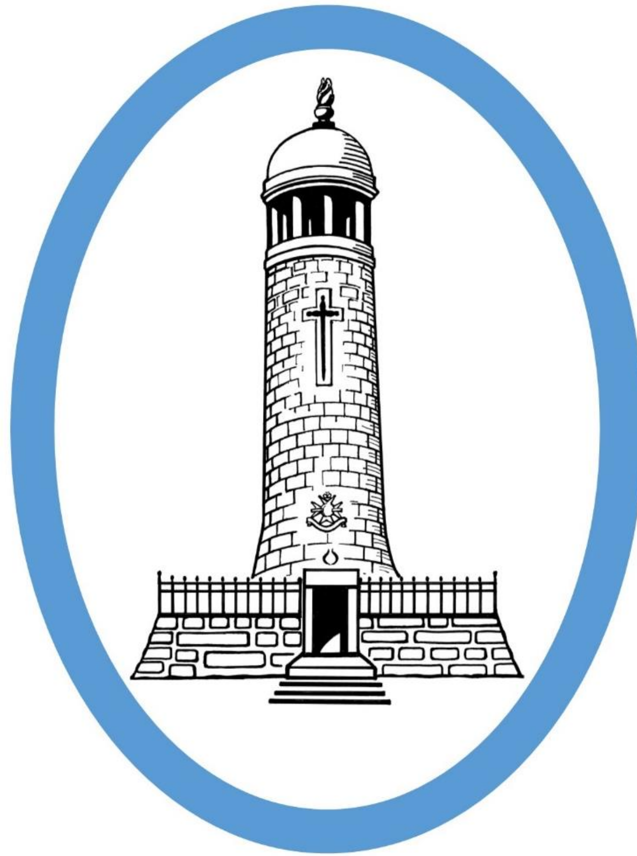


Crich Junior School

Accident and Investigation Policy

This is a standard DCC Policy – apart from the school name no customisation has taken place.

Version:	
Policy Approved At Governors Meeting Date:	Review Date:
Signed (Chair of Governors):	
Signed (Headteacher):	

Accident and Incident Investigation

Introduction

Health and Safety legislation requires employers to adopt a pro-active approach to managing health and safety, principally through assessing risks and then putting in place suitable risk control measures with adequate supervision, training, monitoring and effective management. This forms the risk management system to ensure work activities are safe.

Health and Safety investigations should be an important part of this overall system as if conducted properly they should determine exactly what went wrong, why it did so and then allow the safety management system to be developed and refined to ensure that a similar incident doesn't happen.
Accident investigation therefore should be intrinsically linked to improving risk assessment and other control measures.

Prevention of a reoccurrence of a similar type of incident should be the aim of any investigation; they should never be carried out purely to apportion blame.

Terminology

When investigating accidents and incidents it is important to be clear and consistent as to what we are talking about. The following definitions can be used to establish this.

Accident :	An unplanned or uncontrolled event that leads to injury, loss, damage or ill health	
Incident :	Incidents can be split in to 2 categories as follows;	
	Near Miss	An event that while not causing harm, has the potential to cause injury or ill health (this includes dangerous occurrences)
	Undesired Circumstances	A set of conditions or circumstances that have the potential to cause injury or ill health.

Which Accidents and Incidents Should be Investigated?

This is never an easy decision to make. It is easy to state all accidents and incidents should be investigated, however, in a school for example which may have a number of bumps, scrapes etc each playtime it would be completely

impractical to do this. Other establishments which only have a small number of accidents or incidents may choose to investigate them all.

The decision on whether an accident or incident should be investigated will depend on a number of factors, such as the nature of the injury, or potential injury, the likelihood of a similar accident or injury reoccurring and what lessons can be learned from the incident.

Where establishments choose not to investigate all minor accidents and incidents due to their nature, it is good practice even then to periodically examine accident records. This may show trends developing such as a number of accidents occurring in a certain part of the playground. It may then be decided to investigate why all these accidents have occurred even though individually none of them would warrant investigation.

Accident and Incident Causation

In order to properly investigate accidents and incidents it is important to understand the causes of the accident/incident. Too many investigations focus only on the actual accident/incident and not the other causes, leading to the investigation and any improvements it recommends potentially being flawed.

Accidents and incidents are the result of a sequence of events. Therefore what at first glance appears to be bad luck (wrong place at wrong time) or a 'freak accident' (it just happened), can, when investigated properly and analysed, be broken down into a chain of events that led to the accident.

This chain of events can be broken down into 3 causes

1) Immediate cause	The agent of injury or ill health or the dangerous occurrence:- This could for example be a blade, hazardous substance, dust or gas leak
2) Underlying cause	These fall into 2 categories:-
i) Unsafe acts:	Something a person does or omits to do which may lead to an accident or incident. Examples could include: person removes a guard, person stands on a swivel chair to reach something, person walks past a wet floor and does nothing about it; person ignores risk assessment

ii) Unsafe conditions	A defect in the condition of a premise, machine or equipment which may lead to an accident. Examples could be: wet floor due to leaking pipe or ceiling, broken window not repaired, fire door closer not working or fire door wedged open.
3) Root Cause	A failure from which all other failings grow which can often be remote in time and space from the accident or incident Examples of this could include poor safety culture, management turning a 'blind eye' to safety findings; lack of training; staff not competent; budget pressures; time pressure.

A good accident investigation should consider all of these causes and ensure that any findings are identified and dealt with and not just focus on the direct cause.

Who should be Involved?

In order to investigate accidents properly it is normal to have an accident investigation team. The nature of the team will vary dependent on the seriousness of the incident but will generally contain a minimum of:

- Management representation (one of whom should have sufficient management authority to ensure any findings are implemented and should chair the panel)
- Supervisor / direct line manager
- Union safety representative (where possible) or workforce representative.

Also dependent on the nature of the accident/incident the investigation panel can be supplemented by specialist advisers such as Health and Safety Adviser, Property Division Staff, Head of Department etc.

The Investigation

There are 4 stages to a successful accident investigation

1. **Information gathering**
2. **Analyse the information**
3. **Identify suitable risk control measures**
4. **Devise and implement an action plan to put the measures in place**

Remember the purpose of accident investigation is to prevent recurrence and improve safety management, not to apportion blame. Those involved in the investigation must have an open mind and not pre-judge the outcomes.

NB. Following an accident or incident the site ideally should be left undisturbed other than any necessary work to make the area safe and prevent further accidents/incidents occurring. Any such action should be recorded.

1. Information Gathering

Information gathering deals with facts; namely what is know and what isn't known. It should be timely, explore all reasonable lines of enquiry and the investigative process should be recorded.

The process of information gathering needs to begin as soon as is practicable after the event; ideally straight away. This will stop the information gathered being corrupted either deliberately or with the best intentions e.g. witnesses discussing the event and reaching a consensus agreement on what happened, the site of the accident being disturbed or paperwork altered.

Information is likely to be gathered though some or all of the following.

A) Interviewing those with relevant knowledge

1. Interviewing Witnesses
   Anyone who saw what happened or knows about the conditions that caused the accident.

2. Interviewing Managers/Supervisors
   To establish what safety information and supervision was available to those involved and how they should have been working.

3. Interviewing fellow workers / safety representatives
   These staff can often provide insight into how work is actually done rather than how it is perceived to be done by management.

All statements should be recorded (in writing) and individuals should sign their statement at the base of each page as a true record. Statements should focus not just on the accident/incident itself but on the events leading up to it and the immediate aftermath of it.

B) Detailing the scene

Notes, sketches, measurements and photographs detailing the accident scene and prevailing conditions at the time of the accident. (Notes and

statements should be written up for the formal report but the originals should be kept as an initial record of your findings).

