



**EAST RIDING**  
OF YORKSHIRE COUNCIL

## **Accident/Incident Investigation Safety Guidance Document**

<b>Lead Directorate and Service:</b>	Corporate Resources - Human Resources, Safety Services.
<b>Effective Date:</b>	April 2012
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<b>Approved by:</b>	CMT 26 <sup>th</sup> March 2012 - Minute 13988

## **1. Background**

This safety guidance document provides information on how to investigate and report accidents and incidents, including those of violent/aggressive nature.

## **2. Foreword**

In accordance with the councils' corporate safety policy, the council is committed to pursuing continual improvements in health and safety. This safety guidance document supports this commitment and forms part of the council's health and safety management system.

## **3. Implementation**

Directorates are responsible for the implementation of this safety guidance document, and communication of its content as appropriate.

This safety guidance document is to be fully implemented by schools and all supporting forms are to be used when reporting accidents/incidents.

This safety guidance document is available on the safety services intranet page and, where employees do not have access to the council's intranet, via their line manager/headteachers.

The council relies on the co-operation of all employees, and trades unions for the successful implementation of this safety guidance document.

A review of this safety guidance document will be undertaken two years after its implementation, and where significant changes in legislation or working practices deem this appropriate.

## **4. Roles and Responsibilities**

### **4.1 Directors and Heads of Service**

Directors and heads of services are ultimately responsible and accountable to the chief executive for ensuring this safety guidance document is issued to their management team.

### **4.2. Managers and Headteachers**

Managers and headteachers are responsible for achieving the objectives of this safety guidance document where relevant to their area of service delivery and are responsible for ensuring that:

- The information contained within this safety guidance document is implemented and complied with;
- Appropriate levels of investigation are completed for all accidents/incidents;
- Accidents/incident report forms are completed and submitted to [accident.reporting@eastriding.gov.uk](mailto:accident.reporting@eastriding.gov.uk);
- Following significant incidents risk assessments are updated and lessons learnt incorporated into safety management systems;
- Employees are provided with information, instruction and training, as appropriate, to enable them to undertake their job safely.

### 4.3. Employees

Employees must ensure they carry out assigned tasks and duties in accordance with information, instruction, training and agreed safe systems of work. Specifically they must ensure:

- They report accidents, incidents and near misses;
- This safety guidance document is complied with;
- They participate in investigations and the completion of accident/incident report forms.

### 4.4 Safety Services

The primary function of safety services is to support the council and its employees by providing professional, authoritative, impartial advice on all aspects of health, safety and wellbeing. Where managers or headteacher's require further assistance, safety services will advise on achieving compliance with this safety guidance document.

### 4.5 Occupational Health

Occupational health are available to provide managers, headteachers and employees with guidance on work related health issues. Further information on the role of occupational health can be found on the council's intranet under arvato services

## 5. Arrangements

### Reporting of accidents

The following documents have been prepared for the purposes of reporting accidents and incidents (including those of violence and aggression) and to facilitate a comprehensive investigation to prevent further recurrence:

**Accident Incident Form (AIF)** is the report form for general incidents, including those of a violent and/or aggressive nature, and all accidents.

**Accident Incident Investigation Form (AIIF)** is an accident/incident information gathering form to assist with a full investigation

**Accident Incident Personal Statement (AIPS)** is the official witness statement form. These can be used to identify what was seen, heard or general conditions of the environment but may be useful to record that the individual was present but saw or heard nothing.

A guidance note on the completion of the Accident Incident Form has also been produced which contains a flowchart, to advise in what circumstances it should be completed.

### **Which accidents and incidents should be investigated?**

Having been notified of an accident/incident and been given basic information on what happened, you must decide how it should be investigated and in what depth.

The level of risk and the likelihood of the incident recurring should determine the level of investigation, not simply the injury or ill health suffered on this occasion.

**When should it start?**

Where practical, accidents/incidents should be investigated and analysed as soon as possible.

**What does it involve?**

An investigation will involve an analysis of all the information available; physical (the scene of the incident); verbal (the accounts of witnesses); and written (risk assessments, procedures, instructions, job guides etc), to identify what went wrong and determine what steps must be taken to prevent the incident from happening again.

