CARDIFF COUNCIL

CODE OF GUIDANCE

ACCIDENT/INCIDENT INVESTIGATION

Purpose

This Code of Guidance provides information about the legal requirements and the investigation process which should be undertaken following an accident or incident which has or could have resulted in injury to Council employees and others who may be affected by tasks being undertaken by Council employees. This Code of Guidance should be read in conjunction with the Code of Guidance – Accident Reporting. The guidance is set out as follows:

1.0 General
2.0 Legal requirements
3.0 Why investigate?
4.0 Which incidents need investigating?
5.0 Who should investigate?
6.0 Checklist for investigation.
7.0 Interviewing witnesses
8.0 Who should receive copies of the Accident Investigation Report?
9.0 Further Information
Appendix A Accident/Incident Investigation Report.

1.0 General

1.1 Accidents, cases of work related ill health, dangerous occurrences, near misses and property damage can have high human and financial costs. It is vital therefore that Service Areas put in place arrangements for identifying, recording and investigating **all** relevant incidents. These arrangements should include:

- ascertaining both immediate and underlying causes (there is rarely a single cause)
- putting in place measures to prevent a recurrence. This may need to be done straightaway
- reviewing existing risk assessments
- reviewing control measures and success in meeting them
- identifying activities or jobs causing the greatest number of incidents
- satisfying legal and Council reporting and recording duties (e.g. reporting to HSE via F2508 – see Code of Guidance – Accident Reporting
- if the incident is likely to result in an insurance claim advise the Insurance Section. A detailed report of your accident investigation should be made and this would be used for the basis of the Council's defence of any claim.

2.0 Legal Requirements

2.1 There is no specific legislation at present, which requires employers to investigate accidents, but there is an implied duty in a number of health and safety statutes, for an investigation to take place. The Management of Health

and Safety at Work Regulations 1999 (MHSW), Regulation 5, "Health and Safety arrangements", states that: " Every employer shall make and give effect to such arrangements as are appropriate, having regard to the nature of his activities and the size of his undertaking, for the effective planning, organisation, control, monitoring and review of the preventive and protective measures." The associated Approved Code of Practice (ACOP) says that: "Employers should measure what they are doing to implement their health and safety policy, to assess how effectively they are controlling risk, and how well they are developing a positive health and safety culture. Monitoring would include adequately investigating the immediate and underlying causes of incidents and accidents to ensure that remedial action is taken, lessons are learnt and longer-term objectives are introduced".

2.2 Employers are required under MHSW Regulation 3(1)(a) to "make a suitable and sufficient assessment of the risks to the health and safety of his employees to which they are exposed at work". Regulation 3(3) requires risk assessments to be reviewed where there is reason to believe they are no longer valid, or there has been a significant change in the matters to which it relates. The associated Approved Code of Practice (ACOP) in paragraph 26(a), draws attention to near misses and defects in plant or equipment, and identifies accidents, ill health and dangerous occurrences as events that should trigger a review of risk assessments.

2.3 Trade union appointed safety representatives have the right to "investigate potential hazards and dangerous occurrences at the workplace and to examine the causes of accidents and the workplace" (Safety Representatives and Safety Committee Regulations (SRSC) Regulation 4(1)(a)), and to make representations to their employer on these matters (SRSC Regulation 4(1)(c).

3.0 Why investigate?

3.1 The main aim of investigation is to pinpoint the causes of incidents and take prompt and effective action to prevent recurrence. Key points to consider during investigation are.-

- **the organisation** including relevant policies, standards, procedures and rules
- **the job** including, where relevant, the activity, substances, procedures, equipment (including the maintenance of the equipment where relevant) and premises in use
- **personal factors** including people's behaviour, suitability and competence to carry out the work

3.2 Incidents need examining in sufficient depth so that immediate causes and the underlying failures of systems for managing health and safety are identified. As well as immediate and early remedial action it may be necessary to make longer-term changes. Improvements might include:

- giving training in manual handling techniques
- substituting a solvent with a less hazardous substance
- changing a procedure or other system of work
- instituting health surveillance, e.g. for people working in noisy environments

- providing an interlocking guard
- amending the Service Area Health and Safety Policy and risk assessments

4.0 Which incidents need investigating?

4.1 Be guided by the significance of the incident when deciding on the depth of the investigation. Consider not only the actual consequences but also the potential outcome. The more serious the event or greater its potential, the greater is the effort to be applied. Incidents needing investigation include:

- all injuries, dangerous occurrences and cases of occupational ill health as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)
- all equipment failure, fires, electric shock, explosions and spillages
- any potential or actual release of an environmentally damaging substance
- all near misses and property damage - these incidents may be potentially very serious and merit investigation. Any remedial action taken may help prevent an injury in the future

5.0 Who should investigate?

5.1 Normally line managers will investigate with help as appropriate from the health and safety adviser, if necessary technical staff such as in-house engineers and suppliers of equipment or materials could be involved. The level of management involved will generally be related to the actual or potential significance of the injury, ill health or loss but in most cases, there should be an immediate investigation, possibly by the line manager/supervisor who can ensure that important evidence is not lost.

5.2 Safety representatives are entitled to carry out inspections where there has been a reportable accident or dangerous occurrence or where a reportable disease has been contracted. Managers may be present during these inspections.

5.3 In practice the best approach is normally a joint inspection between managers, safety representatives and an employee with an in depth knowledge of the task being performed. The main purpose is to determine the causes so that the necessary remedial action can be taken. The advantages of a 'team' approach to investigation, involving safety representatives, is that this brings practical experience to the process, team members learn about investigation techniques and about general principles of health and safety management, and they can become powerful advocates for securing implementation of any resulting recommendations for action.

5.4 Training in incident investigation techniques may be necessary especially for interviewing witnesses and the victim. Managers and safety representatives need to understand how to approach witnesses, for example, using 'open' not 'closed' questions and recognising that they may have been traumatised, particularly where the accident involved serious injuries. (See Section 7.0)

6.0 Checklist for investigation

6.1 Use the following checklist to structure investigations and written reports. (The Cardiff Council Accident Investigation Report is attached as Appendix A) It is intended as a guide and is not comprehensive. Be sure to establish at an early stage whether immediate action is needed. For example, it may be necessary to withdraw a machine or substance from use or stop an activity. The most important first step, after dealing with casualties, is to gather key facts about the event and circumstances surrounding it by: interviewing witnesses before their recollection of events alters; gathering all necessary physical evidence; and identifying and securing key documents (for example, recent inspection records, training records etc).

Priority One - Deal with the casualty/ies.

- evaluate the scene and summon assistance from the first aider/emergency services.
- provide first aid to the casualty/ies
- make the scene safe, if necessary evacuate the area/stop machinery (if this can be done without placing yourself at risk) to prevent further injuries, but without moving material evidence unless absolutely necessary.

Obtain basic facts

- names of injured/ill employee(s)/witnesses/ people early on the scene
- condition of plant
- substances in use or present
- layout
- place, time, conditions (lighting, ventilation, slippery, weather conditions etc)
- exactly what happened just before the event and as it unfolded
- injury/ill health/damage/process disruption
- make use of cameras, sketches, measurement to record the undisturbed scene
- obtain witness statement/s using Cardiff Council Witness Statement form or in serious incidents witnesses should be asked to provide a written statement either themselves or the witness dictating the statement to management.

Establish circumstances

- what was being done at the time and what happened?
- immediate causes
- events leading up to the incident
- any evidence linking case of ill health to work
- competence, e.g. what instructions and training were given before the event and how much experience in the job did the people involved (including managers and supervisors) have?
- what were the established methods of work and procedures? Were they being followed?
- risk assessment undertaken, individual/s aware of control measures?

- were individual/s acting on instruction from management or on their own initiative?
- behaviour and actions of individuals
- is there a suspicion that alcohol or drugs were a contributory factor?
- role of supervision and management
- has something similar happened (or nearly happened) before?

Identify preventive measures

- review the risk assessment
- question the adequacy of existing physical safeguards and work methods and any discrepancies with those intended
- reappraise the intended safeguards and work methods – do they comply with the Service Area Health and Safety Policy and do they meet any industry standards or other authoritative guidance?

Establish whether initial response was adequate

- prompt and appropriate action such as making safe and dealing with any continuing risks, electrical isolation, suitable fire fighting, effective first-aid response and correct spillage procedures.

Identify the underlying causes

These might include:
- inadequate supervision
- lack of competence
- inadequate training
- no or inadequate safe system of work
- shortcomings in original design
- inappropriate/defective equipment
- absence of a system for maintenance
- pressure to complete task to inappropriate time schedules
- inappropriate staff behaviour

Determine action needed to prevent a recurrence

In deciding on the right course of action, management need to think whether the outcome could have been more serious and what prevented the more serious consequences from occuring. Recommendations for action must be consistent with the investigation and its findings. Generally it is best to consider the following concepts:

Elimination	Wherever possible the hazard causes should be eliminated
Substitution	Of a process or procedure by another that is hazard free or having a lower hazard level
Mitigation	At times it is not possible to eliminate or substitute in order to control a hazard and in which case steps must be taken to reduce the level of the hazard
Isolation	This places the process, or the hazardous part of the process, in a separate or separated location in order for it

	not to directly interact with the rest of the process
Work Organisation	This may require a change in the actual work process or in the number of people assigned to a task. The requirement for training or the production of Codes of Guidance or Work Instructions may be necessary
Personal Protective Equipment (PPE)	This is the last resort because it should not be relied upon alone. Prescribed PPE must be used with one of the above preceding options

Practical examples of action to prevent a recurrence include:

