Catena
Inspection & Engineering Services Ltd
Lifting Solutions & Supplies
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CHS012

INVESTIGATIONS POLICY

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Links

The following documents are closely associated with this policy:

- CHS001 Health & Safety Policy
- CEP001 Environmental Policy
- CHS011 Accident, Incident, Near Miss & Dangerous Occurrences Reporting & Investigations Policy

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INTRODUCTION

CATENA Inspection & Lifting Engineering Services Ltd (here after known as CATENA) recognises that there is a requirement to investigate and determine the causes of accidents/incidents as current legislation implies that such investigations should be undertaken so that lessons can be learnt, and steps taken to prevent a recurrence.

OBECTIVES

This policy will ensure that CATENA is able to investigate all accidents and incidents to ensure that they are continuing to provide a safe working environment for their employees.

The Health & Safety Executive (HSE) advocate a formal and structured approach to accident investigation in their publication HSG65 'Managing for Health and Safety' Third Ed 2013. In addition, carrying out investigations demonstrates a positive commitment towards achieving a safer working environment.

Some of the benefits can be summarised as follows:

- Reduces the risk of further accidents/pain and suffering for the injured
- Reduces the risk of further environmental incidents and damage to the environment
- Less sickness and injury absence
- Improved efficiency/greater productivity/levels of performance
- Contributes towards general wellbeing of employees
- Improved morale
- Less stress
- Reduces staff turnover and consequent training costs
- Avoids attracting prosecution and/or civil claims for compensation
- Avoids adverse publicity/media attention
- Creates better customer confidence
- Less interference from enforcement agencies
- Compliance with legal requirements

SCOPE

This policy identifies that workplace accidents, ill health, near miss events or environmental incidents identified by Mr M O'Mara as requiring further information will be investigated by suitably trained persons.

- That the 'findings' from such investigations will be recorded on a CATENA accident/incident investigation report form and retained for reference and review (**appendix 1**).
- That any risk control measures introduced as a result of an accident/incident investigation will be monitored to ensure that the actions taken are effective.
- That injuries/ill health conditions which are 'reportable' under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 be notified immediately to Mr M O'Mara
- Significant environmental incidents which involve discharge of substances to land or water must be notified immediately to Mr M O'Mara.

RESPONSIBILITIES

Director - Scope of the Duty
The requirement to investigate relates to all CATENA premises and extends to include all formal activities such as works visits conducted away from the CATENA site. It applies to employees, contractors and members of the public.

Personal Responsibilities – All Employees

Successful management of accidents and occupational ill health systems and environmental incidents require commitment and co-operation from everyone at CATENA. All employees have a responsibility and can make a significant contribution to the prevention of accidents, ill health and environmental incidents by complying with the following:

- Conducting themselves in a manner conducive to their own safety and the safety of others.
- Complying with the requirements of CATENA Health & Safety Policy and Environmental Policy.
- Co-operating with CATENA in complying with statutory obligations and approved codes of practice.
- Reporting all defects in plant and equipment.
- Reporting all defects in procedures or systems of work which it is believed may cause injury, ill health or impact on the environment.
- Reporting all accidents where an injury has been sustained immediately by completing the Accident Book.
- Reporting all accidents where no injury has been sustained (near miss)
- Reporting all environments e.g. substance spill, gas leak, fuel tank failure
- Ensuring that the highest standards of housekeeping are maintained in the workplace.

Definitions	
Accident/Incident	An unplanned event which causes, or has the potential to cause injury, or loss, or damage to plant, premises, materials or the environment.

Reportable Accident	(Including Dangerous Occurrences). Refers to a statutory duty to report it to the enforcement authority, e.g. Health & Safety Executive (HSE).
No Injury Accident (Near Miss)	An unplanned event with the **potential** to cause personal injury or damage to plant/equipment.

EXTENT AND DEPTH OF AN INVESTIGATION

Not all events need to be investigated to the same extent or depth. The greatest effort should concentrate on significant events where there has been significant injury, ill health or damage or where the event had the **potential** to cause widespread or serious injury or damage.

Statistics indicate that many, but certainly not all, injury accidents can be classified as minor and, as such, will usually require minimal investigation and result in simple and obvious precautions to prevent a recurrence, e.g. re-routing trailing equipment leads and improving housekeeping standards to prevent further tripping incidents.

