Incident investigation

Guidelines for managers and supervisors

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

health safety
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Incident investigation: guidelines for managers and supervisors

Contents

1. Introduction

1.1 This guidance document provides managers and supervisors with information on investigating incidents.

1.2 The primary purpose of the incident investigation is to learn the facts of the incident to help prevent a recurrence. It is not about apportioning blame.

2. Definitions

2.1 **Incident**

Work-related event in which an injury, ill health or fatality occurred or could have occurred.

2.2 **Accident**

An accident is a type of incident. It is a work-related event during which injury, ill health or fatality actually occurs.

2.3 **Near miss**

A type of incident in which injury, ill health or fatality could have occurred, but did not actually occur.

2.4 **Undesired circumstance**

A set of conditions or circumstances that have the potential to cause injury or ill health.

2.5 **Dangerous occurrence**

One of several specific, reportable adverse events, as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

3. Why investigate?

3.1 **Legal**

3.1.1 The Council must ensure that it complies with its legal duties.

3.1.2 The Management of Health and Safety at Work Regulations 1999 requires employers to plan, organise, control, monitor and review their health and safety arrangements. Incident investigations form an essential part of this process.

3.2 **Moral**

3.2.1 To gain an understanding of how and why things went wrong.

3.2.2 To prevent a recurrence.

3.2.3 To identify any deficiencies in your risk control management, which will enable you to improve your management of risk in the future.

3.3 **Economic**

3.3.1 To prevent business losses due to disruption, stoppage, absence and the costs of criminal and civil legal actions.

4. Causation factors

4.1 Immediate causes

4.1.1 The most obvious reason an incident happens e.g. the guard is missing; the employee slipped etc.

4.2 Underlying causes

4.2.1 The less obvious system or organisational reason an incident occurred, e.g. pre-start up machinery checks not carried out; the hazard has not been adequately considered in the risk assessment; work pressures are too great etc.

4.3 Root causes

4.3.1 An initiating event or failing from which all other causes or failings spring. Root causes are generally management, planning or organisational failings.

5. Incident reporting

5.1 All work-related accidents, near misses and ill health should be reported using the appropriate form on the *my*HS Portal.

5.2 Line managers should ensure that any work-related incidents reported to them are recorded on the SHE Portal within two working days.

5.3 Further information on incident reporting can be found in Incident reporting - guidelines for managers and employees.

6. The investigation

6.1 Who should investigate?

6.1.1 The Corporate Health and Safety Team investigate all HSE notifiable incidents and produce a report outlining findings and recommendations. They are also available to offer support for other incident investigations.

6.1.2 Managers are responsible for ensuring that other incidents are investigated and should provide feedback to the employee on any action that has been, or will be, taken.

6.1.3 The investigation report template can be used by managers to investigate non-notifiable incidents.

6.2 Gathering the information

6.2.1 Find out what happened and what conditions and actions influenced the incident. Start the investigation straight away, or as soon as you can.

6.2.2 Talk to everyone who was close by when the incident happened, especially those who saw what happened or know anything about the conditions that led to it.

6.2.3 Take witness statements from those who saw the incident take place. Witness statements must be signed by the witness on every page.

6.2.4 The amount of time and effort spent on information gathering should be proportionate to the level of investigation. Collect all available and relevant information. This includes opinions, experiences, observations, sketches, measurements, photographs, check sheets, permits to work and details of environmental conditions at the time etc. Review CCTV footage if available.

6.2.5 This information can be gathered in note form initially with a formal report completed later.

6.3 Consider the where, when, who, how and what?

6.3.1 Where and when did the incident happen?

6.3.2 Who was injured/suffered ill health or was otherwise involved with the adverse event?

6.3.3 How did the incident happen? Note any equipment involved.

6.3.4 Was the staff member wearing the appropriate personal protective equipment (PPE), if required?

6.3.5 What activities were being carried out at the time?

6.3.6 Was there anything unusual or different about working conditions?

6.3.7 Were there adequate safe working procedures in place and were they followed?

6.3.8 Were there suitable and sufficient risk assessments in place?

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

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

6.3.11 Was the risk known? If so, why wasn't it controlled? If not, why not?

6.3.12 Did the organisation and arrangement of the work influence the incident?

6.3.13 Was maintenance and cleaning sufficient? If not, explain why not.

6.3.14 Were the people involved competent and suitable? Did they have the necessary skills, experience and training required to carry out the work activity?

6.3.15 Did the workplace layout influence the incident?

6.3.16 Did the nature or shape of the materials influence the incident?

6.3.17 Was the safety equipment sufficient?

6.3.18 If the incident occurred outside, what were the weather conditions?

6.3.19 Did other conditions influence the incident?

6.4 Analysing the information

6.4.1 Examine all the facts to establish exactly what happened and why.

6.4.2 All the information gathered should be reviewed to identify what information is relevant and what information is missing.

6.4.3 The analysis should be carried out in a systematic way to ensure that all possible causes and consequences of the incident are fully considered.

6.4.4 Identify what the immediate, underlying and root causes of the incident were.

6.4.5 To understand what happened and why, ask the question 'why?' over and over again e.g.

There was a fire in the kitchen

Why? The oil in the deep fat fryer overheated to its auto-ignition temperature.

Why? The fryer was left unattended and the thermostat failed to function.

Why? The kitchen was short staffed and the thermostat was faulty.

Why? The kitchen staff have high levels of stress and the thermostat was not repaired despite being reported as faulty.

Why? Understaffing of the kitchen is routinely done to cut costs. There is a drive to save money. There is no planned preventative maintenance programme. Managers did not believe it was a critical issue.

6.4.6 When you have collected the relevant information, and determined what happened and why, you can then identify the causes of the incident.

6.4.7 If human error is identified as a contributory factor, these can be divided into 3 broad types:

- Skill-based errors (a slip or lapse of memory)
- Mistakes: errors of judgement (rule-based or knowledge-based)
- Violation (rule breaking)

6.4.8 When considering how to avoid human failings, bear in mind that they do not happen in isolation. Consider the following factors that can influence human behaviour:

- Job factors (how much attention is needed for the task; divided attention or distractions are present; inadequate procedures; time available).
- Human factors (physical ability (size and strength); competence (knowledge, skill and experience); fatigue, stress, morale, alcohol or drugs).
- Organisational factors (work pressure, long hours; availability of sufficient resources; quality of supervision; management believes in health and safety).
- Plant and equipment factors (how clear and simple are controls to read and understand? Is the equipment designed to detect or prevent errors? Is the workplace layout user friendly?)

6.5 Identifying suitable risk control measures

6.5.1 The analysis of the information gathered will identify what risk control measures were missing, inadequate or misused.

6.5.2 When deciding which risk control measures to recommend, each one should be evaluated based on their ability to prevent recurrences and if they can be successfully implemented.

6.5.3 Where possible, risk control measures should be prioritised in the following order:

- Measures which eliminate the risk e.g. using inherently safe products.
- 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, PPE.

6.5.4 Measures that rely on engineering risk control measures are generally more reliable than those that rely on people.

6.5.5 Having concluded your investigation, consideration should be given to whether or not a similar incident could occur at a different location. If similar risks are identified, you may wish to consider implementing the risk control measures identified as these locations.

6.6 Implementing the action plan

6.6.1 Senior managers who have the authority to make decisions and act on the recommendations should be involved.

6.6.2 The action plan should have SMART objectives.

Specific – ensure the action plan is specific enough to understand whether or not it has been achieved.

Measurable – setting criteria and specific goals will allow you to measure how effective your plan has been.

Agreed – the goals set in your action plan should be as a result of a team discussion that has been thoroughly considered.

Realistic – setting unachievable goals will not only set you up for failure, but negate the usefulness of the action plan entirely.

Timescale – ensuring you have timescales for specific actions will allow you to track progress and measure results.

6.6.3 Not every risk control measure will be implemented, however, the ones with the highest priority should be implemented immediately.

6.6.4 For those risks that are not high or immediate, the risk controls measures should be put into your action plan in order of priority.

6.6.5 Assign a named person and timescale to each control measure.

6.6.6 Review progress regularly.

6.6.7 All relevant risk assessments and safe working procedures should be reviewed and updated following an incident.