It is important to be open, honest and objective throughout the investigation process. Pre-conceived ideas about the process, the equipment or the people involved in an accident/incident may blind you to the real causes.

**The Level of Investigation**

The table below will assist you in determining the level of investigation which is appropriate for the incident.

Likelihood of recurrence of a similar kind of incident (eg lifting and handling, exposure to harmful substance)	The severity of the incident			
	Minor	Serious	Major	Fatal
Certain				
Likely				
Possible				
Unlikely				
Rare				

<p><b>Minimal</b></p>	<p><b>In a minimal level investigation, the relevant supervisor will look into the circumstances of the event and try to learn any lessons, which will prevent future occurrences.</b></p> <p>The BI510 Accident Book (or equivalent) <b>must be</b> completed</p>
<p><b>Low</b></p>	<p><b>A low level investigation will involve a short investigation by the relevant supervisor or line manager into the circumstances and immediate, underlying and root causes of the incident, to try to prevent a recurrence and to learn any general lessons.</b></p> <p>The BI510 Accident Book (or equivalent) and Accident Incident Form <b>must</b> be completed.</p>
<p><b>Medium</b></p>	<p><b>A medium level investigation will involve a more detailed investigation by the relevant supervisor or line manager, the safety officer and union representatives and will look for the immediate, underlying and root causes.</b></p> <p>The BI510 Accident Book (or equivalent) and Accident Incident Form <b>must</b> be completed plus Accident Incident Investigation Form and Accident Incident Personal Statement(s)</p>
<p><b>High</b></p>	<p><b>A high level investigation will involve a team-based investigation, involving supervisors or line managers, health and safety officers and union representatives. It will be carried out under the supervision of Safety Services and will look for the immediate, underlying and root causes.</b></p> <p>The BI510 Accident Book (or equivalent) and Accident Incident Form <b>must</b> be completed plus Accident Incident Investigation Form and Accident Incident Personal Statement(s)</p>

## Investigations

<b>Minimal</b>	In a minimal level investigation, the relevant supervisor will look into the circumstances of the event and try to learn any lessons, which will prevent future occurrences.
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The Accident Book (BI510 or equivalent) **must be** completed. To complete the form you will need to identify what happened and the details of the injury and the other details listed on the form.

Accidents which fall into this category include: a small cut to a finger, a stubbed toe, etc.

Any individual sustaining an injury is responsible for ensuring that details of the incident are recorded in the Accident Book (BI510 or equivalent)

All accidents will require this process to be undertaken. In some cases this will be the only form required, you may also need to complete a small report highlighting your findings.

Accidents sustained by pupils, residents and non-employees should also be recorded in the Accident Book (BI510 or equivalent)) and should be filed according to your individual systems.

<b>Low</b>	<b>A low level investigation will involve a short investigation by the relevant supervisor or line manager into the circumstances and immediate, underlying and root causes of the incident, to try to prevent a recurrence and to learn any general lessons.</b> <b>These types are normally non-reportable accidents</b>
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In addition to the instructions given in the 'minimal' category above, you will also need to complete an Accident Incident Form.

Instruction on how to complete is linked to this document.

<b>Medium</b>	<b>A medium level investigation will involve a more detailed investigation by the relevant line manager or supervisor, the safety officer and union representatives and will look for the immediate, underlying and root causes.</b> <b><u>All HSE reportable accidents/incidents</u></b>
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You must consult safety services prior to undertaking this type of investigation. All accidents and incidents which are reportable to the Health and Safety Executive must be investigated at this level. This will involve the completion of an Accident Incident Form, an Accident Incident Investigation Form and one or more Personal Statement forms. Copies must be available to the Insurance Section should they be required.

In addition to the completion of forms, photographs and drawings etc. may prove useful.

To assist in the investigation, various other documentation must be made available:

- Safe systems of work and risk assessment documentation;
- Induction records;
- Training records;
- Training course content;
- Working manuals.

### **The Full Investigation (Medium and High)**

There are four steps to the full investigation i.e. gathering the information, analysing the information, identifying suitable risk control measures, action plan and implementation.

These set out in detail the information that should be entered onto the Accident Incident Investigation Form.