C) Examining Paperwork

All paperwork relevant to the accident/incident will need to be examined; this should include for example, risk assessments, safe systems of work, permits to work, lesson plans, training records etc.

To fully establish the facts surrounding the accident / incident you will need to establish the following:-

Where?
When?
Who?
How?
What?

- Where did the accident / incident actually happen and all the details of the scene?

- When did the accident / incident happen, the exact time of the incident and any factors surrounding this?

- Who was involved in the accident / incident not just including anyone who received injuries but witnesses, supervisors, managers etc?

These 3 factors are generally relatively straight forward to establish. The next two: how the incident happened and what happened can be much more tricky and will possibly involve some "detective work". At this stage it is important to keep an open mind, record all the information you can whether or not it seems directly relevant at the time and rule nothing in or out as valid. At this stage the aim will be to try as far as is possible to ascertain the facts relating to what happened. You will need to describe:-

<u>How did the accident / incident happen</u>? - This should be the chronological sequence leading up to the event, the event itself and the immediate aftermath. What was actually being done, by whom, when, and where they were?

<u>What equipment was involved</u>? - Full details of any equipment being used (name type, age, condition who was using it and what training they had should be recorded. Had the equipment been maintained and had it been altered / adapted in any way, and by whom?

<u>Working Conditions:</u> - Detail the conditions in the area where the accident occurred including anything that was different to the norm. Things you may

wish to include are lighting levels, temperature, floor condition, weather (if outside).

Were adequate safety precautions in place? - Were there appropriate safe systems of work / lesson plans / risk assessments in place and were they known and followed? Was there adequate supervision in place? If these were in place then were they suitable and sufficient, if not why and where were they lacking?

Was this a routine task or a new one? If new, were any of the above considered prior to it being undertaken?

Injury (if any) details:- If there was an injury, what was it (cut, burn, break etc.)? What part of the body was injured? (Be as precise as possible as they can help to identify trends). What was the direct cause (agent) of the injury (e.g. unguarded blade) and how was the injury caused (e.g. employee came into contact with blade)? All facts relating to the treatment of the injury (e.g. first aid given by whom and when, taken to hospital, ambulance called, casualty not moved etc.) should also be recorded.

Organisational Factors: - Any organisational factors identified that you discover that could have contributed to the accident/incident e.g. no equipment provided, no access to training, concerns raised by staff being ignored, management culture of overlooking unsafe acts etc. should be recorded.

Human factors: - Were staff/others involved in the accident/incident competent, trained, informed of the risks, monitored. Were there issues such as difficult relationships between those involved; were those involved under stress?

Other factors: - Any other factors you feel may be relevant in contributing to the accident/incident, age of those involved, experience, layout of area where incident took place; was safety equipment provided if necessary and was it adequate/used?

2. Analysing the Information

Analysing the information can take place alongside the information gathering. In fact this is often beneficial as during the analysis questions which require further information to answer may be identified and this information can then be gathered as part of the process.

Analysing the information involves examining all the information gathered and putting it together to ascertain what actually happened and why it happened.

The analysis must be systematic and thorough and decisions not clouded by pre-conceptions. All possible causes and consequences of the accident /incident must be considered.

The aim of the analysis is to identify the sequence of events that led to the accident/incident and to determine all the causes (IMMEDIATE, UNDERLYING AND ROOT CAUSES) that were involved.

