



Proposals for a new duty to investigate accidents, dangerous occurrences and diseases

This consultative document is issued by the Health and Safety Commission in compliance with its duty under Section 50(3) of the Health and Safety at Work etc Act 1974, to consult bodies which appear to it to be appropriate before submitting proposals for making regulations under the Act.

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to reach him no later than 3 September 2001

The Commission tries to make its consultation procedure as thorough and open as possible. Responses to this consultative document will be lodged in the Health and Safety Executive's Information Centres after the close of the consultation period where they can be inspected by members of the public or be copied to them on payment of the appropriate fee to cover costs.

Responses to this consultative document are invited on the basis that anyone submitting them agrees to their being dealt with in this way. Responses, or part of them, will be withheld from the Information Centres only at the express request of the person making them. In such cases a note will be put in the index to the responses identifying those who have commented and have asked that their views, or part of them, be treated as confidential.

CONSULTATIVE DOCUMENT

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INTRODUCTION

1 In 1999 the Health and Safety Commission (HSC) concluded consultation, by means of a Discussion Document (DD) entitled “A new duty to investigate accidents” (reference DDE9, published by HSE Books), on whether to make more explicit in law requirements on employers to investigate the causes of workplace accidents and ill health. Many employers do undertake accident and disease investigation when there has been an event in the workplace which has caused injury or illness in order to ensure lessons are learned, but this is not universal and investigation practices vary across industry sectors and types of business. Although there are duties under some health and safety law that may lead employers to undertake investigation and to take account of the lessons learned, there is no explicit duty to do so. This document sets out the results of the earlier consultation exercise and proposals for further action in the light of them.

BACKGROUND

2 Unless the causes of workplace accidents and ill health are properly understood, lessons will not be learned and suitable improvements will not be made to secure the future health and safety protection of those who may be affected by a work activity.

3 The volume of incidents that could be subject to a proposed new duty to investigate accidents is vast. The total number of workplace injuries to workers is estimated at 1.06 million each year (not including dangerous occurrences or injuries to the public), but the total number of reportable injuries (as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)) to workers is estimated at about 400,000 annually. Reporting levels for accidents are poor, currently in the region of 46%. The current figures for 1999/2000 are:

- 216 fatal injuries
- 28,196 injuries classified as “major” under RIDDOR
- 129,599 other injuries leading to more than 3 days off work
- 24,104 non-fatal injuries to members of the public
- 2,515 reported occurrences of diseases
- 10,002 dangerous occurrences

4 For every accident that takes place there are a large number of near misses or events which have the potential to cause harm. An accident may be the manifestation of the fact that something fundamental is wrong with health and safety management in a workplace – if not rectified it could lead to further injury or damage at a later date.

5 The prime responsibility for accident and ill health investigation and prevention lies with duty holders, primarily employers. If lessons are to be learned from accidents and dangerous occurrences, their underlying causes need to be understood at the very least by

duty holders themselves. They need to understand why events happened, and act to make sure that they do not happen again.

THE PURPOSE OF THIS DOCUMENT

6 This document sets out the HSC's specific proposals, following the earlier consultation exercise, for amending the Management of Health and Safety at Work Regulations 1999 (MHSWR) to introduce a new duty on employers to investigate the causes of workplace accidents. We invite comments on the proposals and on the possibility of using another legislative vehicle, and will decide whether to propose to Ministers the introduction of a new legal duty after considering the responses we receive.

7 This document is also available on the Health and Safety Executive (HSE) website at <http://www.hse.gov.uk/condocs/>. Alternatively, you can obtain further copies from HSE Books at the address on the back cover.

8 The HSC would welcome comments on all the issues raised in this Consultative Document. For your convenience, all the issues on which we are particularly interested in receiving your views are set out in the reply form at Annex 5, which you may find helpful to use when replying. But you can let us have your comments in any format and on any issue relevant to the proposed duty. If you are replying on behalf of an organisation, it would be helpful if you could tell us what that organisation does, and what its aims are.

9 Details of how to reply are on the front cover and in Annex 5. We would like all replies to arrive no later than 3 September 2001. We will acknowledge all responses and give full consideration to the substance of arguments in the development of proposals. We may also contact you again if, for example, we want any further clarification.

10 Annex 5 also invites your views on the method of consulting you on these proposals. If you are not satisfied with the way in which this consultation exercise has been conducted we would like to know. If you cannot sort out the problem with Neville Higham, you can write to Mel Draper, Head of Policy Division, HSE, Rose Court, 2 Southwark Bridge, London SE1 9HS. He will investigate your complaint and tell you what he is going to do about it. We aim to reply to all complaints within 10 working days. If you are not satisfied with the reply you receive, you can raise the matter with the Director General of HSE, Timothy Walker CB, at the same address.

11 If you are replying in a personal capacity, rather than as a postholder of an organisation, you should be aware that information you provide may constitute "personal data" within the terms of the Data Protection Act 1998. For the purposes of this Act, HSE is the "data controller" and will process the data for health, safety and environmental purposes. HSE may disclose this data to any person or organisation for the purposes for which it was collected, or where the Act allows disclosure. You have the right to ask for a copy of the data and to ask for inaccurate data to be corrected.

THE HSC's DISCUSSION DOCUMENT

12 The HSC issued its earlier Discussion Document to promote public debate on the implications of a proposal to introduce a new duty on employers to investigate the causes of workplace accidents, dangerous occurrences and cases of ill health. The Commission took the view that before considering any specific proposals it would be useful to obtain the views of stakeholders in the health and safety system about the need for, and form of, such a duty. The Discussion Document explained the current legal position and practice, and sought views on the need for and possible scope of a new duty.

13 The DD discussed the value of placing a new obligation on duty holders to investigate accidents etc. with a view to taking lessons into account in revising risk assessments. It explored the case for and against a new duty, and considered the scope such a duty might cover and the form it might take.

14 A number of possible options were suggested, although this did not exclude other possibilities. The main options were:

- no change in the law, but to provide further guidance on methods of accident investigation;
- a “simple” duty to investigate accidents. This would require an employer to (i) take steps that are: reasonable and proportionate to the accident, to establish the causes and (ii) take them into account when revising the risk assessment;
- an “elaborated” duty. This would be as the simple duty, but might include a more extensive set of requirements. In particular there might be a graduated approach so that the more serious accidents triggered a more extensive duty, such as a requirement to prepare a written report and send it to the enforcing authority.

15 In all 684 responses were received – 606 in the form of the questionnaire contained in the document. A detailed analysis of the responses is at Annex 2 in respect of those who returned the survey form (87%). Examination of the other responses suggests that the numerical results in Annex 2 provided a representative picture.

16 The results of consultation were clear and, overall, supported a change in the law through amendment of the MHSWR to introduce a duty to take reasonable steps (ie those that are practicable and proportionate to the scale of the incident) to investigate accidents, reportable dangerous occurrences, and reportable diseases, and take the findings into account in revising the relevant risk assessments.

17 Respondents broadly agreed:

- all accidents should be investigated by employers to learn lessons and take corrective action;
- investigation should be proportionate to the scale or complexity of the incident;
- the results should lead to amendment of the relevant risk assessments.

18 Over 90% of respondents felt the HSC should take some further action to encourage employers to investigate accidents. Two thirds believed this should be achieved by a change in the law to introduce a new legal duty requiring employers to investigate workplace accidents. The rest mostly believed the existing implicit duties are sufficient but should be supported by better guidance through a change to the Approved Code of Practice (ACoP) supporting the MHSWR or more general guidance.

19 If there were to be a change in the law, most respondents favoured the introduction of a new duty to take reasonable steps to investigate accidents with a corresponding duty to revise the risk assessment. Most (over 60%) favoured achieving this by amendment of MHSWR. Respondents were divided on their view of whether more complex requirements such as preparing a report were required, and hence we concluded that these elaborations were not supported. Respondents thus preferred a simple duty to take reasonable steps to investigate accidents, dangerous occurrences and diseases.

20 Of those respondents expressing a view, 93% said that such a new legal duty would fit well with existing practice and procedures at their workplace.

21 We consulted representatives of small firms during this process. They were generally supportive of a change in the law through amendment of MHSWR to take reasonable steps to investigate and to take the findings into account in revising the risk assessment. We are conscious that this proposal would apply to all businesses and consider that its potential benefits should apply to all sections of the workforce. Small firms often lack expertise in health and safety, and evidence suggests that the risk of fatal or serious injury is higher in small workplaces.

22 In the light of these responses the HSC decided to publish specific proposals to amend the law to introduce a new duty to investigate accidents etc, and to seek views on these proposals. These are set out in this document.

OUR PROPOSALS FOR A NEW DUTY

23 Details of the proposed new duty are set out in Annex 1 and as drafted would take effect via the Management of Health and Safety at Work (Amendment) Regulations 2001. The new duty takes the form of an amendment to the MHSWR 1999 (which consolidated earlier changes to the original MHSWR) and would amend regulation 3 (risk assessment) to introduce a new Schedule on the investigation of accidents, dangerous occurrences, and diseases into the regulations.

24 The MHSWR, although favoured by the majority of respondents to the DD, is not the only legislative vehicle available to introduce a new duty. The proposals have been drafted so that they could be slotted as a schedule into other health and safety regulations, for example RIDDOR, which would make clear the linkage between reporting and investigation and also make clearer the link with employers' overall management of risk. Alternatively, the proposals could form a stand-alone set of regulations. Whilst there is a good case for pursuing the MHSWR route through its promotion of investigation as a integral part of health and safety management requirements we would be interested in hearing views on other legislative options.

Question 1: Do you agree that the duty to investigate should be incorporated in the MHSWR?

Question 2: If you answered no to question 1, what would be your preferred legislative route? Please give reasons for your answer.

25 Paragraph 1 of the Schedule - Interpretation - sets out the definitions that would apply. They establish a clear link with RIDDOR. The proposed new duty uses the definitions contained in RIDDOR to define the scope of the incidents that need to be investigated by the duty holder - all injury accidents reportable under RIDDOR, all dangerous occurrences reportable under RIDDOR, and all diseases reportable under RIDDOR. In addition, the duty holder for the proposed duty to investigate would be the person responsible for making a report under RIDDOR (see paragraph 30). The HSC will be starting work on a fundamental review of RIDDOR in 2001/02.

26 The responses to the DD showed a small majority in favour of including all accidents, ie not just those reportable under RIDDOR, within the scope of any new duty. We have considered how we might define “accident” to cover all workplace unplanned events with the potential for causing harm. This has proved to be difficult without including many minor incidents that we are not convinced should be within the scope of the legal duty. In addition, we have concerns that an all-embracing definition could, due to the number of incidents covered, lead to a largely bureaucratic and process dominated reaction from some employers. We consider that some qualification in terms of seriousness is necessary if the duty is to be clearly understood and not be unduly burdensome.

27 We have prepared the draft duty on the basis of limiting the duty to all accidents reportable under RIDDOR and would be very interested in hearing from you on this issue. The duty also applies to those dangerous occurrences reportable under RIDDOR, and to those diseases reportable under RIDDOR.

Question 3: Do you agree that the duty to investigate should apply to those accidents reportable under RIDDOR?

Question 4: If you answered “no” to question 3, what range of accidents do you think we should include within the scope of the duty? Please give reasons for your answer.

28 It has also been suggested that the new duty could also apply to “near misses”, in addition to those dangerous occurrences reportable under RIDDOR. We recognise that near misses can be just as important as an event leading to injury. For example, the fall of a heavy object from a great height would not necessarily be reportable, unless someone was injured when it fell. However, it would be sensible for the employer to investigate such an event and take appropriate action to prevent a recurrence. Again, we are cautious about extending the scope of the duty to such a wide range of events as drawing up a legal definition would be difficult and employers might be uncertain as to what is covered. It could lead to employers

introducing overly bureaucratic systems. It would not sit easily with the approach we have proposed to restrict the scope of the duty to those accidents reportable under RIDDOR. HSE would however publish supporting guidance and would use this as a means of setting out good practice that employers could follow in addition to their responsibilities under the proposed new duty.

Question 5: Do you agree that the duty to investigate should apply to “near misses”, but limited to those dangerous occurrences reportable under RIDDOR?

Question 6: If you answered no to question 5, what scope do you think the duty should encompass? Please give reasons for your answer.

29 The proposed new duty to investigate would also apply to those diseases reportable under RIDDOR. At the moment, employers must report cases of disease promptly to the enforcing authorities if they receive, in respect of an employee, a doctor's written diagnosis of one of the occupational diseases listed in RIDDOR Schedule 3. Before they make the report, employers must also consider whether the ill employee's current job involves the corresponding work activity also specified in the Schedule. This in itself may involve making enquiries. However, we recognise that there are some difficulties associated with the investigation of workplace health and there is significant under-reporting at present. And, in investigating the cause of some diseases or conditions (and when developing solutions), employers may need to seek assistance. Nevertheless, the responses to the DD showed that there was strong support for an explicit duty on employers to investigate cases of disease reportable under RIDDOR.

Question 7: Do you agree that the duty to investigate should apply to diseases, but limited to those reportable under RIDDOR?

Question 8: If you answered no to question 7, what scope do you think the duty should encompass? Please give reasons for your answer.

30 The proposed duty to investigate will be placed on the responsible person, as defined in RIDDOR, who has the legal duty to report accidents, dangerous occurrences and diseases under those regulations. The definition of the responsible person in RIDDOR would capture the person best placed to carry out the investigation in all circumstances. In the great majority of cases the responsible person is the employer. But this is not always the case, for example the responsible person in RIDDOR in the case of a mine is the manager of the mine, or in the case of an offshore installation is the owner of a mobile installation and the operator

of a fixed installation. In such cases these people would be best placed to carry out an investigation.

Question 9: Do you agree that the duty holder should be the same person as the one who has the legal duty under RIDDOR to report accidents, dangerous occurrences and diseases?

Question 10: If you answered no to question 9, who do you think should be responsible for carrying out the investigation? Please give reasons for your answer.

31 Sub-paragraphs 1(2) - (4) of the Schedule make clear that the duty holder should take reasonable steps, that is those that are practicable and proportionate to the scale of the incident, to investigate the underlying causes, and to take the findings into account in the review of *any* relevant risk assessment (see paragraph 40).

32 Paragraph 2 - Duty to investigate - sets out the requirement on the duty holder to investigate any RIDDOR reportable accident, dangerous occurrence, or disease. The duty holder would be required to commence the investigation as soon as possible, and in all circumstances within three days of the event having to be notified to the enforcing authority. This means that any investigation should normally be started within four days in the case of fatal accidents, major injuries to people at work and in certain circumstances to people not at work, and dangerous occurrences. In the case of over-three-day injuries, the duty holder would again be required to start an investigation as soon as possible, and in all circumstances within three days of the event having to be reported to the enforcing authority. This means that the investigation should be started at the latest within thirteen days of the injury occurring. In the case of diseases, the investigation should commence at the same time as the disease is reported to the enforcing authority.

33 In practice, this will mean that investigations should commence as soon as possible after the reportable event has occurred, and in most cases immediately after the event. Time limits, based on the RIDDOR notification and reporting timescales, have been included in the draft proposals as a means of ensuring that there is an obligation to commence an investigation within a reasonable period.