#### **Step 1 - Gathering the Information**

Find out what happened and what conditions and actions influenced the incident. Begin straight away, or as soon as practicable.

The amount of time and effort spent on information gathering should be proportionate to the level of investigation. Collect all available and relevant information. That includes opinions, experiences, observations, sketches, measurements, photographs, check sheets, permits-to-work and details of the environmental conditions at the time etc. This information can be recorded initially in note form, with a formal report being completed later. These notes should be kept at least until the investigation is completed.

Talk to everyone who was close by when the incident happened. Make a list of all persons in the area when the accident occurred even if they saw or heard nothing.

The following numbered questions appear on the Accident Incident Investigation Form, your answers should contain as much detail as possible (use the guidance as appropriate).

- Where, when and who?
- Where and when did the incident happen?
- Who was injured/suffered ill health or was otherwise involved with the incident?
- Gathering detailed information: How and what?

Be precise and establish the facts as best you can. There may be a lack of information and many uncertainties, but you must keep an open mind and consider everything that might have contributed to the incident.

#### **How did the accident/incident happen? Note any equipment involved.**

Describe the chain of events leading up to, and immediately after, the incident. All the factors should be recorded in chronological order. Work out the chain of events by talking to the injured person, eye witnesses, line managers, health and safety representatives and fellow workers to find out what happened and who did what. In particular, note the position of those injured both immediately before and after the incident. Be objective and, as far as possible, avoid apportioning guilt, assigning responsibility or making snap judgements on the probable causes.

Plant and equipment that had a direct bearing on the incident must be clearly identified. This information can usually be obtained from a nameplate attached to the equipment. Note all the details available, the manufacturer, model type, model number, machine number, year of manufacture and any modifications made to the equipment. Note the position of the machinery controls immediately after the incident. This information may help you to spot trends and identify risk control measures. You should consider approaching the supplier if the same machine has been implicated in a number of accidents/incidents. Be precise, shop floor process and layout changes are a regular occurrence.

Ensure that all items relating to the incident are left in place until such time that instructions from the investigating officer or the HSE Inspector are given to put the area back into use. Cordon off the area as appropriate so as to restrict access.

### **What activities were being carried out at the time?**

The work that was being done just before the incident happened can often cast light on the conditions and circumstances that caused something to go wrong. Provide a good description, including all the relevant details, e.g. the surroundings, the equipment/materials being used, the number of employees engaged in the various activities, the way they were positioned and any details about the way they were behaving etc.

### **Was there anything unusual or different about the working conditions?**

Describe what was new or different in the situation. Learning how people deal with unfamiliar situations will enable similar situations to be better handled in the future.

Was the way the changes, temporary or otherwise, were introduced a factor? Were the workers and supervisors aware that things were different? Were workers and supervisors sufficiently trained/experienced to recognise and adapt to changing circumstances?

### **Were there adequate safe working procedures and were they followed?**

Accidents/incidents often happen when there are no safe working procedures or where procedures are inadequate or are not followed. What was it about normal practice that proved inadequate? Was a safe working method in place and being followed? If not, why not? Was there adequate supervision and were the supervisors themselves sufficiently trained and experienced?

### **What injuries or ill health effects, if any, were caused?**

It is important to note which parts of the body have been injured and the nature of the injury - i.e. bruising, crushing, a burn, a cut, a broken bone etc. Be as precise as you are able. Precise descriptions will enable you to spot trends and take prompt remedial action.

Facts such as whether the injured person was given first aid or taken to hospital (by ambulance, a colleague etc.) should also be recorded here.



### **If there was an injury, how did it occur and what caused it?**

The details of injury is made of two different aspects:

- The object that inflicted the injury; and
- The way in which the injury was actually sustained.

For example:

The object that inflicted the injury may be a hand-held tool like a knife or a chemical, a machine, or a vehicle etc. The way in which it happened might, be that the employee cut themselves or spilt chemicals on their skin.

### **Was the risk known? If so, why wasn't it controlled?**

You need to find out whether the source and its potential consequences were known, and whether this information was communicated.

The existence of a written risk assessment for the process or task that led to the incident will help to reveal what was known of the associated risks. A judgement can be made as to whether the risk assessment was 'suitable and sufficient', as required by law and whether the risk control measures identified as being necessary were ever adequately put into place.

### **Did the organisation and arrangement of the work influence the incident?**

The organisational arrangement sets the framework within which the work is done.

- Standards of supervision or on-site monitoring;
- Lack of skills or knowledge;
- Inappropriate working procedures;
- Lack of planning may mean that some tasks are not done, are done too late or are done in the wrong order.

### **Was maintenance and cleaning sufficient?**

Lack of maintenance and poor housekeeping are common causes of accidents/incidents. You should observe the location of the incident as soon as possible and judge whether the general condition or state of repair of the premises, plant or equipment was adequate. Those working in the area, together with witnesses, and any injured parties, should also be asked for their opinion. Working in the area, they will have a good idea of what is acceptable and whether conditions had deteriorated over time.

### **Were the people involved competent and suitable?**

Training should provide workers with the necessary knowledge, skills and hands-on work experience to carry out their work efficiently and safely. The fact that someone has been doing the same job for a long time does not necessarily mean that they have the necessary skills or experience to do it safely. This is particularly the case when the normal routine is changed, when any lack of understanding can become apparent. There is no substitute for adequate health and safety training. People should also be matched to their work in terms of health, strength, mental ability and physical stature.

### **Did the workplace layout influence the incident?**

The physical layout and surroundings of the workplace can affect health and safety. Injuries may be caused by sharp table edges. Hazardous or highly inflammable fumes may be produced in areas where operatives work or where there are naked lights. The workplace may be organised in such a way that there is not enough circulation space. Or, it may be impossible to see or hear warning signals, e.g. during vehicle movements.

Employees should be able to see the whole of their work area and see what their immediate colleagues are doing. The workplace should be organised in such a way that safe practices are encouraged.

### **Did the nature or shape of the materials influence the incident?**

As well as being intrinsically hazardous, materials can pose a hazard simply by their design, weight, quality or packaging, e.g. heavy and awkward materials, materials with sharp edges, splinters, poisonous chemicals etc.

The choice of materials also influences work processes, e.g. a particularly hazardous material may be required. Poor quality may also result in materials or equipment failing during normal processing, causing malfunctions and accidents.

### **Did difficulties using the plant and equipment influence the incident?**

Plant and equipment includes all the machinery, plant and tools used to organise and carry out the work. All of these items should be designed to suit the people using them. This is referred to as ergonomic design, where the focus is on the individual as well as the work task the item is specifically designed to carry out. If the equipment meets the needs of the individual user, it is more likely to be used as it is intended - i.e. safely. Consider user instructions here. A machine that requires its operator to follow a complicated user manual is a source of risk in itself.

### **Was the safety equipment sufficient?**

You should satisfy yourself that any safety equipment and safety procedures are both sufficient and current for all conditions in which work takes place, including the provision and use of any extra equipment needed for employees' safety. For example:

- Extra technical safety equipment at machines;
- Power supply isolation equipment and procedures;
- Personal protective equipment (PPE);
- Building safety systems, e.g. an extract ventilation system.

Make a note of whether the safety equipment was used, whether it was used correctly, whether or not it was in good condition and was working properly etc.

### **Did other conditions influence the incident?**

'Other conditions' is intended to cover everything else that has not been reported yet, but which might have influenced the incident. For example:

- Disagreements or misunderstandings between people;
- The weather;
- Unauthorised interference in a process or job task;

- Defective supplies or equipment;
- Deliberate acts, such as trespass or sabotage.

## **Step 2 - Analysing the Information**

An analysis involves examining all the facts, determining what happened and why. All the detailed information gathered should be assembled and examined to identify what information is relevant and what information is missing. The information gathering and analysis are actually carried out side by side. As the analysis progresses, further lines of enquiry requiring additional information will develop.

To be thorough and free from bias, the analysis must be carried out in a systematic way, so all the possible causes and consequences of the incident are fully considered. A number of formal methods have been developed to aid this approach.

### **What were the immediate, underlying and root causes?**

It is only by identifying all causes, and the root causes in particular, that you can learn from past failures and prevent future repetitions.