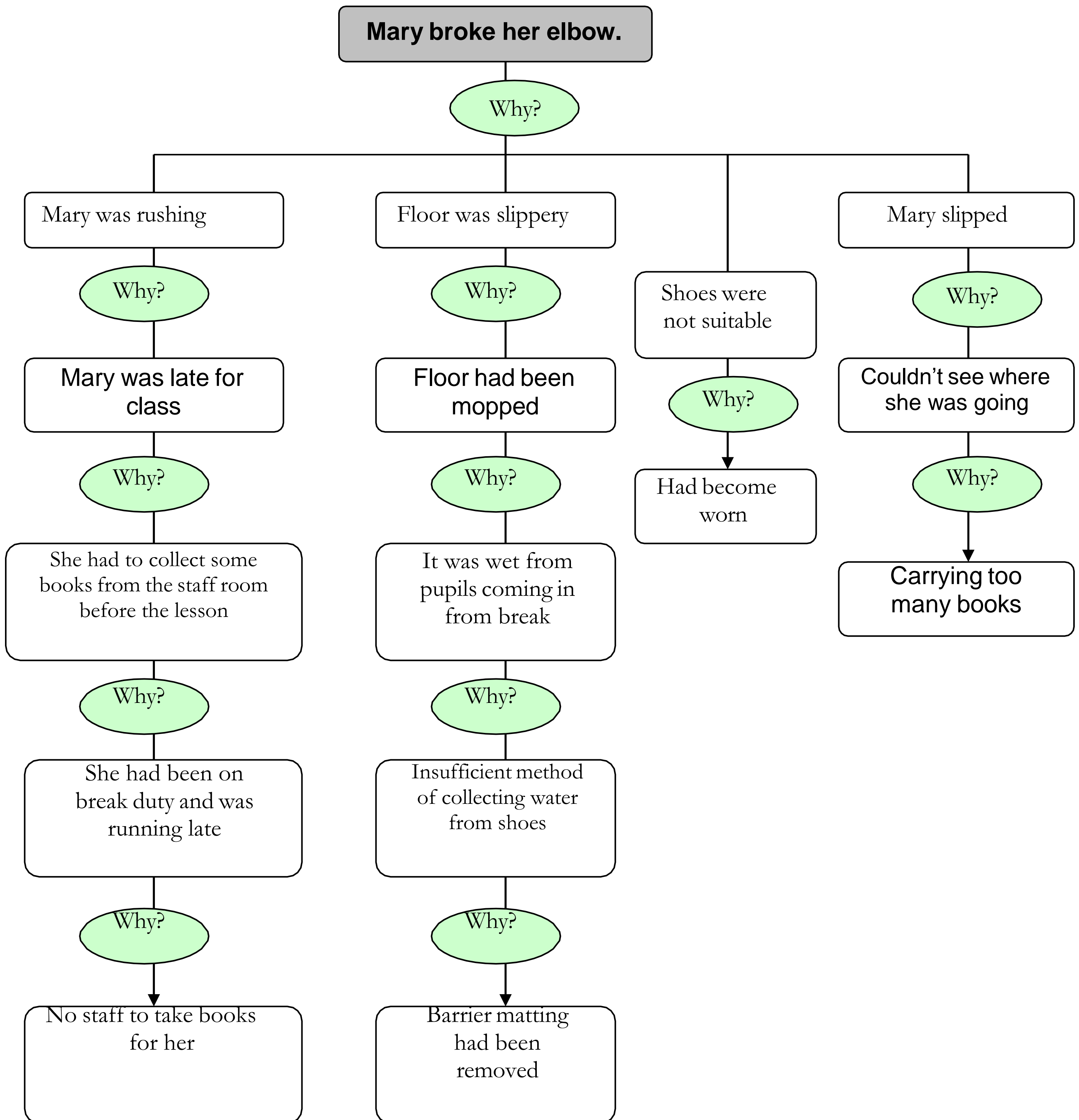
It is vital to identify all the causes; in particular root causes to ensure that all necessary lessons are learned and that appropriate actions are taken to prevent future incidents.

Be objective when examining possible causes, each should be given serious consideration before it is either accepted as a causative factor or rejected.

There are numerous analytical techniques that can be used, however, for most accident/incident analysis in Children's Services Department settings/establishments the simple "Why" technique will be more than sufficient.

This technique orders the information you have gathered and you simply ask "why?" over and over again until the answer is no longer meaningful. Start with the accident/incident, then on the next line the reasons why it happened, and then expand from there.

A base model is shown below:



This simple technique can be used to systematically identify causes of the incident / accident. Remember to focus on all the causes including the root causes which are nearly always failings in the management system.

3. Identify Suitable Control Measures

Having identified the causes of the accident / incident the next stage is to identify possible solutions to the causes and to evaluate these.

All the risk control measures possible for each cause which could have prevented the accident / incident occurring should be listed. These should then be considered as to their ability to prevent recurrences and whether or not they can be successfully implemented.

Having decided which control measures can be successfully implemented and will successfully deal with the causes of the accident / incident (it is possible to have more than one control measure for each of the causes) then they should be prioritised. Prioritisation should be based on a measures effectivements and not on its ease of implementation.

Generally prioritisation should be in the following order:-

a) Measures which eliminate the risk: e.g. substitute a hazardous product for a non-hazardous one, change work methods to eliminate hazardous tasks (a good example of this is window cleaners using pole systems to clean from the ground rather than climb ladders).

b) Measures which combat the risk at source: e.g. guarding machinery dust and fume extraction.

c) Measures which rely on human behaviour: safe working procedures, Personal Protective Equipment, training.

It can be seen from this that measures which rely on engineering risk control measures are more reliable than those which rely on human factors.

Finally, having looked at the first three stages of the investigation for the particular event, you should consider whether there are wider implications i.e. could the same or similar event happen elsewhere in the establishment or at other similar establishment? If so, then you should ensure that the findings of the investigation are published for the good of others who could be affected.

As a minimum, all the Risk Assessments relating to the accident / incident should be reviewed (not just aspects of the Risk Assessment directly relating to the accident / incident identified in the investigation). You should also at this point, when considering risk assessment, think about the wider

implications. If flaws have been found in any of your Risk Assessments, would it be sensible to review all your Risk Assessments and safe systems of work at this point?

4. Action Plan & Implementation

In order for any action plan to be successful it is important that it is agreed and endorsed by Senior Management who have the power to ensure the decisions reached are implemented. If the investigations panel is chaired by a Senior Manager this may be sufficient. However, it may be necessary to present the findings and action plan to Senior Management team or similar for endorsement, resourcing and action.

The action plan itself should detail the risk control measures to be implemented as decided in the first three stages of the investigation. It should ensure the priority of these is very clearly highlighted: it should detail what actions and resources will be necessary to ensure the control measures are successful; who will need to carry out the necessary actions and when these should be completed by.

When prioritising actions, the prioritisation should be based on which measures are necessary immediately to ensure the safety of staff, pupils and clients and not on ease of implementation.

In order to achieve the above, all the risk control measures proposed should be SMART (Specific, Measurable, Agreed, Realistic, and Time weighted).

Once the plan has been agreed someone in a responsible position with sufficient authority should be given the responsibility for ensuring its implementation. This does not mean they physically have to do everything but they should monitor the progress of the plan at regular intervals. If there are any delays or departures from the agreed timescales these should be reported back to Senior Management and a course of action agreed to deal with this.

It is good practice to ensure that employees and their representatives are kept informed of the progress of the action plan.

Once a control measure on the action plan has been implemented that should not be seen as the end of the process for that issue.

The control measures implemented should be monitored and reviewed in the same way as any other health and safety issue; to ensure they have been effective, are usable and have not created different or new risks that weren't identified. The findings of any review should also be reported to Senior Management.

APPENDIX 1

INCIDENT INVESTIGATION FORM

(Accident, Assault, Near Miss/Dangerous Occurrence)

Please read carefully before completing the form:

Following an incident at work an accident and/or assault form must be completed and a copy sent to the departmental health and safety section. These must be submitted as soon as possible to meet legal requirements.

In addition where appropriate and/or where requested to do so by the Health and Safety section, this investigation form must be completed by the manager. It is the responsibility of the manager to arrange to meet the injured person and, if necessary, with his/her line manager/supervisor to establish the circumstances leading up to the incident. The injured person can if they wish have their employee representative with them whilst discussing what happened.

For the purposes of this document the definition of an accident is any unplanned/unpremeditated event caused by unsafe acts and/or conditions whether injury was caused or not.

This form can also be used to investigate assaults (physical or verbal) and near misses. The definition of a near miss is an unplanned event that has the potential to cause injury to people or damage to property.

1. Details of Injured Person	
Name	
Age	
Employee Number	
Job Title	
Contact Number	
Base Address	
Incident Location	

2. Cause of the incident and full description of what happened

Please read the following notes prior to completing this section. When completing this section it is important to ensure all the details and circumstances leading up to the incident and what actually happened are recorded as accurately as possible.

Generally the principal cause of incidents fall into one and/or all of the following categories:

- Attitude – Factors that could affect the employee's attitude could be; influences at home, training, experience, personal habits, whether they are mentally and/or physically suited to the job and work problems and grievances.
- Unsafe Acts – These are generally described as things people do that can result in incidents causing injury, damage to equipment or both. Examples of this could be; Misuse of equipment, using defective or worn equipment, not following correct procedures, not using protective equipment, untidiness, negligence/horseplay or failing to replace guards after removal for machinery.
- Unsafe Condition – These can be best described as conditions that are liable to lead to an incident. Examples of this could be; poor housekeeping, poor lighting, incorrect or inadequate guards, defective equipment or poor design/construction.
- Inadequate procedures – Examples of this are lack information, instruction and training; failure to communicate and understand risk assessments or safe systems of work; Not wearing mandatory PPE

3. Injuries & First Aid Provided
What were the resulting injuries?
If first aid treatment was administered please provide details of what treatment was provided and the name of the first aiders?
If the injured person was taken to hospital please provide details of how they were transported and which hospital they were taken to?

4. Witnesses
Please provide name, address and contact details of any witnesses

5. Additional information & consideration's Please answer all of the following questions with either a **yes, no or n/a**. Where it asks for further details please complete as indicated.	
	(y, n, n/a)
Were there any photographs taken relating to the incident? (If yes attach to this form)	
If applicable have you drawn a sketch of the incident? (If yes attach to this form)	
Have relevant risk assessments been carried out? (If yes attach all copies of risk assessments, methods statements, safe working procedures etc to this form)	
Where applicable were all mandatory certificates/inspections in place/available e.g. LOLER inspections? If yes attach all copies to this form)	
Have all relevant risk assessments been identified, undertaken and communicated to the injured person? (If yes provide details and attach to this form)	
Were the control measures identified in the risk assessments being correctly implemented & followed? (If yes explain how it was communicated. If no please give reasons)	
Was the correct PPE being used? (please provide details of type, if possible include standard of PPE e.g. if they were wearing a mask what type of mask)	
Had the injured person received any information, instruction, training related to the activity being undertaken prior to the incident occurring? (if yes please provide details and where possible copies of training records)	
If applicable was there suitable and sufficient supervision at the time of the incident?	
Has the injured person reported any similar incidents previously? (if yes please give details)	
Has the injured person had an incident of any type in the last 2 years? (if yes please provide details)	
Has the injured person or other persons associated with incident behaviour contributed to the incident?	

6. Concluding Remarks and further observations This section is for the manager to draw conclusions and make any observations themselves in order for appropriate further action to be advised of. You may wish to use your own experiences and knowledge here, but it is important that personal opinion is not included.

7. Recommended Further Action Please indicate below as appropriate	
	(y, n, n/a)
No Further Action Required	
Review Procedures (Please provide details)	
Carry out and/or review risk assessments (please provide copies)	
Further, information, instruction and training required (Please provide details)	
Line Manager interview/meeting with employee (please provide details of interview)	
Disciplinary Investigation (Please contact your Departmental HR section for further advice)	
Other (Please provide details)	

8. Details of Person Completing Form	
Signature	
Print Name	
Designation	
Date	

Please return the completed form to your Departmental Health and Safety Section (A copy should be retained for your records)