CONTENTS **Page**

1.0 INTRODUCTION 1
2.0 REQUIREMENT FOR ACCIDENTS / INCIDENTS OR NEAR MISS TO BE INVESTIGATED 2
3.0 INVESTIGATION ARRANGEMENTS 2
4.0 INVESTIGATION PROCEDURES 3
5.0 WITNESSES 4
6.0 ACTION PLAN 5
7.0 INFORMING OTHERS 5
8.0 INCLUSION IN MONTHLY SLT'S AND HEALTH AND SAFETY MEETINGS 6
9.0 MONITORING AUDIT AND REVIEW 6

1.0 INTRODUCTION

Accidents / Incidents and near miss events can be indications that the arrangements which are in place to control risk have been ineffective. According to the Health and Safety Executive (HSE) at least 70% of accidents are preventable by management actions and that accidents and near miss are opportunities to learn from mistakes. These lessons cannot be learned unless the investigations take place and are thorough, fully exploring the cause and harm. In the case of a near miss event the cause and potential harm of the event.

The management of Health and Safety at Work Regulations 1999, Regulation 5 requires employers to plan, organise, control, monitor & review their health & safety arrangements. Reporting and investigating form an essential part of this process.

There are other very good reasons for effective and thorough investigation, which include:

- Moral obligation.
- Report to Enforcing Authority.
- Damage to plant and equipment.
- Loss of Working Time and Financial Impact; and
- Insurance Obligations.

The organisation requires accident, incident, and near miss or identified hazards information in order to be pro – active in improving health and safety rather than merely reactive, to help reduce the likelihood of injury to persons involved with our business, especially the people we support for whom we have an extra duty of care.

Reasons for Investigating of Accidents / Incidents and Near Miss events include:

- Determine the causes of the occurrence.
- Ensure that any preventative measures taken are adequate to prevent a recurrence and to secure compliance with the law.
- Determine whether any specific breaches of legislation have occurred.
- Increase the knowledge and awareness of the employer/employee; and
- Determine whether lessons can be learnt – Policy review, training requirements etc.

This procedure is applicable to all members of staff, contractors and visitors involved in or witness to an accident, incident or near miss.

Implementation: It is the responsibility of line managers to ensure that staff members are aware of and understand this procedure and guidance and any subsequent revisions.

2.0 REQUIREMENT FOR ACCIDENTS / INCIDENTS OR NEAR MISS TO BE INVESTIGATED

The organisation requires that all accidents / incidents or near miss are investigated, however, the depth of investigation will be influenced by the following factors:

- The type of incident - fall from height, chemical handling, machinery - including vehicles.
- The form and severity of the injury, or the potential for severe injury or damage.
- Whether the accident indicates the continuation of a particular trend in accident experience.
- The extent or involvement of machinery, plant or dangerous substance.
- The possibility of a breach of law.
- Whether accident is RIDDOR reportable; and
- Whether there are likely to be claims against insurance policies.

The My Compliance system is in place for the recording and investigation of all incidents. Investigation records are an integral part of this system.

3.0 INVESTIGATION ARRANGEMENTS

All accidents, incidents and near misses are required to be reported / recorded through the agreed reporting mechanisms (My Compliance) but a decision needs to be made on the level of investigation that needs to be carried out.

Clearly all serious occurrences need a more thorough investigation, which would include looking at the likelihood of the event occurring again and the worst-case potential consequence.

Depending on the potential severity and complexity of the event, the investigation and action plan shall be completed by the appropriate level of personnel, someone who has the authority, status, and knowledge to make and implement recommendations. This will usually be the designate manager in liaison with the Health and Safety Manager, however should the investigation require a team approach, a team can be made up of the following:

- Someone familiar with the work location.
- A manager (Services Manager / Department Manager / Facilities).
- Health and Safety Representative.
- Health and Safety Manager; and
- Other specialist professional(s).

Any findings and recommendations should be reported to Chief Officer.

Ideally an investigation will occur as soon as possible, if not immediately, after the event has happened. If it is left more than a few days then people’s memories can fade.

Levels of Investigation

Minimal investigations – A Manager looks at the circumstances of the undesired event, identifies how to prevent future similar incidents and completes required action, documenting records accordingly (online reporting).

Low level investigations – A Manager does a short investigation into the circumstances and looks at the immediate underlying and root causes of the undesired event to try and prevent it from happening again.

Medium level investigations – A more detailed investigation involving the above together with support as required from the Health and Safety Manager.

High level investigation – The highest level of investigation, using a team-based approach this includes Departmental heads, Line Managers, Supervisors, the Health and Safety Manager, Employee Representatives but is led by the Health and Safety Manager.

4.0 INVESTIGATION PROCEDURES

The quality of the investigation and the accuracy of the findings are dependent on the investigation commencing immediately after the accident. This is particularly true when it comes to interviewing witnesses and recording the conditions of the accident location.

The purpose of investigation is to:

- Establish causation (immediate/underlying/root including contributory causes.
- Identify underlying failures in health and safety management systems.
- Identify reasons for any substandard performance.
- Learn from events.
- Identify corrective actions required to prevent/minimize recurrence; and
- Satisfy legal reporting and investigation requirements.

The main elements of an investigation

The event

- What has happened?
- Where has it happened?
- Who has it happened to?
- When did it happen?

The Scene

The place where the accident actually happened – note that there may be more than one scene e.g. fall through barrier onto ledge and then onto floor off ledge.

Evidence

Factual things involved in the event; this can include witness statements, pieces of equipment, documents, photographs, it may even involve a room or section of the building.

Witnesses

This will include anyone present at the time of the event and those not present but who may be able to add information. The best witnesses are those who saw the accident, ensure that they give a witness statement by completing the witness statement section of the electronic accident / incident report form.

To enable a picture to be built up of what happened it is important to talk to anyone involved – including people not actually there at the time but who may have valuable information to input into the investigation – e.g. maintenance personnel.

The investigation will depend upon evidence gathered and witness statements.

Investigation report

The main document that will be produced will sum up what you believe caused the accident and will identify the measures you believe are required to prevent it or reduce the likelihood of it from occurring again. This must be accurate, brief, and clear.

Investigation File

This is the document that will, if required, be used in any court proceedings. It will contain every document you have produced in respect to the investigation and will identify what exhibits have been seized, by whom and where they are. If every investigation is treated as though it were a fatality or as though it were to be subject to court scrutiny, producing a file would become second nature.

The following procedure is recommended:

1. First any casualties should be checked over and provided with first aid as applicable and / or other medical aid as circumstances require, ensure the area is safe and left alone / prevent access.
2. Look at the overall picture first.
3. Use the camera to take photographs of the accident scene.
4. Collect names and contact details of witnesses, to include all those who saw, heard, felt or smelt something related to the event.
5. Interview witnesses separately to ensure that each tells their own story without influence from others. Take full statements about what they have seen and heard, as soon as possible after the event.
6. Clarify the facts where discrepancies occur.

Establish the facts as quickly and completely as possible about:

- The general environment.
- The equipment, product or procedure involved; and
- The sequence of events leading to the accident.

Establish the immediate cause(s):

These are aspects of the accident / incident which directly influenced the outcome (damage or injury) and are often referred to as “direct causes”. They are the features of an accident / incident which immediately contributed to harm or damage being caused.

Establish underlying cause(s):

These aspects of the accident / incident are effectively contributory breaches which in themselves did not cause harm but made a significant contribution to the accident/incident. They are often referred to as “in-direct causes”.

Establish root cause(s):

Generally, these are aspects of our safety management performance or system which have in some way failed – were the policies or procedures adequate, were they implemented / did staff comply with them – if not why not?

5.0 WITNESSES

- Interview them separately so that they can speak freely, without embarrassment and with no influence from others.
- Ask open questions and do not lead witnesses.

- Interview them at the scene of the accident if possible.
- Make the interview as informal and unthreatening as possible – you are establishing what happened, not allocating blame.
- Ask questions to draw out information.
- Feedback to witnesses what you understand they said, to check that your version is correct.
- Include full name and address, telephone number and signature.
- Encourage witnesses to let you know if they subsequently remember anything else that may be relevant.

6.0 ACTION PLAN

When carrying out an investigation fill in the action plan section of the investigation form (on the online reporting system) correctly and ensure that the relevant people are informed. Additional information other than that requested on the form may be required – depending upon the severity and complexity of the incident.

Recommended remedial action should include measures which will prevent similar accidents / incidents or near misses and take account of whether the safety precautions were adequate, but not implemented / complied with. Remedial actions could include any actions reduce the consequence of the event reoccurring as well as actions to prevent reoccurrence, for example:

- Better guarding or barriers where appropriate.
- Better test and maintenance schedules.
- Revised systems of work.
- Safe systems of work – new written or reviewed.
- Improved inspection regime.
- Improved supervision, training instruction and information.
- Improved communication.
- Provision and use of personal protective equipment; or
- Review of similar activities in other areas.

Ensure that remedial action is taken immediately, even if it is only a temporary one for high-risk tasks / activities, do not carry out until sufficient remedial action is implemented. Also, permanent action is taken as soon as possible with planned completion dates recorded.

Details of actions to be completed to prevent an occurrence must be recorded, and should:

- Identify and consider alternative or improved measures of risk control (training, signage, guarding).
- Identify risk assessments / policies or procedures to be reviewed.
- The action plan should have SMART objectives, i.e. Specific, Measurable, Agreed, and Realistic, with timescales recorded.

Review findings and recommendations:

- The report writer's Manager and the Health and Safety Manager should review the report.
- They should evaluate the quality of the report and give feedback on how it could be improved.

7.0 INFORMING OTHERS

The report and action plan must be communicated to the relevant interested parties:

- Who will have a duty to complete actions they have been made responsible for.
- Have a direct health and safety responsibility involved (Line Management).

- Relevant external agencies requiring a statutory report; and
- Health & Safety representatives and committees.

8.0 INCLUSION IN MONTHLY SLT's and HEALTH AND SAFETY MEETINGS

Accidents / Incidents and Near Miss events and reports are to be included in the monthly SLT's and health and safety meetings to:

- Monitor that the completion of recommended remedial actions have been taken on time.
- Check the ongoing effectiveness of actions.
- Raise the awareness of events to all staff groups; and
- Ensure the full local compliance with this policy.

9.0 MONITORING AUDIT AND REVIEW

The ongoing implementation of this policy will be monitored through supervision, Health, and Safety Committees and also the company Health and Safety Audit Process.