Safety and Health Services investigation guidance for managers

Why investigate?

- Prevent recurrence and future harm (including near misses)
- Improve morale, the working environment and productivity
- Improve safe working methods and risk assessments
- Identify any trends and patterns
- Fulfil our legal requirements

Which incidents should be investigated?

The potential consequences should determine this (not just the injury or ill health on this particular occasion).

- Where the outcome could have easily and foreseeably been much worse (this includes near misses where no one was hurt in this particular occurrence).
- Where this type of incident has happened frequently (even if you wouldn’t investigate the incident in isolation)
- Where the incident has or could have affected the public (e.g. visitors, students etc.)

Both local management and the workforce should be involved in investigations. It’s important that the investigation is led by someone with the authority/seniority to make decisions and take actions resulting from the investigation recommendations.

- In a minimal level investigation, the relevant individual locally will look into the circumstances of the event and try to learn any lessons which will prevent future occurrences.

<table>
<thead>
<tr>
<th>Likelihood of recurrence</th>
<th>Minor</th>
<th>Serious</th>
<th>Major</th>
<th>Fatal</th>
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<td>Certain</td>
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<td>Likely</td>
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(Minor: limited injuries, no time off work.
Serious: Time off work needed as a result.
Major: e.g. broken bones, fractures, amputation, unconsciousness.
Fatal: one or more deaths.)
A low level investigation will involve a short investigation by the relevant person (e.g. SSA and/or line manager) into the circumstances and immediate, underlying and root causes of the adverse event, to try to prevent a recurrence and to learn any general lessons.

A medium level investigation will involve a more detailed investigation by the relevant person(s) (e.g. line manager), SSA and employee representatives and will look for the immediate, underlying and root causes. Findings from the investigation should be shared with the relevant local H&S committee / group. Findings may also be shared with other areas within the University where similar risks exist by Safety and Health Services.

A high level investigation will involve a team-based investigation and will usually be supported by an adviser from Safety and Health Services. The investigation team should include the local manager(s), the SSA and employee representatives. Depending on the severity of the incident, Senior Management at the University may also be involved and request details, updates and reports. The investigation will look for the immediate, underlying, and root causes in detail. Findings from the investigation should be shared both at local H&S committees/groups and amongst relevant meetings of senior management.

*adapted from the HSE’s Investigating accidents and incidents: http://www.hse.gov.uk/pubns/hsg245.pdf

Identifying immediate and underlying/root causes:

Finding the immediate causes of an accident can provide a short term fix but will not prevent a similar accident occurring in future. Identifying the underlying and root causes will allow learning and prevention of future incidents.

Tips:

- Start the investigation as soon as possible whilst the facts of the event are still clear and evidence such as witness statements, photos etc. are easily obtained.
- Take photos of the incident (including location, equipment, other relevant items) as quickly as possible.
- Prevention and learning is the key objective
- Look at the facts and report these rather than your and others’ opinions
- Try not to blame whilst investigating (individual actions can be considered separately after the investigation is concluded)
- Investigations where the sole cause is identified as operator error are generally not acceptable – there is usually an underlying or route use – i.e. what conditions caused the error (e.g. training, equipment design etc.)

Some questions to ask:

Questions to ask in an accident investigation include the following (some of these will have already been answered on the incident report):

- Where and when did the accident happen?
- Who was injured/suffered ill health?
- What was damaged?
- Who was involved?
• How did the accident happen?
• What activities were being carried out at the time?
• What did witnesses see, hear, smell, feel, taste?
• Was there anything unusual or different about the working conditions?
• Were there adequate safe systems of work and did people stick to them?
• Was the activity being properly supervised/managed?
• What were the outcomes of the accident - injury, disease, damage, death, near miss, loss?
• What was the cause of any injury?
• What were the immediate and underlying causes of the accident?
• What does the relevant risk assessment say?
• Was the risk known? If yes, why was it not controlled? If no, why not?
• Did the work organisation (or lack of it) impact on the accident?
• Was maintenance and cleaning adequate?
• Were the people involved suitable and competent?
• Did the workplace layout influence the accident?
• Did the nature, shape or form of the materials influence the accident?
• Did the work equipment influence the accident? Was it difficult/awkward to use?
• Had the people involved received adequate information, instruction and training?
• Was this clearly documented?
• Was adequate safety equipment provided and used correctly?
• What other conditions influenced the accident?

Further help

More information on incident investigation can be found on the HSE’s website: http://www.hse.gov.uk/pubns/hsg245.pdf.

A template to assist managers when undertaking an investigation is available from Safety and Health Services: http://www.bristol.ac.uk/safety/media/fo/incident-investigation-fo.docx

Incident investigation documents should be uploaded to the University Incident Reporting and Investigation System: http://www.bristol.ac.uk/safety/accident