AC/0917 (05)

Safety Code of Practice

October 2017

Investigating Accidents and Incidents Policy

Contents

1. POLICY STATEMENT

The Dominic Barberi Multi Academy Company is committed to providing an environment which is as healthy and as safe as possible for its students, staff and visitors. However accidents and incidents do happen and there is a statutory requirement to report all serious accidents, dangerous occurrences and instances of occupational ill health. Of which some are reportable to the Health and Safety Executive (HSE).

The DBMAC and school have a duty to record all accidents, incidents, near misses or dangerous occurrence and these maybe subject to investigation (depending on the circumstances) This applies to all staff, students and visitors. All submitted documents will be subject to monitoring to ensure that procedures are in place to prevent, as far as possible, similar accidents, incidents, near misses or dangerous occurrences happening and minimise further risks.

2. INTRODUCTION

Every year people are killed or injured at work. Over 40 million working days are lost annually through work-related accidents and illnesses. Recent figures show that an average of 250 employees and self-employed people are killed each year as a result of accidents in the workplace. A further 150 000 sustain major injuries or injuries that mean they are absent from work for more than three days. Over 2.3 million cases of ill health are caused or made worse by work.

According to the Labour Force Survey 3, over 40 million working days are lost through work-related injuries and ill health, at a cost to business of £2.5 billion.

Carrying out your own health and safety investigations will provide you with a deeper understanding of the risks associated with school/DBMAC activities. Blaming individuals is ultimately fruitless and sustains the myth that accidents and cases of ill health are unavoidable when the opposite is true. Well thought-out risk control measures, combined with adequate supervision, monitoring and effective management (ie a risk management system) will ensure that your work activities are safe. Health and safety investigations are an important tool in developing and refining risk management systems.

3. RESPONSIBILITIES

3.1 The responsibility of the employer

- To ensure you are operating your organisation within the law.
- The Management of Health and Safety at Work Regulations 1999, regulation 5, requires employers to plan, organise, control, monitor and review their health and safety arrangements. Health and safety investigations form an essential part of this process.
- We are expected to make full disclosure of the circumstances of an accident to the injured parties considering legal action. The fear of litigation may make you think it is better not to investigate, but you can't make things better if you don't know what went wrong! The fact that you thoroughly investigated an accident and took remedial action to prevent further accidents would 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.

4. GATHERING INFORMATION

4.1 Information and insights gained from an investigation

- An understanding of how and why things went wrong.
- An understanding of the ways people can be exposed to substances or conditions that may affect their health.
- 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.)
- Identifying deficiencies in any risk control management, which will enable you to improve your management of risk in the future and to learn lessons which will be applicable to other parts of your organisation

4.2 Benefits arising from an investigation

- The prevention of further similar adverse events. If there is a serious accident, the regulatory authorities will take a firm line if you have ignored previous warnings.
- The prevention of business losses due to disruption, stoppage, lost orders and the costs of criminal and civil legal actions.
- An improvement in employee morale and attitude towards health and safety. Employees will be more cooperative in implementing new safety precautions if they were involved in the decision and they can see that problems are dealt with.
- The development of managerial skills which can be readily applied to other areas of the organisation

4.3 Which events should be investigated?

- Having been notified of an adverse event and been given basic information on what happened, you must decide whether it should be investigated and if so, in what depth.
- It is the potential consequences and the likelihood of the adverse event recurring that should determine the level of investigation, not simply the injury or ill health suffered on this occasion. For example: Is the harm likely to be serious? Is this likely to happen often? Similarly, the causes of a near miss can have great potential for causing injury and ill health. When making your decision, you must also consider the potential for learning lessons. For example if you have had a number of similar adverse events, it may be worth investigating, even if each single event is not worth investigating in isolation. It is best practice to investigate all adverse events which may affect the public.

4.4 What makes a good investigation?

- Investigations should be conducted with accident prevention in mind, not placing blame. Attempting to apportion blame before the investigation has started is counterproductive, because people become defensive and uncooperative. Only after the investigation has been completed is it appropriate to consider whether any individuals acted inappropriately.
- Investigations that conclude that operator error was the sole cause are rarely acceptable. Underpinning the ‘human error’ there will be a number of underlying causes that created the environment in which human errors were inevitable. For example inadequate training and supervision, poor equipment design, lack of management commitment, poor attitude to health and safety.
- The objective is to establish not only how the adverse event happened, but more importantly, what allowed it to happen.

4.5 Information gathering

- Explores all reasonable lines of enquiry;

- Is timely;
- Is structured, setting out clearly what is known, what is not known and records the investigative process.

4.6 Analysis

- Is objective and unbiased;
- Identifies the sequence of events and conditions that led up to the adverse event;
- Identifies the immediate causes;
- Identifies underlying causes, ie actions in the past that have allowed or caused undetected unsafe conditions/practices;
- Identifies root causes, (ie organisational and management health and safety arrangements – supervision, monitoring, training, resources allocated to health and safety etc).

4.7 Risk control measures

- Identify the risk control measures which were missing, inadequate or unused;
- Compare conditions/practices as they were with that required by current legal requirements, codes of practice and guidance;
- Identify additional measures needed to address the immediate, underlying and root causes;
- Provide meaningful recommendations which can be implemented. But woolly recommendations such as 'operators must take care not to touch the cutters during run-down' show that the investigation has not delved deep enough in search of the root causes.

4.8 Action plan and implementation

- Ensure any action plan deals effectively not only with the immediate and underlying causes but also the root causes;
- Include lessons that may be applied to prevent other adverse events, eg assessments of skill and training in competencies may be needed for other areas of the organisation;
- Provide feedback to all parties involved to ensure the findings and recommendations are correct, address the issues and are realistic;
- Should be fed back into a review of the risk assessment. Reviewing of risk assessment following completion of investigation.
- Communicate the results of the investigation and the action plan to everyone who needs to know.
- Include arrangements to ensure the action plan is implemented and progress monitored.

5. INVESTIGATION PROCESS

- The urgency of an investigation will depend on the magnitude and immediacy of the risk involved (eg a major accident involving an everyday job will need to be investigated quickly). However, The DBMAC has set a standard for investigation works to start within 48 hours from being reported (excluding non-working or school days).
- The length of time to complete and investigation will depend on the complexity, (eg, if you need to speak to 4 witnesses that work varied working patterns, this may take longer to gather information).
- Only the principal or health and safety lead for the DBMAC facility can undertake an investigation. However, it is recognised that if the principal or health and safety lead are unavailable, then a senior leadership team member would need to undertake the investigation.
- The DBMAC has a standard accident and incident investigation form (appendix 1) which should be used to gather information. This is not limited and there maybe additional supporting information to go alongside the investigating documents, eg further witness statements, photos, videos, maps, drawings etc.
- The DBMAC has a standard witness information gathering form (appendix 2) which can be used to assist the investigation.

- On completion of the investigation process and implementation of the necessary actions, only the Principal or health and safety lead for the facility/ DBMAC building can close the matter.
- It is expected that each school/department will have contingency plans in place to ensure that in the case of the investigating person(s) being away from the workplace, incident investigations are always commenced within 48 hours of the incident being reported.
- Investigation documents and supporting information should be submitted to The DBMAC Governance Officer for central records and monitoring

6. MONITORING ACCIDENTS AND INCIDENTS

- All completed forms, investigating documents or supporting evidence must be sent to the DBMAC Governance Officer (currently Maureen Jackson) ensuring that the data is recorded for future reporting.
- All Accidents, incidents near misses and dangerous occurrences for the DBMAC should be reviewed every 12 months by DMBAC board and monitored for;
    1. Trends
    2. Re occurring incidents
    3. Making changes or improvements to reduce further risk
    4. Identify safeguarding improvements
    5. Training requirements or support measure for individuals, team, supervision or management.

6.1 Statutory requirements

- Under the reporting of injuries, diseases and dangerous occurrences regulations 1995 (RIDDOR), some accidents must be reported to the HSE. The employer must keep a record of any reportable injury, disease or dangerous occurrence. This must include the date and method of reporting, the date, time and place of the event: personal details of those involved and a brief description of the nature of the event or disease. This record can be combined with other accident reports.

6.2 Record keeping

- Records of all submitted accident, incident, near misses or dangerous occurrence should be kept for a minimum of 3 years.
- Records of all minor accident forms should be kept for a minimum of 3 years
- Records should be kept of all investigations for a minimum of 3 years.
- All records submitted by any employee, students or visitor in relation to this policy are considered sensitive and should be stored safety on secure network/drives.

6.3 Support services

- For any specific investigating accidents and incidents advice, staff can contact our DBMAC health and safety servicer provider, which is currently Oxfordshire County Council.

Approved by AUDIT COMMITTEE: OCTOBER 2017. To be reviewed October 2018

Verified by Company Secretary

Date___4th October 2017_____

Name___Maureen D Jackson_____

Appendix 1 – Accident and Incident investigation form

The Dominic Barberi Multi Academy Company

Accident and Incident Investigation Form

Overview

Reported by:		**Date/Time of Event:**		
Incident	Ill Health	Minor Injury	Serious Injury	Major Injury
Brief Details (What, where, when, who and emergency measures taken):				
Date investigation started:		Time investigation started::		

Assessment to be carried out by principal or health and safety lead for the facility

Type of event		Actual/potential for harm	
Accident	**Near-miss**	**Fatal or major**	**Minor**
Ill health	**Dangerous occurrence**	**Serious**	**Damage only**

RIDDOR reportable?	**Y/N**	**Date/time reported**
DBMAC accident/incident record completed	**Y/N**	**Date entered/reference**

Investigation level

High level		**Low level**	
Medium level		**Minimal**	

Assessment carried out by:	**Date:**

Step 1 – Investigation information gathering

1. Where and when did the accident/incident happen?

2. Who was injured/suffered ill health or was otherwise involved with the accident / Incident?

3. How did the accident/incident happen? (Note any equipment involved).

4. What activities were being carried out at the time?

5. Was there anything unusual or different about the working conditions?

6. Were there adequate safe working procedures and were they followed?

7. What injuries or ill effects, if any, were caused?

8. If there was an injury, how did it occur and what caused it?

9. Was the risk known? If so, why wasn't it controlled? If not known, why not?

10. Did the organisation and arrangements of the work influence the accident / incident?

11. Was maintenance and cleaning sufficient? If not, explain why not

12. Were the people involved competent and suitable?

13. Did the workplace or school layout influence the accident / incident?

14. Did the nature or shape of the materials influence the accident / incident?

15. Did difficulties using the equipment influence the accident / incident?

16. Was the safety equipment sufficient?

17. Did other conditions influence the accident / incident?

Step 2 - Analysis and further Action

18. What were the immediate and underlying causes?

Analysis

Step 3 - Identifying suitable risk control measures

19. What risk control measures are needed / recommended?

1
2
3
4
5
6

20. Do similar risks exist elsewhere? If so, what and where are they?

21. Have similar accidents / incidents occurred before? Give details.

Step 4 - The risk control action plan

22. Which risk control measures should be implemented in the long and short term?

Control	Completion Date	Person Responsible
1		
2		
3		
4		
5		

23. Which risk assessments and safe working procedures need to be reviewed and updated?

Name of risk assessment safe working procedure	Completion Date	Person Responsible
1		
2		
3		
4		
5		

24. Have the details of the accident / incident and the investigation findings been recorded and analysed? Are there any trends or common causes which suggest the need for further investigation? What did the accident / incident cost?

Signed by investigating person	
Name of investigating person	
Position of investigating person	
Date investigation completed	

Appendix 2 – Witness statement accident and incident information gathering form

This form is for any person(s) that witnessed the accident or incident to gather key facts and information.

Name of witness	
Job role / position	
Contact number	
Date form completed	

Please provide as much accurate information regarding the accident / incident you have witnessed. This information will only be used to solely to assist in the investigation. Consider covering these points in your written description: where/what/why/who/how

Signed by witness	