Royal Society for the Prevention of Accidents

National Occupational Safety and Health Committee

Future HSE guidance on accident investigation

For many years, RoSPA (and latterly IOSH) has campaigned for an explicit legal duty to require employers to investigate accidents, incidents and cases of work related ill health.

RoSPA has favoured a goal setting approach to complement the duty of employers in the Management of Health and Safety at Work (MHSW) Regulations to carry out suitable and sufficient risk assessment. We are strong supporters of team based investigation.

There is widespread acceptance that capability to investigate and learn from accidents is essential in the context of managing for health and safety (MfH&S). This is recognised, albeit briefly, (see annexe one) in the HSE's new suite of MfH&S guidance which replaces HSG65. Emphasis is also placed on the value of learning from significant near-misses.

At the same time, available research suggests that most accidents and incidents are not investigated at all and those that are investigated, are not investigated in sufficient depth and with sufficient rigour to enable employers to learn lessons, not only to prevent recurrence but to address underlying weaknesses in management processes. In practice open and objective investigation of accidents is often hampered, not only by lack of clear procedures and necessary competence but by fears among managers and other employees about liability and disciplinary action or even prosecution.

In contrast to the legal duty to carry out risk assessment, there is no complementary duty to carry out an investigation, for example, if an accident occurs leading to injury, if a case of work related ill-health is diagnosed or if incidents – including unsafe acts and conditions – occur in the workplace.

The nearest thing to a duty is the requirement in sub para 1 of Regulation 5 on the MHSW Regs: "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 meaning of '*monitoring*' in relation to investigation was reinforced to some extent by relevant clauses in the MHSW ACoP but this is being withdrawn.

In 1999 RoSPA with others, succeeded in persuading the then Health and Safety Commission (HSC) to consult on a specific duty to investigate linked to RIDDOR (see http://www.hse.gov.uk/consult/condocs/cd169.pdf). (The latter feature was not favoured by RoSPA however.)

Following consultation, proposals for prescriptive regulations on these lines were sent to the Cabinet Office and following further discussion, the HSC was asked to consider the option of producing guidance instead. In due course HSG245 was published ('*Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals* '– see http://www.hse.gov.uk/pubns/books/hsg245.htm). In the light of production of the

new HSG65 it is now proposed however to remove this fairly elementary guidance and to rely instead on a much shorter guidance leaflet.

Notwithstanding the value of a leaflet to introduce readers to essential features of investigation, RoSPA has questioned the wisdom of HSE abandoning even the limited guidance available in 245, especially since there is still a dearth of good guidance available from other sources. (An example of an exception might be online RSSB guidance on accident investigation, see http://www.rssb.co.uk/NP/SMS/Pages/AccidentInvestigationGuidance.aspx .)

RoSPA has sought to highlight the need for good investigation practice on its website (see 2001 challenge at http://www.rospa.com/news/releases/detail/?id=188) in articles, in its training programmes, through its awards and through its joint guidance on operational readiness to investigate produced jointly with NRI (see DORI at http://www.nri.eu.com/WP1.pdf).

RoSPA is meeting HSE shortly to discuss their plans and would like ideas and suggestions from the Committee on ways forward.

Roger Bibbings

Occupational Safety Adviser 24 September 2013

Annexe one

From the new HSG65

Investigating accidents and incidents

In any business or organisation things don't always go to plan. You need to prepare to deal with unexpected events in order to reduce their consequences. Workers and managers will be more competent in dealing with the effects of an accident or emergency if you have effective plans in place that are regularly tested.

You should monitor and review any measures you have put in place to help control risk and prevent accidents and incidents from happening. Findings from your investigations can form the basis of action to prevent the accident or incident from happening again and to improving your overall risk management. This will also point to areas of your risk assessments that need to be reviewed.

An effective investigation requires a methodical, structured approach to information gathering, collation and analysis.

Why investigate?

Health and safety investigations form an essential part of the monitoring process that you are required to carry out. Incidents, including near misses, can tell you a lot about how things actually are in reality.

Investigating your accidents and reported cases of occupational ill health will help you uncover and correct any breaches in health and safety legal compliance you may have been unaware of.

The fact that you thoroughly investigated an incident and took remedial action to prevent further occurrences would help demonstrate to a court that your company has a positive attitude to health and safety.

Your investigation findings will also provide essential information for your insurers in the event of a claim.

An investigation can help you identify why the existing risk control measures failed and what improvements or additional measures are needed. It can:

- provide 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);
- improve the management of risk in the future;
- help other parts of your organisation learn;
- demonstrate your commitment to effective health and safety and improving employee morale and thinking towards health and safety.

Investigating near misses and undesired circumstances, where no one has been harmed, is as useful as, and may be easier than, investigating accidents.

In workplaces where a trade union is recognised, appointed health and safety representatives have the right to:

- investigate potential hazards and dangerous occurrences in the workplace
- examine causes of workplace accidents

Key actions in effective accident/incident investigation

Leaders

Verify that plans are in place to deal with immediate risks following unforeseen events.

Make sure there is a reporting process so that leaders are informed of accidents, incidents or cases of occupational ill health.

Consider lessons from the accident/incident history of others in similar industries or organisations - could the same mistakes be avoided?

Ensure that people are held to account if failings reoccur.

Managers

Formulate plans:

- What must workers report?
- How will reporting procedures be communicated to workers?
- How will work-related ill health, accidents or near misses be notified?
- Who will assist in the investigation?

- What action will be taken as a result?
- How will you identify trends?

Ensure reporting procedures are suitable and workable.

Examine all incident/accident/near-miss reports and identify trends.

Be proportionate in any investigation, according to the level of risk identified. Establish what happened, when, where and why. Collect evidence:

- consider what the evidence shows
- compare what you have found against industry standards/HSE guidance etc

Investigate accidents with a high priority - before people's memories fade and while evidence is still available.

Look at root or underlying issues not just immediate causes:

- immediate causes - premises, plant and substances, procedures, or people
- underlying causes - management arrangements and organisational factors such as design, selection of materials, maintenance, management of change, adequacy of risk controls, communication, competence etc

Record and keep findings:

- They may be required later in a formal investigation or legal proceedings

Engage specialist help to support complex investigations, e.g. an operation involving major accident hazards

Worker consultation and involvement

Involve workers or their representatives in the planning process and in the target-setting process

Carry out joint investigation with workers' representatives.

Involve workers or their representatives in monitoring performance.

Competence

Consider how competency is achieved, tested and maintained

Do investigators have the necessary training, knowledge and experience to carry out their duties?

Consider whether training issues contributed to causes of accidents/incidents/near misses

Seek specialist advice if needed.