- improve physical safeguards
- provide and use local exhaust ventilation
- use mechanical handling aids such as sack trucks, forklift trucks
- introduce better test and maintenance arrangements
- improve work methods
- provide and use personal protective equipment
- make changes to supervision and training arrangements
- review similar risks in other Service Areas
- set up a system to assess the risks from new plant and substances at the planning stage
- review procedures involving contractors
- update standards and policies
- introduce monitoring and audit systems
- better communication

Implement, analyse, and review

Once the initial action is taken, Service Area management need to:

- identify underlying causes and corrective action
- implement follow up action promptly
- check that follow up action has been taken
- analyse data systematically to identify trends and features
- question the overall response - did it fully reflect the risks?
- review performance periodically

7.0 Interviewing witnesses

7.1 Extricating accurate information from witnesses can be very difficult. Some witnesses may be reluctant to say anything. The investigators' role here is to put the witness at ease and rapid fire questioning is unlikely to produce useful results. Allowing the witness to have a companion, e.g. a colleague or trade union representative, present (providing that they are not/will not form part of the investigation and that they do not interrupt the questioning) will sometimes help to reduce the tension.

7.2 Other witnesses may be very talkative and imaginative. In this situation the investigator might find it useful to allow the witness to tell their account of the incident and then to go back to the beginning and re-state it. With repeated tellings the tension will disappear along with the possible wilder imaginings.

7.3 The table below illustrates the type of questions which may be asked and the purpose of such questions.

Question Type	Purpose	Question Form	Illustration
Open	To establish rapport. To explore background To explore opinion and attitude	Contact General Opinion-seeking	“Can you tell me what happens in this area?” “Please tell me about…..? “How do you feel about…..?
Probe	To seek more information To seek more information To clarify understanding	Extension Hypothetical Summary	“How do you mean?” “What would you do if….? “As I understand it…..?
Closed	To establish specific facts or information	Yes/No response Identification of person, time, location or number	“Are you….? “At what time did..…?

7.4 Communication is a two way process and the investigator must develop skills to facilitate that communication. Listening skills are as important as questioning skills.

7.5 One skill of effective listening is to listen with empathy. Understanding speakers’ points of view makes them feel one is interested and paying attention. As the listener it is easy to become distracted by emotions, others present, the body language of the speaker or writing whilst listening.

7.6 To overcome these difficulties a useful skill to develop is that of reflective listening where the interviewer reflects back the emotions and content of what is being said. e.g. Interviewee - “I never get told about the chemicals we work with. Nobody answers my questions and I don’t know who to turn to”. Interviewer – “So you’re wondering where to get information?”

7.7 All witnesses must produce a written statement of the events. This avoids filtering out of information by the interviewer and the removing of bias. The written statement will enable the interviewer to pick out areas where he/she requires further clarification.

7.8 Ideally the victim should be the first to be interviewed but his/her injuries might be serious or he/she might be suffering from shock and in such circumstances he/she should not be pressed for an explanation until he/she has sufficiently

recovered. In the case of less serious accidents or where there are no injuries or shock then the employee should be questioned at the earliest opportunity. The general principle of interviewing the witness may be applied to the victim interview.

8.0 Who should receive copies of the Accident Investigation Report?

8.1 Once completed, the report should be shared with individuals / groups / organisations who need to know. Recipients of the report will or may include:

- those involved in the accident. It is often useful to discuss the final draft of the report with those involved prior to issuing a final report
- line mangers
- Service Area Health and Safety Advisers
- employee representatives
- legal advisers
- insurance officers/insurers
- the appropriate enforcement authority. Enforcement authorities are likely to request a copy of the report for an accident they are investigating or an accident reportable under RIDDOR.

9.0 Further Information

Legislation

Management of Health and Safety at Work Regulations 1999 ACOP HSE Books L21
Safety Representatives and Safety Committees Regulations 1977 (as amended)
Reporting of Injuries, Diseases and Dangeorus Occurrences Regulations 1995 (RIDDOR)

Guidance

Croner at CCH Health and Safety at Work Special Report – Investigating Accidents Issue 54, August 2001.

GEE Accident Management and Investigation.

Appendix A.

Cardiff Council Accident/Incident Investigation Report

Cardiff Council Accident/Dangerous Occurrence Report Form completed and attached?	Yes / No / NA
Cardiff Council Witness Statements completed and attached?	Yes / No / NA
Cardiff Council Violence at Work Report Form completed and attached?	Yes / No / NA
Cardiff Council Service User/Public Accident Report Form completed and attached?	Yes / No / NA
F2508 completed and attached?	Yes / No / NA

Name of investigator:
Position/title of investigator
Service Area

1. What happened? – One line description

2. What were the consequences or potential consequences? – One line description

3. Brief description of incident (additional sheet may be used if required)

4. Immediate causes: What unsafe acts or conditions caused the event?

5. Underlying and root causes: What people, organisational, environmental, technical or job factors caused the event?

6. Remedial Actions: Recommendations to prevent recurrence.

Remedial Action	Person Responsible	Date Completed

Signature of investigator:
Date: