing to replace guards properly after removal.

Sometimes these problems are directly under the control of the employee but the manager should be identifying these problems and looking at solutions, e.g.

- a) Has the employee/customer received correct training or instructions;
- b) Is the correct equipment available?
- c) Is the person directly in charge of the situation ensuring that correct procedures, tools and equipment being used?

The manager by turning a "blind eye" to any of the afore-mentioned acts is virtually guaranteeing that an accident will occur in the future. He/she could be held responsible in a criminal/civil prosecution by their omission Section 7(a) Health and Safety at Work Act, to act in a safe way.

Unsafe Conditions

These can be described as conditions that by their nature are liable to lead to an accident.

Examples are:

1. Poor housekeeping.
2. Poor lighting.
3. Poor ventilation.
4. Defective equipment.
5. Incorrect or inadequate guarding.
6. Poor design/construction.
7. Lack of maintenance.

These are mainly the responsibility of the management although employees/customers can help to reduce the problem by reporting them.

Unsafe conditions do not always cause accidents but if left unattended, the potential for injury/damage remains.

The problem with unsafe conditions is that they are continually being created. It does not seem to matter how well trained the staff and customers are, they will always have the potential for causing unsafe conditions, e.g. fire doors wedged open, materials stacked in corridors is ongoing and frustrating but is the responsibility of management to maintain a safe working environment.

To eliminate unsafe actions and conditions, management must create a positive attitude amongst the staff and customers towards safety procedures. A system of periodic inspection and assessment should be implemented to control and eliminate these unsafe acts and conditions.

Near Miss

A 'near miss' is any incident, accident or emergency which did not result in an injury. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) have a specific definition of a "dangerous occurrence". These are reportable in the same way as reportable accidents are.

Recording non-reportable near misses is *not* a statutory requirement but doing so and using the information provided is good safety management practice as reviewing the report (at the time and/or periodically) may help to prevent a re-occurrence. Recording these near misses can also help identify any weaknesses in operational procedures as deviations from normal good practice may only happen infrequently but could have potentially high consequences. A review of near misses over time may reveal patterns from which lessons can be learned.

Where a review of near miss information reveals that changes to ways of operating, risk assessments or safety management arrangements are needed, these changes should be put into effect.

Accident, Incident and Near Miss Investigation Form

Note: **Must** be completed by the manager/supervisor

Incident report No:

1. Incident Details

Name of injured person (if relevant):

Your site/operation:

Date of incident:

Time of incident:

Type of incident (tick the box applicable)

Date form completed:

Fatality	RIDDOR major injury	RIDDOR more than 3 day injury	RIDDOR dangerous occurrence	RIDDOR disease	Minor Injury	Non-RIDDOR dangerous occurrence	Near miss
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If the incident is RIDDOR reportable, has the HSE been informed (HSE contact details below)?

Yes/No

If the incident is a fatality or major injury, has the HSE been informed by telephone?

Yes/No

If the incident is RIDDOR reportable, has Safety Department been contacted by telephone?

Yes/No

RIDDOR can be reported to the HSE by telephone on 0845 300 9924 or on www.riddor.gov.uk

Date HSE informed of incident

Date Safety Advisor informed

Nature of Disease/Injury (Describe)

Lost time (days)

From

To

First aid treatment given:

Yes/No

Treatment given by (name)

2. About the incident

Where on Site did the incident occur (Give full address)

Were there any witnesses If so give names and contact details

What happened (please be factual and do not speculate):

Name:

Signature

In your Opinion what was the cause of the accident?

3. Confirmation of details on incident report form

Do you agree with the fact of the incident as stated in the accident report form?

Yes/No

Do you agree with the cause of the incident as stated in the accident report form?

Yes/No

If you do not agree with the facts or cause as stated in section 4 of the accident report form, please state why below:

4. Incident investigation outline details

Please answer the below questions as applicable to the incident (note if no injury – i.e., a dangerous occurrence or near-miss – answer below for the incident):

Did the incident occur while the injured person was doing a task they were authorised to do?

Yes/No/NA

Was the injured person carrying out the task they were doing correctly?

Yes/No/NA

If the injured person was not authorised/not carrying-out the task correctly have they been disciplined?

Yes/No/NA

Does a risk assessment exist for the task?

Yes/No/NA

Does the risk assessment cover the hazard/s and risk/s associated with the task adequately?

Yes/No/NA

Had the injured person been inducted on the risk assessment?

Yes/No/NA

Had induction/training been recorded and is the record document available?

Yes/No/NA

Does a company standard and/or local operation procedure exist for the task?

Yes/No/NA

Does the company standard/operating procedures cover the task adequately?

Yes/No/NA

Had the injured person been inducted on the company standard/operating procedure?

Yes/No/NA

Had induction/training been recorded and is the record document available?

Yes/No/NA

If a hazardous substance was involved does a COSHH or similar assessment exist?

Yes/No/NA

Had the injured person been inducted on the COSHH assessment?

Yes/No/NA

Had induction/training been recorded and is the record document available?

Yes/No/NA

Is there a PPE issue (and if relevant maintenance) record?

Yes/No/NA

Was the required PPE for the task being worn by the injured person?

Yes/No/NA

If equipment (of any type, plant, vehicles etc) was involved do maintenance, daily check etc records exist?

Yes/No/NA

Please attach copies of risk assessment, training records and safe working systems.

If you have answered NO to any of the relevant questions above, please comment on why below

5. Manager's comments, previous incidents and remedial actions

If a similar incident has occurred at the site/operation previously, please comment below on why the remedial actions carried-out as part of the investigation into the previous incident/s were not effective:

Please give below a synopsis of the remedial actions you intend to pursue to prevent a reoccurrence, including any comments (please not that significant actions need to be included on your improvement programme):

Please note that any risk assessment and/or operating procedures etc as identified in section 3 above which need reviewing and/or writing need to be in place within 28 days of the incident.

Signed
(manager):

Manager's name
(block capitals
please):

Date: