Footwear, Leather, Textile and Clothing Industries

Health & Safety Committee

Investigating Accidents and Incidents

A guide for the Footwear, Leather, Textile and Clothing Industries.

FLTC-HSC GN/2/April15

Introduction

Recent figures show that an average of 170 employees and self-employed people are killed each year as a result of accidents in the workplace. Tens of thousands sustain major injury or injuries that mean they are absent from work for more than three days and millions of cases of ill - health are caused or made worse by work.

According to the Labour Force Survey millions of working days are lost through work –related injuries and ill health, at a cost to business of billions of pounds.

Clearly, there are good financial reasons for reducing accidents and ill health. However, learning the lessons from what you uncover is at the heart of preventing accidents and incidents. Carrying out your own investigations will provide you with a deeper understanding of the risks associated with your work activities.

Well thought – out risk control measures, combined with adequate supervision, monitoring and effective management will ensure that your work activities are safe.

This guide will help you to adopt a systematic approach to determining why an accident or incident has occurred and the steps you need to take to make sure it doesn't happen again.

What the law requires

Apart from the duty to take reasonable steps to investigate accidents recorded under the Social Security (claims and payments) Regs there is no specific duty on employers to investigate injuries, diseases or near misses, although this is one of the statutory safety reps functions.

Instead of legislation, in 2004 the HSE produced a guidance document 'investigating accidents and incidents' (**HSG 245)**

Social Security (claims and payments) Regulations 1979(regs 24 and 25)

Regulation 24 – requires any employed worker to give their employer notice of any personal injury caused by an accident. The notice can be given orally or in writing. Schedule 4 to the Regulations sets out what information must be recorded e.g. name, address, occupation, date and time of accident, place of accident and the cause and nature of the injury.

Regulation 25 – requires the employer to make any book or electronic recording system readily accessible in the workplace to enable injured workers, or someone acting on their behalf, to record an injury. It requires the record to be kept for a minimum of 3 years. The employer is required to take reasonable steps to investigate the circumstances of every accident of which notice has been given, and if any discrepancies are found, they too should be recorded.

The Management of Health and Safety at Work Regs , Reg 5 requires employers to plan, organise, control, monitor and review their Health and Safety arrangements. Health and Safety investigations form and essential part of this process.

Why Investigate?

There are hazards in all workplaces; risk control measures are put in place to reduce risks to an acceptable level to prevent accidents and cases of ill- health. You need to investigate adverse events for a number of reasons in addition to what the law requires, these include;

Information and insights gained from an investigation;

A true snapshot of what really happens and how work is really done (workers may find short cuts to make their work easier or quicker and may ignore rules .You need to be aware of this.

Identifying deficiencies in your risk control management, which will enable you to improve your management of risk in the future and to learn lessons which will be applicable to other parts of your organisation.

Benefits arising from an investigation

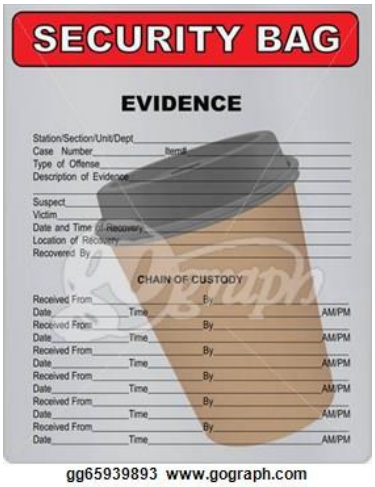
An improvement in employee morale and attitude towards health and safety. Employees will be more co-operative in implementing new safety precautions if they were involved in the decision and they can see that problems are dealt with.

The prevention of business losses due to disruption, stoppage, lost orders and the costs of criminal and civil legal actions

The development of managerial skills which can be readily applied to other areas of the organisation.

What makes a good investigation?

It is only by carrying out investigations which identify root causes that organisations can learn from their past failures and prevent future failures.



Investigations should be conducted with accident prevention in mind, not placing blame. Attempting to apportion blame before the investigation has started is counterproductive, because people become defensive and un-cooperative. Only after the investigation has been completed is it appropriate to consider whether individuals acted inappropriately.

The objective is to establish not only how the adverse event happened, but more importantly, what it allowed to happen.

The investigation should be thorough and structured to avoid bias and leaping to conclusions. Don't assume you know the answer and start finding solutions before you complete the investigation. A good investigation involves a systematic and structured approach.

A step by step guide to health and safety investigations

Steps to take following an adverse event;
(Summary from ISBN 0 7176 2827 2)

Emergency response;

Take prompt emergency action (e.g. first aid)

It is important to have emergency plans in place for recognised potential hazards.

Make the area safe

Who should carry out the investigation?

For the 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, the "responsible person," health and safety professionals and union safety representatives should be involved.

It is essential that the investigation team is either led by, or reports directly to someone with authority to make decisions and act on their recommendations

When should it start?

In general, adverse events should be investigated and analysed as soon as possible. This is not simply good practice; it is common sense – memory is best and motivation greatest immediately after an adverse event.

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 adverse event from happening again

Initial report

Preserve the scene; take photographs!

Note the names of the people, equipment involved and the names of witnesses

Report the adverse event to the person responsible for health and safety who will decide what further action (if any) is needed.

Initial assessment and investigation

Report the adverse event to the regulatory authority if appropriate e.g. via the HSE website www.hse.gov.uk

The four steps include a series of numbered questions. These set out in detail the information that should be entered onto the adverse event investigation form

Step one - Gathering the Information

Explores all reasonable lines of enquiry, is timely and is structured, setting out clearly what is known, what is not known and records the investigative process.

Step Two - Analysing the Information

Identifies the sequence of events and conditions that led up to the adverse event

Identifies underlying causes i.e. actions in the past that have allowed or caused undetected unsafe conditions/practices

Identifies root causes (i.e. organisational and management health and safety arrangements – supervision, monitoring, training, resources allocated to Health and Safety etc.)

Step Three – Identifying suitable risk control measures

Identify the risk control measures which were missing, inadequate or unused

Compare conditions/practices as they were with that required by current legal requirements, codes of practice and guidance

Identify additional measures needed to address the immediate, underlying and root causes

Provide meaningful recommendations which can be implemented.

Step Four – the action plan and its implementation

Provide an action plan with SMART objectives (specific, measurable, agreed, realistic and timescaled)

Ensure that an action plan deals effectively not only with the immediate and underlying causes but also the root causes

Include lessons that may be applied to prevent other adverse events e.g. assessments of skill and training in competencies

Provide feedback to all parties involved ensuring the findings and recommendations are correct, address the issues and are realistic

Should be fed back into a review of the risk assessment

Communicate the results of the investigation and the action plan to everyone who needs to know.

Note; These last 3 steps, though essential are often overlooked but without them, the full benefits of the investigation will not be realised and in the long term nothing will change.

IMPORTANT; the four steps include a series of questions. These set out in detail the information that should be entered onto the adverse event investigation form.

POSSIBLE QUESTIONS FOR ACCIDENT INVESTIGATION

Finding out what happened

Initial questions

who was injured/affected?
what happened?
where?
when? date and time
was the incident:
ill health?
near miss?
accident? and was this a minor injury, serious injury, major injury?

RIDDOR reportable?
what injuries or ill health effects?
how did it happen?
what equipment involved?
what activity taking place?
emergency measures taken?
reported by?

Finding the cause

Immediate causes - problems with the place, plant/equipment, process, people

Underlying causes - problems with control, co-operation, communication, competence, design, implementation, risk assessment

Questions to identify immediate causes

Place or premises where incident happened

If there was anything about the condition of the workplace that contributed to the incident, use the following questions as a start. These may also suggest other areas to consider.

Were the access and egress adequate?
Were the access and egress points being used?
Was the workplace suitable for the task in hand?
Was there sufficient space for the task in hand?
Was the workplace being used as intended?
Were people segregated from hazardous areas/processes/machinery?
Was the work environment (lighting, temperature and ventilation) suitable?

Did the ergonomics of the workstation suit the person using it?
Was the work area clean and tidy? (Routine cleaning programme and dealing with spills.)
Were weather conditions a factor?
Were the noise levels within acceptable levels?
Were the appropriate warning signs in place?
Were contractors provided with adequate information on access/egress and the hazards within the premises?

Plant, equipment and substances (used or generated)

If there was anything about the plant, equipment and substances (used or generated) that contributed to the adverse event, use the following questions as a start. These may also suggest other areas to consider.

Were the most suitable plant and equipment available for the job?
Were the plant and equipment used suitable for the person using them?
Were the plant and equipment used suitable for the job?
Had the plant and equipment been chosen, or modified, so that its health and safety efficiency could not be improved?
Were plant and equipment in working order and adequately maintained?
Was there a routine maintenance programme? Was there a procedure for repair when a defect was discovered?
Were the plant and equipment being properly used?
Were there adequate controls or guards for the safe use of the equipment?
Were the controls or guards fitted, maintained and properly used?
Were the controls well laid out and easy to understand?
Were the most suitable materials or substances available for the job?
Were the correct materials being used?
Were the materials as specified?
Were the materials or substances used suitable for the job and person?
Were the materials or substances being properly used?
Was exposure to hazardous materials and by-products adequately controlled?
If the need for personal protective equipment (PPE) had not been identified, was it safe to do the job without PPE?
If necessary, was suitable PPE available?
If necessary, was the correct PPE used?
If the correct PPE was used, was it used correctly?

	Process and procedures If there was anything about the procedures, instructions or information (or the lack of them), that contributed to the incident, use the following questions as a start. These may also suggest other areas to consider. Were there safe working procedures and instructions for the tasks under consideration? If there were safe working procedures and instructions, were they up to date? If there were safe working procedures and instructions, were they realistic, accurate and adequate? If there were safe working procedures and instructions, did they deal with the circumstances of the adverse event? If there were safe working procedures and instructions, were the correct ones followed? If there were safe working procedures and instructions, were they provided or readily available to those carrying out the work? Including contractors? If there were safe working procedures, were they policed? Was the level of supervision adequate? Including for contractors? Were the training needs for this activity identified? If there were safe working procedures and instructions, were they used as part of training? Were contractors working in accordance with agreed method statements and safe systems of work? Were contractors informed of the safe working procedures they should adopt? ***People*** If there was anything about the people involved that contributed to the incident, use the following questions as a start. These may also suggest other areas to consider. Were the people involved suited for their job? physically and emotionally (young people need special consideration)? competence (skilled, knowledgeable and experienced)? Was the health of people who could be affected monitored? Were the people performing their work as expected? Were workers employed by contractors suitable and competent? Was the event free of human failings? Was it a mistake? If it was a mistake consider :

	Was it a slip or lapse caused by: fatigue – not enough rest breaks, working excessive hours, already tired? boredom or lack of motivation? being distracted? being preoccupied, eg angry or excited? being under too much pressure, ie too much or too many things to do? too little time? taking substances, such as alcohol, medicines or drugs? Was it a violation, ie breaking the rules or taking short cuts? Was it based on the belief that the rules are too restrictive and are not enforced anyway? More detailed information can be found in the HSE publication HSE publication, *Investigating accidents and incidents* (HSG 245), http://www.hse.gov.uk/pubns/hsg245.pdf.

	Information, instruction and training Information should be given in a way that the employee can be expected to understand (for example it might be necessary to make special arrangements if the employee does not have English as their first language or has difficulty with reading) ***TU Safety Reps and employees;*** Consulting with Trades Union appointed safety representatives (see Safety Representatives and Safety Committees Regulations 1977) or other employee representatives (see Health and Safety Consultation (with employees) Regulations is a legal requirement. ***Role and functions of TU Safety Representatives;*** Safety Representatives are not restricted to inspections and involvement in the risk assessment process. Under the SRSC Regs (above), Safety Representatives can investigate; • Potential hazards • Dangerous occurrences • Causes of accidents and occupational health • Complaints from their members Under the Health and Safety at Work Act 1974 (sect 28(8)) reps are also entitled to receive information from inspectors. Working jointly with TU Safety Representatives and employees representatives is a very useful means of communicating on Health and Safety matters in the workplace. Remember; involving employees in decisions can help foster closer working relationships and make employees more receptive to new ideas. **Further Information** http://www.hse.gov.uk/toolbox/managing/reporting.htm http://www.hse.gov.uk/workers/faqs.htm http://www.hse.gov.uk/riddor/reportable-incidents.htm