Accident/Incident Categories

Accidents/Incidents can be classified into the following main groups which arise from ordinary everyday causes:	
Falls of Persons	Due to slippery or uneven floor surfaces, defective or insecure ladders, badly maintained steps or stairways, inadequate working platforms, openings in floors, fragile roofs, etc.
Falls of Objects	Due to badly stacked materials, dropping tools and equipment from elevated workplaces.
Handling Goods	Due to faulty lifting techniques, load too heavy or awkward, or lack of protective clothing and equipment (boots, gloves).
Stacking Against Object	Due to overcrowding, poor housekeeping obstructions in gangways and improper storage.
Hand Tools	Due to incorrect use of tools or the use of defective tools.
Machinery in Motion	Entanglement of clothing, hair and jewellery on rotating shafts, e.g. lathes. Trapping of hands and fingers between gears and rollers.

	Crushing of limbs where one part of a machine closes on another.
Others	Radiations Fire Noise Chemicals Pollution incident Live Electrics

Accident Causation

It is very rare for an accident to arise from a single cause; more frequently there is a combination of factors which must be present simultaneously. These can be grouped as follows:

IMMEDIATE CAUSES	
Unsafe acts (of persons) including:	**Unsafe conditions (job factors) including:**
The behaviour, suitability and competence of those doing the work.	The adequacy of the workplace precautions for the premises, plant, substances involved and the procedures and systems of work used.
Underlying / root causes Management and organisational factors	

Near Miss Events

A Near Miss incident could be described as an undesired event or condition where no injury, ill health, damage or other loss occurs.

Example

Any non-compliance that could have led to an accident, e.g.:

- Observation of unsafe conditions such as fire risks or faulty equipment.
- Observation of unsafe acts such as non-authorised personnel entering restricted areas.
- Falling or flying objects that do not make contact with individuals or cause any significant property damage.

Investigating the cause of these **no injury accidents** (near misses) and taking account of the lessons learned is equally as important as investigating **injury accidents**.

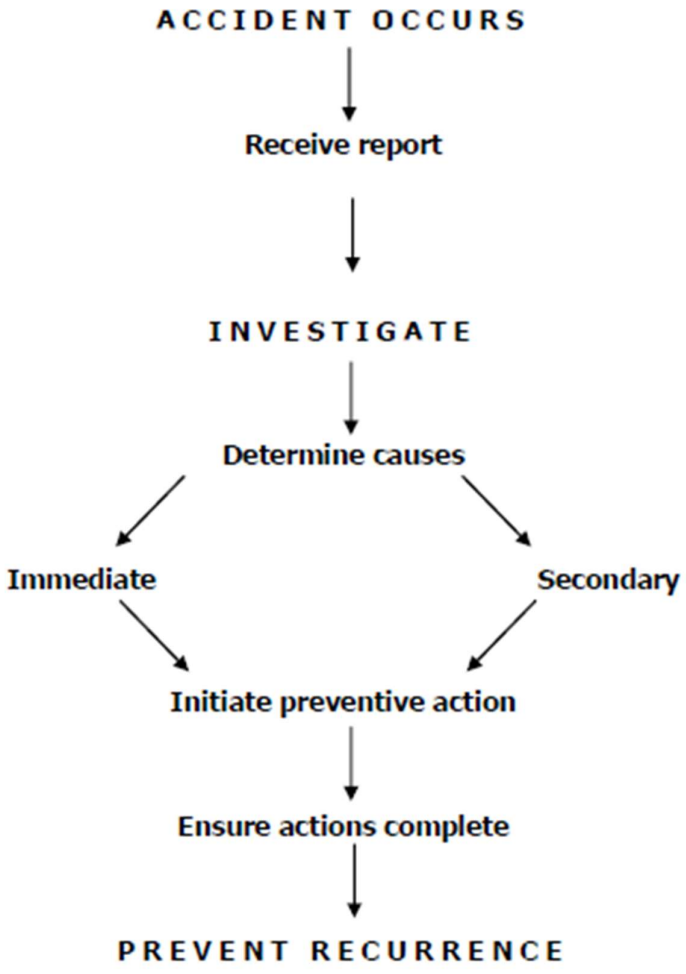
Research studies have shown that for every serious or disabling injury 600 unplanned events of the same type had occurred.

1 Serious or disabling injury accident 10 Minor injury accidents 30 Property damage accidents 600 No injury/no damage accidents

The ratio 1 – 10: 30 – 600 represents an average from a great variety of industries and serves to illustrate that there are many near miss accidents for every injury or damage accident. It therefore follows that investigation of these near miss events provides an opportunity to prevent the injury accident itself from happening in the first place.

ACCIDENT INVESTIGATION PROCEDURES

A structured approach to accident/incident investigation should be adopted as follows:



Actions Prior to an Investigation

Render first aid and/or arrange hospitalisation.
Make the situation safe and prevent further release of substances, injury or damage if it is safe to do so.
Notify Mr M O'Mara immediately (by telephone) if the injury/ill health condition is reportable to the HSE under RIDDOR 2013

The Investigation

A good investigation will be prompt and thorough. It should seek to:

- Collect evidence about what has happened.
- Assemble and consider the evidence.
- Compare the findings with appropriate legal and industry standards and draw conclusions
- Implement the findings and track progress.

If an injury is fatal the accident scene must not be disturbed, and this includes plant, equipment and substances. The police and HSE will always investigate a fatality

Sources of Information

It is important to gather information about the accident/incident scene, to assess the adequacy/ relevance of formally documented procedures and to obtain witness testimonies.

Consider the following:

- **Physical Conditions/Accident Scene**
    - Premises, place of work
    - Access and egress
    - Environmental conditions, e.g. lighting, temperatures, state of floors, space

- Plant and substances in use
- Location and relationship of physical parts
- Any post event tests, checks and sampling

Documentary Evidence

- Documents help establish what should have happened as well as providing evidence about the adequacy/quality of risk assessments, inspections, tests, etc.

Information From:

- Written Instructions/Procedures
- Risk Assessments
- Policies
- Records of Earlier Inspections/Audits, Tests, Examinations and Surveys, etc.

Interviews

- Interviews provide both direct testimony as well as an opportunity to cross refer to issues arising from examination of the physical conditions and documentary evidence.

Information From:

- Those involved
- Witnesses
- Those observing or involved before the event, e.g. inspection, maintenance staff.

Preventive Action

Arising from the investigation 'findings', action should be taken to remedy the deficiencies identified. It may be necessary to prioritise these actions into **immediate** and **long-term** measures. It would, for instance, be relatively simple to clear spillages and improve housekeeping standards but it will take a little longer to develop policies, change procedures, arrange appropriate training or conduct risk assessments, etc. An action plan should be developed to indicate what is to be done, by whom and by when. The actions taken should be monitored to ensure effectiveness and reviewed if circumstances change.

Management for Accident/Incident Prevention

The Health & Safety Executive estimates that 8 out of every 10 accidents are primarily caused through a lack of effective management control and are therefore preventable. Whilst investigating accidents is important as a means of learning lessons and improving safety management systems, it is by definition a reactive measure triggered after the event.

There is an accepted hierarchy of accident prevention strategies which are proactive in nature and should be adopted in order to prevent/minimise the risk of accidents occurring.

These are as follows:

- Eliminate the risk, e.g. buying ready sawn timber rather than use a circular saw
- Substitution by something less hazardous
- Total enclosure (enclose it in a way that eliminates or controls the hazard, i.e. processing hazardous substances in an enclosed piped system)
- Partial enclosure. The use of LEV systems, fume cupboards, bunding etc.
- Guarding/segregation of people
- Permit to work systems, e.g. hot work permits to control fire risks
- Reduce the period of exposure
- Written procedures that are known and understood by those affected
- Adequate supervision
- Adequate training
- Information/instruction (signs, labels, handouts)
- Personal protective equipment (PPE)

The use of PPE should be regarded as a last resort option in the absence of any more reliable or permanent means of control.
All these measures should be considered within the overall context of achieving 'a safe system of work' that reduces the risk to an acceptable level.

Interviews – Some General Notes

When carrying out an investigation it is always preferable to interview the people involved in the accident/incident. Some general points apply:

- Put the person at ease. Stress that the purpose of the interview is to establish the facts so that steps can be taken to prevent a recurrence and definitely not to apportion blame to anybody.
- Ask what happened – do not interrupt – be a good listener.
- Don't ask leading questions or make assumptions. Don't try to put words into the witness's mouth. Some people will tell you what they think you want to know.
- Be considerate, not sarcastic – it may lead to distortions, so don't appear in a bad light.
- Ask questions to bring out the facts you want to know.

Remember: It is important to try to establish the underlying causes (management and organisational factors) as well as the immediate causes (unsafe acts and conditions).

SUMMARY DO	**DON'T**

Put people at ease	Interrogate
Listen	Interrupt
Be sympathetic	Get into an argument
Be firm	Make promises
Be honest	Make assumptions
Be tactful	Be sarcastic
Be courteous	Apportion blame
Be interested	
Be considerate	
Differentiate between opinion and fact	

ACCIDENT/INCIDENT INVESTIGATION REPORT FORM

Appendix 1

Name of Injured Person(s) (if applicable):	
Location of Accident/Incident:	**Time: am/pm**
Witnesses:	**Addresses/Tel/Fax/Email:**
Description of how accident/incident occurred: (include details of any machinery/equipment/substances involved)	

Use this space to sketch site if necessary:

Immediate causes: What unsafe acts or conditions caused this event?

Underlying Causes: What organisational and/or job factors caused the event?
Remedial Actions: Recommendations to prevent a recurrence

By Whom/By When will the remedial action be taken?	
Signature of Investigator(s):	**Date:**
Print Name:	
Follow-up action/review of recommendations and progress:	

Name of Reviewer:	
Position/Title of Reviewer:	
Signature of Reviewer:	**Date:**

- On completion, this form should be attached to the relevant Accident Report Form and retained for future reference and review.

Appendix 2

EXAMPLES

Accident/Incident Causation – Immediate Causes

Unsafe Acts

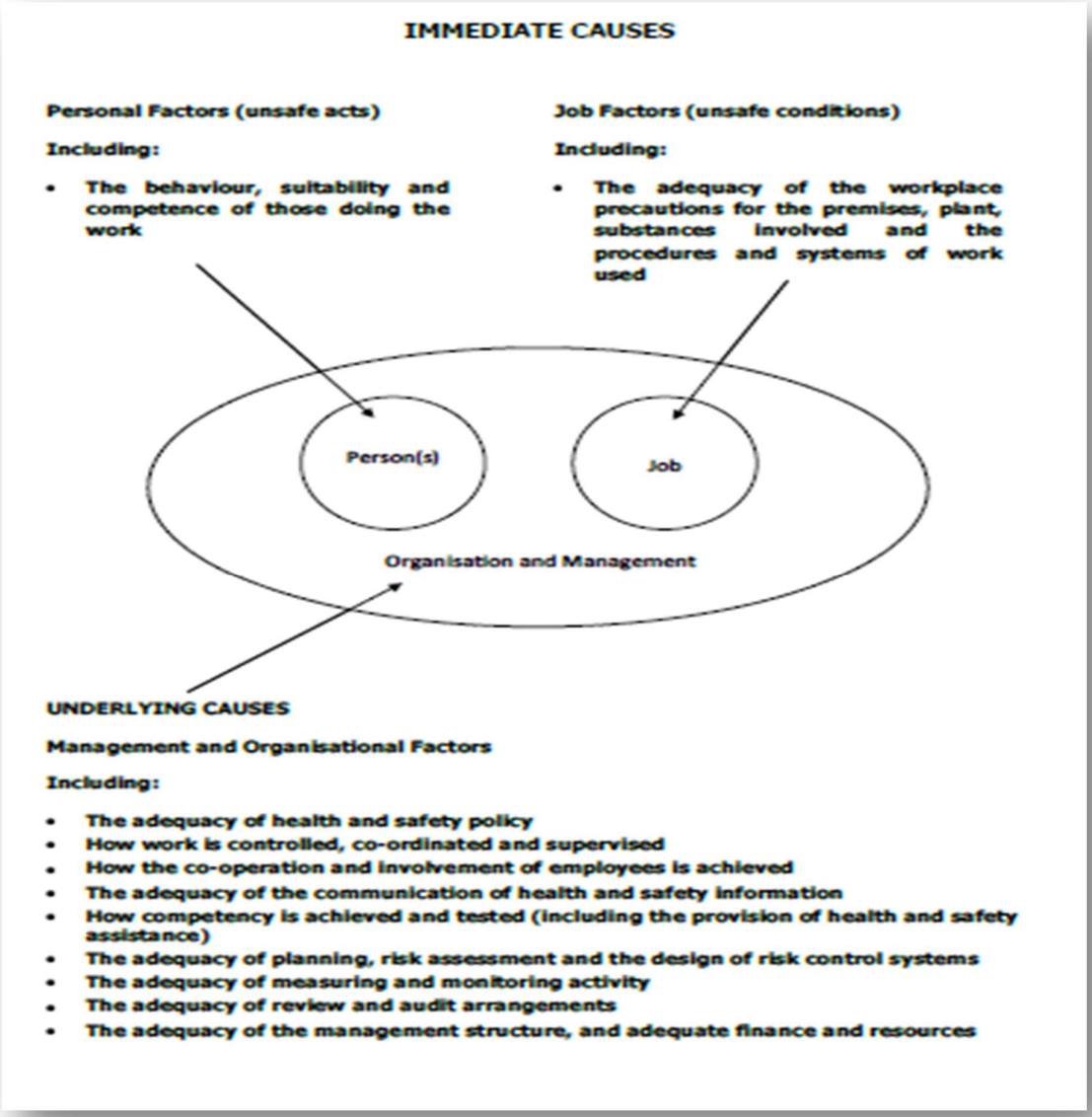
- Operating equipment without authority
- Failure to warn
- Failure to secure
- Operating at improper speed
- Removing safety devices
- Using equipment improperly
- Failing to use personal protective equipment (PPE) properly
- Improper loading
- Improper placement
- Improper lifting