The causes of accidents/incidents often relate to one another in a complex way, sometimes only influencing events and at other times having an overwhelming impact, due to their timing or the way they interact. The analysis must consider all possible causes. Keep an open mind. Do not reject a possible cause until you have given it serious consideration. The emphasis is on a thorough, systematic and objective look at the evidence.

### **What if ‘human failings’ (errors and violations) are identified as a contributory factor?**

If your investigation concludes that errors or violations contributed to the incident, consider carefully how to handle this information.

Not addressing the ‘human’ factors greatly reduces the value of the investigation. The objective of an investigation is to learn the lessons and to act to prevent recurrences through suitable risk control measures.

## **Step 3 - Identifying Suitable Risk Control Measures**

A methodical approach adopted in the analysis stage will enable failings and possible solutions to be identified. These solutions need to be systematically evaluated and only the optimum solution(s) should be considered for implementation. If several risk control measures are identified, they should be carefully prioritised as a risk control action plan, which sets out what needs to be done, when and by whom. Assign responsibility for this to ensure the timetable for implementation is monitored.

### **What risk control measures are needed/recommended?**

Your analysis of the incident will have identified a number of risk control measures that either failed or that could have interrupted the chain of events leading to the incident, if they had been in place. You should now draw up a list of all the alternative measures to prevent this, or similar, accidents/incidents.

Some of these measures will be more difficult to implement than others.

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

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

- Measures which eliminate the risk, e.g. use 'inherently safe' products, such as a water-based product rather than a hydrocarbon-based solvent;
- Measures which combat the risk at source, e.g. provision of guarding;
- Measures which minimise the risk by relying on human behaviour, e.g. safe working procedures, the use of personal protective equipment.

In general terms, measures that rely on engineering risk control measures are more reliable than those that rely on people.

### **Do similar risks exist elsewhere? If so, what and where?**

Having concluded your investigation of the incident, consider the wider implications. Accidents/incidents might not have occurred at other locations yet, but make an evaluation as to whether the risks are the same and the same or similar risk control measures are appropriate.

Develop an action plan to introduce similar controls for other locations.

### **Have similar accidents/incidents happened before? Give details.**

If there have been similar accidents/incidents in the past why have they been allowed to happen again? The fact that such accidents/incidents are still occurring should be a spur to ensure that action is taken quickly.

Remember that there is value in investigating near misses and undesired circumstances: it is often only a matter of luck that such accidents/incidents do not result in serious injuries or loss of life.

## **Step 4 - The Action Plan and its Implementation**

### **Which risk control measures should be implemented in the short and long term?**

#### **The risk control action plan**

An action plan for the implementation of additional risk control measures is the desired outcome of a thorough investigation. The action plan should have SMART objectives, i.e. specific, measurable, agreed, and realistic, with timescales.

Not every risk control measure will be implemented, but the ones accorded the highest priority should be implemented immediately. In deciding your priorities you should be guided by the magnitude of the risk ('risk' is the likelihood and severity of harm). Ask yourself 'what is essential to securing the health and safety of the workforce today?' What cannot be left until another day? How high is the risk to employees if this risk control measure is not implemented immediately? If the risk is high, you should act immediately.

For those risks that are not high and immediate, the risk control measures should be put into your action plan in order of priority. Each risk control measure should be assigned a timescale and a person made responsible for its implementation.

It is crucial that a specific person, preferably a director or senior manager, is made responsible for ensuring that the action plan as a whole is put into effect. This person doesn't necessarily have to do the work themselves but they should monitor the progress of the risk control action plan.

Progress on the action plan should be regularly reviewed.

**Which safe working procedures and risk assessments need to be reviewed and updated?**

All relevant safe working procedures and risk assessments should be reviewed after a significant accident/incident. The findings of your investigation should indicate areas of your safe working procedures and risk assessments that need improving.

<b>High</b>	<b>A high level investigation will involve a team-based investigation, involving senior managers, line managers or supervisors, health and safety officers and union representatives. It will be carried out under the supervision of Safety Services and will look for the immediate, underlying and root causes.</b>
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This will include all the other sections and will be lead by a nominated safety officer. You will be notified of your role within this investigation. The process will mirror that of a full investigation for a medium accident but the level of supporting evidence and statements will be subject to deeper analysis potentially utilising specialist support.