ANNEX -The Accident Book

Introduction

All firms with more than 10 employees are required to keep a record of accidents. This is a requirement of the Social Security (Claims and Payments) Regulations 1979. Previous legislation requiring certain other firms to keep an accident book remains in force. Other organisations may also require the collection and retention of information about accidents e.g. The Care Quality Commission formally the Commission for Social Care Inspection.

The current version of the Accident Book came into use in 2004 in order to meet the requirements of the Data Protection Act 1998. The booklet is designed so that an individual making an entry is unable to access details of previous entries. This is achieved by using a stapled/perforated format.

Each individual report can be removed once completed and stored separately.

Accident Recording and Analysis

The recording of accidents is a vital activity for all employers.

It is good practice to monitor the number and type of accidents that are recorded.
The number and pattern of accidents will provide an indication of what circumstances/activity or equipment is causing accidents and indicates whether risks are being adequately controlled.
An increase in eye injuries in a workshop environment may indicate that the rules regarding the wearing of eye protection are not being followed. Alternatively it might be that the right type of eye protection is not being provided.
An increase in back injuries might be indicative of a need for manual handling training or retraining, that goods have started to arrive in larger or heavier sizes or that mechanical handling equipment is defective or broken.

Alternative Recording Approaches

It is possible to replace the BI 510 Accident Book with an alternative recording system such as one's own computer systems. However, alternative systems must, as a minimum, contain the same information as the BI 510 although they can include additional data. For example a firm might wish to record information unique to its own premises or manufacturing procedures such as the building where the accident occurred or the process being carried out

Any alternative approach must comply with the Data Protection Act.

As a minimum the following must be recorded:

- Full name, address and occupation of the injured person
- Date and time of the accident
- Location of the accident
- Nature of the injury and how it was caused

Storage and Retention Procedures

The traditional practice of placing a copy of the Accident Book in the First Aid room or a suitable location near to the shop floor is no longer acceptable. Employers must establish a system for the control of accident reports in order to achieve confidentiality requirements. After a report has been completed it should be removed from the Accident Book and handed to a suitable nominated person for filing in a safe and secure place.

Accident Investigation

The examples above indicate that reporting of accidents is an important first step - but it must be accompanied by investigation in order to determine the true, underlying cause in order that suitable controls can be developed and implemented.

The report of an accident investigation should include:

- Description of events
- Cause(s) of accidents
- Any immediate actions taken to prevent a recurrence
- Any training issues or requirements that have been identified
- Photographs, drawings etc
- Witness statements
- Conclusions and any recommendations for long term/permanent controls

RIDDOR

Certain types of injury have to be reported to the enforcing authorities - the HSE or the Local Authority. The types of injury are set out in the Reporting of Injuries and Dangerous Occurrences Regulations 1995 as amended in 2013.

Key Action Steps

- Purchase copies of the Accident Book (or develop an equivalent in-house system)
- Ensure that there are suitable arrangements, policies and procedures for the reporting of all accidents
- Draw up and implement a suitable procedure for managing accident reports
- Nominate suitable individual(s) who will receive accident reports for secure storage
- Monitor accidents to spot trends
- Investigate accidents to determine the underlying cause
- Frame and implement suitable controls to prevent reoccurrence
- Ensure compliance with RIDDOR

References

The Accident Book Cost: Available from HSE Books and booksellers

RIDDOR reporting website: www.riddor.gov.uk

Guidance Document

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This document will be available on the following websites:

British Footwear Association – **www.britishfootwearassociation.co.uk**
UK Leather Federation – **www.ukleather.org**
Community – **www.community-tu.org**