



Incident Investigation Procedure

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About Subvision Surveys

Subvision Surveys is a niche provider of professional surveying services to Utilities, Asset owners and to the construction industry.

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1. Purpose

The purpose of this procedure is to ensure a safe workplace for all employees, contractors and clients through effective and systematic Incident investigation and reporting mechanisms, to ensure that further risks of workplace incidents are eliminated.

2. Scope

This procedure is applicable to all employees, contractors of the organisation.

3. References

Refer to Individual state/country enforcing authority websites (Codes of Practice or Standards) in relation statutory reporting requirements of incidents.

4. Relevant Documents/Database

- Incident Reporting and Investigation Form Appendix 9 and 10

5. Procedure

What is an incident?

'Incident' for the purposes of this procedure includes:

- Any event that results in injury or disease no matter how minor;
- Any dangerous occurrence - this term includes near misses - any event that endangers the health or safety of a person;
- Any event that results in death.

Systematic Management of Incidents

Subvision Surveys is committed to maintaining a safe and healthy environment for all employees and non-employees. Whilst incidents involving employees or non-employees should never occur, unfortunately due to a number of reasons, they may still happen.

Incident investigation and analysis can be still seen as a systematic pro-active approach to the continuous improvement of the OHS Management System. Constructive investigations yield essential information, which will assist in:

- Determining injury rates
- Identifying trends and problem areas;
- Permitting comparisons to be made, for example between injury rates for different areas of the workplace, across different time frames and involving different types of injury;
- Complying with legal requirements, for example, providing data required for personal injury claims involving workers compensation payments.
- Identifying the basic causes that contributed directly, or indirectly, to each incident
- Identifying deficiencies in the OHS Management System that permitted the incident to occur; and
- Suggesting specific corrective action alternatives for the management system.

Reporting Process

1. Employee witnesses or is involved in an incident – the employee must complete Incident Reporting and Investigation Form and Injury Register (if injured) and report to management within 24 hours.
2. The responsible manager will report injury to insurer and enforcing authority (if applicable) within the statutory reporting timeframes.
3. Management in consultation with employees will ensure immediate interim action is taken as required to minimise risk within the workplace.

4. Manager will investigate incident and review concerns raised. The level of investigation will be determined at this stage.
5. The responsible manager will carry out necessary interviews and review documentation (within the investigation team – if full investigation is warranted).
6. The responsible manager will complete the final section of the Incident Reporting and Investigation Form.
7. The responsible manager will complete the necessary risk management documentation ie. risk register and action plan.
8. Corrective actions will be implemented according to the risk action plan.
9. All documentation must be kept on file for easy access and retrieval, if required.
10. All incidents will be reviewed by management and health and safety representatives on a regular basis.

Determining the Root Cause

All incidents, including near misses, must be reported within 24 hours of the occurrence an investigation undertaken by management (scope of investigation dependant on degree of injury).

There are essentially two major reasons why the organisation investigates incidents, these are:
To determine the true and accurate circumstances which led up to and contributed to the event, and
To prevent the event occurring again, potentially with even greater repercussions.

Root Causes

Identifying the root cause of an incident may be a relatively complicated process. Several coincidental causes making up a chain of causation factors may be identified, none of which alone may have resulted in the incident.

The basic concept of incident prevention is that incidents can have several causes, each of which must be identified and controlled.

Accurate, clear and complete information is needed from the investigation process. Details which should be recorded and included in the incident investigation report are:-

- A description of the sequence of events leading to the incident
- Correct identification of all causal factors
- A description of all causal factors
- The corrective actions already taken
- Further recommendations for corrective actions; and
- Review and sign-off by senior management

Investigation of Incidents

Accurate, clear and complete information is needed from the investigation process. It is important when investigating incidents not to allocate blame. If attempts are made to apportion blame, people who might otherwise provide useful information and guidance on remedial action needed, will simply become defensive. The results could be:-

- Witnesses not revealing all of the circumstances and events surrounding the incident
- Deliberate obstruction or provision of false information and
- The removal of relevant information, documents or evidence

The investigator(s) must remain impartial and objective if all of the causes are to be established.

For the incident investigation to be successful in identifying all of the causes of the incident, it will be necessary to establish:

The events and circumstances leading up to the incident -

- The types of events and circumstances leading up to the incident, which will be relevant for the investigation, may include:-
- The system of work currently in place
- The instructions given for the work variations from instructions or safe work systems
- Workplace conditions such as lighting, floor surfaces, stair treads and handrails, warning signs, and temperature and weather, if the incident occurred outside

- The exact location of the incident, with sufficient detail for the spot to be readily identified by somebody else reading the report
- The materials in use or being handled; and
- The type of equipment in use

Facts of the incident – facts relevant to the incident may include:

- The state of the work system and the actions which occurred at the moment of the incident
- The people directly involved, and those involved at a distance, if any
- The tools, equipment, materials and fixtures directly involved; and
- The time the incident occurred

Facts of events immediately after the incident – relevant facts from events which occurred immediately after the incident may include:-

- The injuries or damage resulting directly from the incident
- The events leading to consequential injury or damage
- The people involved, including those rendering aid; and
- Any problems in dealing with the injuries, such as the lack of a process for releasing a trapped person, presence of a faulty extinguisher etc.

Basic Factors

In the investigation of the events leading up to an incident, there will be a number of basic factors to consider. They are important in determining causation. The basic factors comprise elements which must exist to enable the sequence to continue, and hence the damage to occur. These elements contribute to all incidents. In conducting an effective incident investigation, it is essential to look for each of these components and not to look for any single cause:

- Design Factors – poor systems design may result in exposure to hazards such as unguarded dangerous parts of machinery, ineffective safety devices or inadequate ventilation.
- Environmental Factors – The production system environment has a direct effect on safety behaviour. How people function in the work environment depends on what they experience in it. The environmental factors may be both physical and psychosocial.
- Behavioural Factors – behavioural factors can result in exposure to hazards. Examples of behavioural factors are the misuse of safeguards, the improper use of tools and equipment, ignoring cautionary notices, failure to wear personal protective equipment, horseplay or poor standards of housekeeping.

The reasons that lie behind the disregard for accepted safe systems of work and safety practices, procedures or rules need to be examined. Such behaviour is not accepted within the organisation. Managers should look at improved communication, further training, supervision, counselling or modification of controls before disciplinary procedures are to be initiated.

Systems and Management Factors

It is necessary to locate, within the various levels of the management system, errors and omissions which permitted the event to occur. Such elements will always be present and the design, environmental and behavioural factors identified above can be traced or related to management failures.

When Should You Investigate?

Some incidents may require more detailed investigation and analysis; the risk management analysis tool will identify when a more detailed investigation utilising a group investigation technique should be used.

Composition of a Standard Investigation Team

The size and make-up of the investigation team is dictated by the incidents seriousness or complexity. A standard investigation team for a minor injury or property damage incident would usually consist of:

- The relevant Senior Manager
- Relevant employees ie. health and safety representatives
- Specialist Consultants (Where applicable)

In the event of an incident which is reported to the enforcing authority regarding a notifiable incident, the investigation team may involve specialist consultants and the enforcing authority representatives.

Reporting to Statutory Authorities

The organisation will comply with all the statutory reporting requirements. These arrangements oblige the organisation to report the details of certain incidents to the relevant enforcing authority. The types of incidents which must be reported are usually: -

- Incidents resulting in loss of life (which must be reported immediately)
- Incidents resulting in a worker taking a number of days off work due to injury; and
- Incidents involving damage or potential damage to dangerous items of plant (such as boilers)

Refer to the Enforcing Authority website for up-to-date reporting timeframes and procedure.

Review of Corrective Actions

The responsible manager will review the information gained from the incident investigation and carry out a risk management process.

After the investigation has been conducted, the Incident Investigation and Reporting form will be completed detailing the action needed to be carried out to eliminate or minimise the hazard using the risk management processes.

Risk Identification, Assessment and Control

The organisation shall identify and assess all hazards that have caused incidents using the following risk management methods:

- Defining the scope of the activity that is to be assessed.
- Identifying the risks.
- Assessing the risks.
- Controlling the risks.
- Monitoring and reviewing the process.

The organisation shall implement all controls using the following hierarchy of hazard control:

- Eliminating the hazard.
- Substituting the hazard.
- Modifying the process.
- Isolating the hazard.
- Implementing engineering controls.
- Using a combination of controls.
- Using back up controls, such as personal protective equipment.

See 'Five Steps to Risk Assessment Document' for further information on risk identification, assessment and control and the hierarchy of hazard control.

In addition, the organisation shall:

- See that all corrective actions identified in an investigation are authorised with signed documentation.
- Allocate responsibility against each corrective action, to ensure everyone is aware of what is required of them. Any lack of response shall be tracked to the responsible person.
- Ensure any corrective actions have a time frame allocated to them for completion.
- Ensure all employees concerned have received sufficient training, or arrange for retraining, as deemed necessary by the findings of the investigation.
- Where a specific task or process has caused the incident, a job safety and environmental analysis will be undertaken in order to re-assess the risks associated within the area.
- After implementing corrective actions, ensure they are evaluated at a future time. This is to ensure that the controls have not caused any further hazards, and that they are in fact appropriate to reducing the likelihood of a recurrence of the same event.

Use of Incident Statistics

The organisation will use the information gained from incident statistics to measure trends over a period of time so that the organisation has an indication of whether it is improving, stable or deteriorating with regards to Health and Safety performance.

Negative Performance Indicators

The organisation will measure "Average Lost Time Rate" and the average time lost per occurrence of injury or disease. This rate is an indication of the severity of occurrences being experience by employees over a period of time.


Positive Performance Indicators

It is important to note that negative performance indicators such as "Average Lost Time Injuries" give an indication of the state of the OHS Program and should be used with caution. Positive Performance Indicators are pro-active and show the effectiveness of training, management commitment and support, and resources given to safety, which are all part of the larger picture.

Statistics will also provide the organisation with an indication of the effectiveness of the corrective or preventative actions taken to minimise or eliminate the hazard which caused the accident.

Privacy Considerations

The Privacy Act provides the legislative basis for protection of individuals' rights in regard to disclosure of personal information. Personal information may only be divulged in circumstances which correspond with the stated use.

Signed: (Employer)		Date:	01 st April 2021	
Subject to review, monitoring and revision by:	James Hook	Review Date:	1 st March 2022	Sooner if work activity changes