- Improper position for task
- Servicing equipment in operation
- Horseplay
- Under influence of alcohol and/or other drugs

Unsafe Conditions

- Inadequate guards or barriers
- Inadequate or improper protective equipment
- Defective tools, equipment or materials
- Congestion or restricted action
- Inadequate warning systems
- Poor housekeeping – disorderly workplace
- Hazardous environmental conditions – gases, dusts, smoke, fumes, vapours
- Noise exposures
- Radiation exposures
- High or low temperature exposures
- Inadequate or excessive illumination
- Inadequate ventilation

Appendix 3


IMMEDIATE CAUSES
Personal Factors (unsafe acts)
Including:
• The behaviour, suitability and competence of those doing the work
Job Factors (unsafe conditions)
Including:
• The adequacy of the workplace precautions for the premises, plant, substances involved and the procedures and systems of work used
Person(s)
Job
Organisation and Management
UNDERLYING CAUSES
Management and Organisational Factors
Including:
• The adequacy of health and safety policy
• How work is controlled, co-ordinated and supervised
• How the co-operation and involvement of employees is achieved
• The adequacy of the communication of health and safety information
• How competency is achieved and tested (including the provision of health and safety assistance)
• The adequacy of planning, risk assessment and the design of risk control systems
• The adequacy of measuring and monitoring activity
• The adequacy of review and audit arrangements
• The adequacy of the management structure, and adequate finance and resources

Appendix 4

Standards

Standards Which Could Apply and Should Be Considered

Agreements	Are there any written agreements?
Custom and Practice	Is there a generally agreed way of working which is considered acceptable?
CATENA Health & Safety Policy and Environmental Policy	Is there anything in the CATENA health and safety policy which may be applicable?
Legislation	Is there relevant legislation which may be applicable?
Codes of Practice	Is there a relevant code of practice?
Other Official Guidance	Is there any official guidance?
Professional Standards	Are there any authoritative standards? E.g. those issued by British or European standards institutes/lead bodies?
Other Workplace Standards	Are there any standards in related workplaces that can be quoted as a comparison?

Appendix 5

CHECKLIST

INFORMATION YOU NEED TO COLLECT IN THE EVENT OF AN ACCIDENT/INCIDENT

- Details of any machinery involved, including make, serial number, age, maintenance records, etc.
- Details of any hazardous substances involved, including copies of health and safety data sheets, COSHH assessments, full names of substances, quantities used, etc.
- Details of how the accident occurred.
- A sketch of the area if appropriate – use space available on Accident/Incident Investigation Report Form (**Appendix 4**).
- Photographs where appropriate (check that it is safe to take photographs, especially if there are any flammables are in the area).
- Any documents, e.g. test certificates, maintenance records, results of workplace exposure monitoring, e.g. noise, dust, fumes, gases, radiations.
- Details of any instructions given to staff/students regarding the work activity.
- Details about other similar accidents, incidents, near misses, etc. previously documented.
- Details of any protective clothing or equipment provided and its suitability, maintenance, etc.
- Details of employee/student formal training.
- Details of School/Service COPS/operating procedures relevant to the accident/ incident.
- Copy of any relevant risk assessment documentation.
- Copy of any Permit to Work documentation if applicable.
- Details of the first aid available and administered if appropriate.
- Records of audits/inspections carried out.

If the HSE have expressed their intention to investigate the accident or occurrence, the factual evidence must not be disturbed or destroyed. This relates to plant, equipment, machinery, substances or any other materials which may help to establish how and why the accident/incident occurred.

REVIEWING THE POLICY

Overall responsibility for policy implementation and review rests with the Company senior management. However, all employees are obliged to adhere to and support the implementation of the policy. The Company will inform all employees of the policy and any amendments to the policy

Additional Information

If you require any additional information or clarification regarding this policy, please contact the CATENA office