Question 11: Do you agree that an investigation should commence within the timescales set out in paragraph 32?

Question 12: If you answered no to question 11, what time limits do you think should be set for the commencement of investigations? Please give reasons for your answer.

34 There is a recognition (paragraph 2(3) of the Schedule) that someone who is self-employed and is therefore the responsible person may not always be able to commence an investigation within the prescribed time limits. In such cases the duty allows for the investigation to be started as soon as practicable. We are also conscious that in many cases such as in small businesses and on farms the responsible person could be related to the injured or deceased person. HSC would ensure that Health and Safety Inspectors from all enforcing authorities are aware of the need for sensitivity in such cases.

35 The intention of paragraph 2(4) is to ensure that when Health and Safety Inspectors decide to investigate particular incidents themselves (under the powers in Section 20 of the Health and Safety at Work etc Act 1974 (HSWA)), they have the authority to direct the duty holder about their investigation process to ensure confusion does not arise from parallel investigations. It is not the intention of this paragraph that duty holders would seek advice routinely from Health and Safety Inspectors on how to go about investigations in particular cases - the supporting guidance would provide details on the principles of how to go about carrying out an investigation.

36 There would also be a requirement on the duty holder to involve, as appropriate, the appointed safety representatives or the workforce's elected representatives in any investigation. We believe that a team approach, involving line managers and safety representatives, supported where appropriate by safety professionals, can only lead to more informed investigations which should help to establish underlying causes. (See also paragraph 41.)

37 Paragraph 3 deals with record keeping. We believe some record needs to be kept, if only to demonstrate compliance with the requirements. Our intention is that the record should be proportionate to the scale of the problem, and to the need to revise relevant risk assessments. The approach set out here is intended to ensure that a record is kept that an investigation has been carried out, and that any changes to the relevant risk assessment(s) are recorded. Such records should be retained for a period of three years - this is consistent with the period specified in the Social Security (Claims and Payments) Regulations 1979 for the retention of accident book entries.

38 We do not want to introduce overly bureaucratic record keeping requirements, but need to ensure that there is an identifiable audit trail for Health and Safety Inspectors to follow when necessary. An alternative option might be for the duty holder to keep a record of the significant findings of an investigation where there are five or more employees - this would then be consistent with the other record keeping requirements in the MHSWR. There is a case for all duty holders irrespective of size keeping a record of the significant findings of an investigation. This would be consistent with the record keeping requirements of RIDDOR.

39 Another option might be to require all investigation findings to be recorded and, where appropriate, acted upon to prevent a recurrence, which could include not only amendment of the risk assessment but also changes in the arrangements for planning, organising, monitoring etc the health and safety arrangements in the workplace (as required by regulation 5 of MHSWR). We would welcome comments on this aspect of the proposed duty, and in particular on the extent to which companies already keep written records of investigations; for example companies will be protecting their interests by carrying out a

prompt investigation after an accident etc to meet the requirements of the personal injury pre-action protocol under the Civil Procedure Rules.

Question 13: Are the draft regulations' proposals for keeping a record of investigations sensible and workable, or would you prefer to align any record keeping requirements on investigations with:

- **the record-keeping requirements in the MHSWR;**
- **or the record-keeping requirements in RIDDOR ;**
- **or link them to the requirements in regulation 5, as well as regulation 3, of MHSWR?**

Question 14: What arrangements do you currently have in your workplace for record keeping in respect of the investigation of accidents etc? (See also question 18.)

40 There is also a requirement to ensure that the results of the investigation are brought to the attention of any person who has made a risk assessment relevant to the work or activity in relation to which the accident, dangerous occurrence, or disease occurred (paragraph 3(1)(b)). This is necessary as the person required to make a risk assessment, ie the duty holder, under these proposals, may not always be the same person as the duty holder under regulation 3 of MHSWR or the duty holder under risk assessment provisions in other health and safety law, eg regulation 6 of the Control of Substances Hazardous to Health Regulations 1999. Furthermore, there could be occasions where the duty holder is responsible for the risk assessment requirements in the MHSWR, but where it might be appropriate for another duty holder's risk assessment to be revised also. Where this exchange of information is necessary, the easiest way to provide this may be via an investigation report.

41 There is also a requirement in paragraph 3(3) to inform safety representatives or the workforce's elected representatives of the findings of the investigation. This requirement would apply to anyone who has made a risk assessment relevant to the work activity in relation to which the accident, dangerous occurrence, or disease occurred, and has been informed of the results of the investigation by the responsible person. Other relevant requirements include that to require safety representatives' etc participation in the investigation:

- paragraph 36 refers to the requirement in the proposed duty on the duty holder to involve them in any investigation;
- the requirements in the Safety Representatives and Safety Committees Regulations 1977, the Health and Safety (Consultation with Employees) Regulations 1996, and the Offshore Installations (Safety Representatives and Safety Committees) Regulations 1989 to consult safety representatives etc on measures at the workplace which may substantially affect the health and safety of the workforce (eg where the findings of an investigation may lead to a revision of the risk assessment).

Together these should enable the active involvement of the workforce throughout the investigation process.

42 A further option could be to introduce a legal requirement on the duty holder to inform the person or persons directly involved in the incident of the investigation findings. This information could be provided via the safety/workforce representatives in some cases but it is good practice for employers to do so. Views on this would be welcome.

43 Another option could be to introduce a legal requirement on the duty holder to pass the investigation findings to their employers' liability insurer. This might help to speed up the civil claims process and to protect their interests under the Civil Procedure Rules. Conversely, it could be argued that the insurance industry already has good channels of communication with companies and would find it difficult to process copies of all investigation findings. Account would also need to be taken of the Government's policy to minimise where appropriate the regulatory impact of new proposals on business. Views on this option would be welcome.

Question 15: Do you think that the legal duty should be extended to include providing the investigation findings to others, eg the person(s) involved in the event, or employers' liability insurers? Please give reasons for your answer.

44 Paragraph 5 deals with exemption-making powers. These are standard clauses. They would provide HSE with some flexibility if circumstances arise that were not foreseen at the time the regulations were prepared.

45 Finally, we would also be interested to hear if you have any general points that you would like to make about the proposed approach set out in the draft proposals. Space for this is provided on the reply form.

Question 16: Do you have any general points you want to make about the approach we have adopted in these proposals?

Regulatory Impact Assessment

46 When preparing proposals for Regulations, HSC is required to submit to Ministers for their approval a document known as a Regulatory Impact Assessment (RIA). An RIA: describes the issue that has given rise to the need for regulation; compares various options; and identifies costs and benefits, to assist informed public debate about regulation. We have prepared a draft RIA for this proposal, a summary of which is at Annex 3. We would be grateful for your views on it, and for any information you have that would help to improve it. If you would like a copy of the full RIA please contact Neville Higham (contact details on the front cover).

47 There are some gaps in the information available to help us to quantify the costs and benefits of introducing a new duty to investigate, in particular on the amount of time and resource currently devoted to investigations. We have therefore had to make some assumptions, mainly based on a research project carried out by Human Reliability Associates (HRA) for HSE during the summer/autumn of 2000. A summary of the research findings is at Annex 4. If the assumptions we have made are borne out in practice, the cost to business of introducing the new duty as set out in Annex 1 is estimated at £18 million each year in present value terms. The new duty would need to lead to a reduction in accidents and ill health of some 3% for benefits to employers to balance the costs. A reduction in accidents and ill health of some 1% would be necessary for benefits to society to balance the costs.

48 The HRA study contains much useful information and data. We would welcome views and comments on any of the HRA study findings (Annex 4), for example on how to reinforce the links between risk assessment, performance monitoring and audit, near-miss and incident investigation; how best to de-couple issues of blame and liability from the process of objective investigation etc.

Question 17: We would welcome comments on the assumptions made in compiling the draft RIA and on its conclusions.

Question 18: We also would like to hear from you about the arrangements you currently have in place for the investigation of accidents, dangerous occurrences and diseases. In particular, we would like to hear from you about the amount of time currently spent on the investigation of accidents etc in your workplace.

This Consultation Exercise

49 We are always trying to improve how we conduct consultation exercises. We would be grateful for your feedback on the quality of this Consultative Document. It would be very useful if you could answer the following question.

Question 19: In your view, how well does this document represent the different policy issues involved in this matter? (Very well, well, not well, or poorly)

2001 No.

HEALTH AND SAFETY

*Management of Health and Safety at Work
(Amendment)
Regulations 2001*

<i>Made- - - -</i>	2001-
<i>Laid before Parliament</i>	2001-
<i>Coming into force</i>	2001-

The Secretary of State, in exercise of the powers conferred on him by section 15(1), (2), (5)(b) and (9) of, and paragraphs 15(1), 20, and 21(a) of Schedule 3 to, the Health and Safety at Work etc Act 1974¹ ("the 1974 Act") and of all other powers enabling him in that behalf and for the purpose of giving effect without modifications to proposals submitted to him by the Health and Safety Commission under section 11(2)(d) of the 1974 Act after the carrying out by the said Commission of consultations in accordance with section 50(3) of the 1974 Act, hereby make the following Regulations:-

Citation and commencement

1. *These Regulations may be cited as the Management of Health and Safety at Work (Amendment) Regulations 2001 and shall come into force on [].*

¹ 1974 c.37; sections 15(1) and 50(3) were amended by the Employment Protection Act 1975 (1975 c.71) Schedule 15, paragraphs 6 and 16(3) respectively.

Amendments to Management of Health and Safety at Work Regulations 1999

2. The Management of Health and Safety at Work Regulations 1999² shall be amended as follows-

(a) after regulation 3 there shall be inserted the following regulation -

"Investigation of Accidents etc, dangerous occurrences and diseases

3A - Schedule 1 to these Regulations (Investigation of accidents,dangerous occurrences and diseases) shall have effect.";

(b) in regulation 4 for the words "Schedule 1" there shall be substituted "Schedule 1A";

(c) the Schedule 1 shall be numbered "Schedule 1A" and Schedule 1 set out in the Schedule to these Regulations shall be inserted before that Schedule.

Signed by authority of the Secretary of State

2001

Parliamentary Under Secretary of State
Department of the Environment,
Transport and the Regions.

² S.I 1999/3242.

THE SCHEDULE

Regulation 2

"SCHEDULE 1

INVESTIGATIONS OF ACCIDENTS, DANGEROUS OCCURRENCES AND
DISEASES

Regulation 3A

Interpretation

1. —(1) *In this Schedule, unless the context otherwise requires -*

"the 1995 Regulations" means the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995³;

"accident, dangerous occurrence or disease" means an accident, dangerous occurrence or disease, as the case may be, which by virtue of any provision of the 1995 Regulations (other than regulations 5(1)(b) and 6) is required to be notified or reported to the relevant enforcing authority;

"investigation" shall be construed in accordance with sub-paragraphs(2) to (4) below;

"relevant risk assessment" means an assessment of risks to persons carried out pursuant to any of the relevant statutory provisions and which assessment is relevant to the work or activity in relation to which the accident, dangerous occurrence or disease occurred;

³ S.I. 1995/3163.

"representative of employee safety" means a representative of employee safety within the meaning of the Health and Safety (Consultation with Employees) Regulations 1996⁴ who represents a group of employees containing an employee in relation to whom the accident, dangerous occurrence or disease occurred and who is employed by the responsible person;

"responsible person" means the person who, by virtue of any provision of the 1995 Regulations is required to notify, or send a report to, the relevant enforcing authority in respect of the accident, dangerous occurrence or disease concerned;

"safety representative" means a safety representative-

- (a) within the meaning of the Safety Representatives and Safety Committees Regulations 1977⁵ who represents a group of employees containing an employee in relation to whom the accident, dangerous occurrence or disease occurred; or*
- (b) elected pursuant to the Offshore Installations (Safety Representatives and Safety Committees) Regulations 1989 whose constituency contains a member in relation to whom the accident, dangerous occurrence or disease occurred.*

and in relation to a mine or quarry it also means the panel of persons appointed under section 123 of the Mines and Quarries Act 1954⁶ or the committee of

⁴ S.I. 1996/1513.

⁵ S.I. 1977/500; amended by S.I 1992/2051 and S.I 1996/1513.

⁶ 1954 c.70.

persons appointed under regulation 40 of the Quarries Regulations 1999⁷ for the mine or quarry in relation to which the accident, dangerous occurrence or disease occurred.

(2) References in this Schedule to a responsible person carrying out an investigation are references to his taking such steps as are reasonable for a person in his position to take to ascertain, so far as it is possible to do so, the cause of the accident, dangerous occurrence or disease so as to enable the cause to be considered in the review of any relevant risk assessment.

(3) The steps referred to sub-paragraph (2) above include undertaking, or causing to be undertaken, enquiries and, where appropriate, examinations and tests.

(4) In determining what steps are reasonable for the purposes of sub-paragraph (2), regard shall be had in particular to the severity or potential severity of the accident, dangerous occurrence or disease.

Duty to investigate

2—(1) The responsible person shall carry out an investigation into any accident, dangerous occurrence or disease.

(2) The investigation shall be-

⁷ S.I. 1999/2024.

(a) commenced as soon as is practicable and no later than the time the accident, dangerous occurrence or disease is required to be notified or reported to the relevant enforcing authority pursuant to the 1995 Regulations (or if both are required, no later than 3 days after the time it is required to be so notified);

(b) completed as soon as is practicable.

(3) Where the responsible person himself suffers injury as a result of the accident, or suffers from the disease, and that renders him incapable of commencing the investigation into that accident or disease within the time referred to in sub-paragraph (2)(a) above, he shall commence the investigation as soon as is practicable.

(4) An inspector may give a responsible person such reasonable directions as he thinks fit with respect to the manner in which an investigation under sub-paragraph (1) above is to be carried out, and the responsible person shall comply with any such directions.

(5) The responsible person carrying out the investigation shall permit any safety representatives and representatives of employee safety to participate in that investigation.

Record and report of investigation

3.__(1) A responsible person who has carried out an investigation pursuant to paragraph 2(1) above shall-

(a) keep a record showing that the investigation has been carried out, and

(b) where any other person has made a relevant risk assessment, inform that person of the result of the investigation as soon as is practicable after its completion.

(2) The record referred to in sub-paragraph (1)(a) above shall be kept for a period of three years.

(3) Every person who has made a relevant risk assessment for a workplace shall, as soon as is practicable after becoming aware of the result of the investigation, ensure that relevant safety representatives and representatives of employee safety whose functions relate to that workplace are informed of that result.

Saving

4. Nothing in this Schedule shall affect or prejudice the operation of any requirement imposed by or under any enactment relating to the investigation of an accident, dangerous occurrence or disease.

Exemptions

5-(1) Subject to sub-paragraph (2) above, the Health and Safety Executive may, by a certificate in writing, exempt any person or class of persons from any requirement imposed by this Schedule and any such exemption may be granted subject to conditions and with or without limit of time and may be revoked by a certificate in writing at any time.

(2) *The Executive shall not grant any such exemption unless, having regard to the circumstances of the case and, in particular to-*

(a) the conditions, if any, which it proposes to attach to the exemption; and

(b) any other requirements imposed by or under any enactments which apply to the case,

it is satisfied that the health and safety of persons who are likely to be affected by the exemption will not be prejudiced in consequence of it."

EXPLANATORY NOTE

(This note is not part of the Regulations)

1. *These Regulations amend the Management of Health and Safety at Work Regulations 1999 by introducing into those Regulations a new Schedule containing provisions relating to the investigation of those accidents, dangerous occurrences and diseases as are required to be notified or reported to the relevant enforcing authority under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (regulation 2 and the Schedule).*

2. *The provisions contained in the Schedule-*

- (a) require the responsible person to carry out an investigation into any accident, dangerous occurrence or disease. The "responsible person" is defined as the person who is required under the 1995 Regulations to notify or send a report to the relevant enforcing authority of that accident, dangerous occurrence or disease;*
- (b) empower an inspector to give directions as to the manner in which the investigation is to be carried out;*
- (c) require the responsible person to permit safety representatives and representatives of employee safety to participate in the investigation;*

- (d) *require the responsible person to keep a record of the investigation and to inform any person who has carried out a risk assessment relevant to the work or activity concerned of the result of the investigation;*
- (e) *require a person who has carried out a relevant risk assessment to notify safety representatives and representatives of employee safety of the result of the investigation;*
- (f) *provide that the above requirements shall not prejudice those contained in other legislation relating to the investigation of accidents, dangerous occurrences or diseases;*
- (g) *empower the Health and Safety Executive to exempt persons from any of the above requirements.*

3. *A copy of the regulatory impact assessment prepared in respect of these Regulations can be obtained from the Health and Safety Executive, Policy Division, Rose Court, 2 Southwark Bridge, London SE1 9HS. A copy has been placed in the library of each House of Parliament.*

THE PRINCIPAL RESULTS OF CONSULTATION

Background

A total of 684 responses were received. A proforma was included at the end of the document to assist the respondent in structuring their response. A total of 606 responses were received in this format.

The discussion document attracted responses from a wide range of organisations, but the largest group of respondents was industry.

TYPE OF ORGANISATION	NUMBER OF RESPONDENTS	AS A %
Company	289	47.7
Local Authority	120	19.8
Voluntary body	11	1.8
Public organisation	19	3.1
Employer organisation	39	6.4
TU/employee organisation	26	4.3
H & S consultant	38	6.3
Private individual	27	4.5
Other	37	6.1

Key Findings

Question 1 asked: 'Should HSC take further action to encourage accident investigation by employers?'

Almost all respondents thought the Commission should take some action.

	TOTAL	AS A %
Yes	562	92.7
No	37	6.1
No Opinion	6	1
No Answer	1	0.2

We then sought views on whether this action ought, on the basis of the analysis in the document, to be a change in the law.

Question 4 asked: ‘Should there be a change in the law to introduce a new duty on employers to investigate workplace accidents?’

About two thirds of the respondents thought there should be a change in the law.

	TOTAL	AS A %
Yes	403	66.5
No	184	30.4
No Opinion	14	2.3
No Answer	5	0.8

We then probed the views of those who were not in favour of a change in the law to see what action, if any, they supported.

Question 7 asked: ‘If answer to Q4 was “no”, should HSC consider changing the guidance contained in MHSWR ACoP to set out a preferred method of investigation?’

Almost two thirds of those not in favour of a change in the law favoured more guidance on the MHSWR ACoP.

	TOTAL	AS A %
Yes	112	60.9
No	62	33.7
No Opinion	6	3.3
No Answer	4	2.2

We tried to find out if those also opposed to further guidance in the ACoP favoured any further, additional guidance at all.

Question 8 asked: “If answer to Q7 was “no”, should HSE provide better guidance to help employers undertake better accident investigation?”

Almost all favoured some guidance.

	TOTAL	AS A %
Yes	56	90.3
No	4	6.5
No Answer	2	3.2

It is therefore clear that almost everyone thinks some action is needed, two thirds favouring a new legal duty, the remainder favouring further guidance (most of these favouring further guidance in the MHSWR ACoP). We then set out to examine what change in the law was favoured.

Question 9 asked: ‘If there should be a change in the law, should a new regulation be introduced placing an explicit duty on employers to take reasonable steps to investigate the cause of accidents?’

	TOTAL	AS A %
Yes	469	77.4
No	113	18.6
No Opinion	13	2.1
No Answer	11	1.8

Over three quarters favoured an explicit duty on employers to take reasonable steps to investigate the cause of accidents.

Most of these favoured a two-pronged approach, with a corresponding obligation to reflect on the outcome of such investigations when revising risk assessments.

Question 10 asked: ‘If answer to Q9 was yes, should the risk assessment requirement in MHSWR be amended to ensure employers fully take account of accidents when revising their risk assessments?’

	TOTAL	AS A %
Yes	419	89.3
No	34	7.2
No Opinion	11	2.3
No Answer	5	1.1

We then sought views on the form of any change in the law.

Question 11 asked: ‘If there was to be a change in the law, do you have a view on whether it should be in the form of:’

	TOTAL	AS A %
Amend MHSWR	365	60.2
A new free standing regulation	134	22.1
Both	4	0.7
No Opinion	78	12.9
No Answer	25	4.1

Most favoured incorporation of the new duty into MHSWR rather than a new set of regulations.

Having established that most respondents sought a duty to take ‘reasonable’ steps to investigate accidents, we sought information on how much prescription respondents sought. The results were mixed in that while respondents thought investigation should be proportionate to the scale of the incident, it was thought that the manner of the investigation should be prescribed, to determine root causes.

Question 13a asked: ‘If there should be a new legal duty, should accident investigation be proportionate to the scale of the incident?’

	TOTAL	AS A %
Yes	522	86.1
No	71	11.7
No Answer	13	2.1

Question 13b asked: ‘If there should be a new legal duty, should employers be encouraged to determine the root cause of accidents?’

	TOTAL	AS A %
Yes	585	96.5
No	6	1
No Answer	15	2.5

Question 15 asked: ‘If there should be a new regulation introduced either in MHSWR or as a free standing regulation, should it prescribe the manner of the investigation and the output?’

	TOTAL	AS A %
Yes	402	66.4
No	182	30
No Answer	22	3.6

The degree of prescription people were seeking can be seen from the following table which shows the proportion of the 606 respondents favouring a particular degree of prescription.

Should the regulations require:

ACTION	(PERCENTAGE SAYING 'YES')		
	For Accidents	For RIDDOR Dangerous Occurrences	For RIDDOR diseases
• Production of a report on the incident	42	47	41
• For this to be sent to the enforcing authority on request	43	44	40
• That safety representatives be involved	37	38	39
• That the employer follows directions on investigation by the enforcing authority	34	35	33
• That the employer is discharged from a duty to investigate if the enforcing authority investigates	15	14	12

This presents a mixed picture but no 'elaborated' duty gained the support of a majority of consultees. Overall the safest conclusion is that while there is support for what the document called a 'simple' duty to investigate causes, there is not the same degree of evidence of support for the 'elaborated' duty including these extra requirements.

A major issue is whether the duty should apply to investigation of all accidents or a limited sub-set of more serious accidents, and whether it should also apply to those dangerous occurrences and cases of work related ill health reportable under RIDDOR. The results were that, if there was to be a legal duty, the percentages supporting the following propositions were:

It should apply to all accidents	48
It should only apply to RIDDOR reportable accidents	33
It should only apply to RIDDOR reportable major injury accidents	15
It should also apply to RIDDOR reportable diseases	73
It should also apply to RIDDOR reportable dangerous occurrences	75

The strong support for also requiring investigation of diseases and dangerous occurrences is noteworthy.

Finally, three quarters of respondents and 93% of those expressing a view indicated that the legal duty would accord with what was already done at their workplace, supporting the view that these changes would only affect a minority of employees.

Question 14 asked: ‘If there should be new legal duty, would it fit well with existing practice and procedures in your workplace?’

	TOTAL	ASA %
Yes	455	75.1
No	36	5.9
No Opinion	74	12.2
No Answer	41	6.8

Sensitivity Tests

We carried out some sensitivity tests on these results in particular to see if the responses from local authorities (which comprised a fifth of the total) distorted the figures. However excluding responses from local authorities and public organisations did not move any of the percentages quoted above up or down by more than a couple of percentage points and did not change any conclusions.

Proposals for a new duty to investigate accidents, dangerous occurrences and diseases

Regulatory Impact Assessment

Summary of costs and benefits

1 It is estimated that a duty to investigate all workplace accidents, diseases related to work activity and dangerous occurrences reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) would cost employers an estimated £18 million each year. If current costs to society as a whole of these events are reduced year on year by as little as 1%, the benefits would balance the investigation costs.

2 If the duty is expanded to include all non-reportable accidents and new cases of ill health that lead to time off work, the annual cost is increased to £24 million. If the duty is further expanded to include all workplace accidents and new cases of work related ill health, then the total cost is estimated at approximately £36 million per year.

3 On the other hand, the total cost to society of workplace accidents and cases of work related ill health that could be prevented by these proposals are estimated at around £1.8 billion each year. A 1% reduction in this total would provide benefits of £18 million, although it is difficult to say at this stage how effective the new duty would actually be in reducing work related accidents, diseases and dangerous occurrences.

4 The total cost to employers of workplace accidents and work related ill health that could be prevented by these proposals is estimated at approximately £600 million per year. If the duty to investigate applies to all RIDDOR reportable accidents, diseases and dangerous occurrences then these costs of £18 million would need to be balanced by a 3% reduction in costs to employers per year for benefits to balance costs.

5 The duty would apply to all companies. The compliance costs for a “typical” business are estimated as follows. Current rates of incidences of new cases of illness and accidents are around 9,000 in total each year for every 100,000 employees, of which around two-thirds would lead to absence and one-third be reportable (or lead to more than three days absence if not reportable). This means that an average large firm employing 10,000 people would expect 900 cases each year; a medium size employer with 200 employees might expect 20; and a small firm with 10 employees might expect one case each year.

6 Allowing for the extent of current investigation, this suggests average additional costs of around £2,400 each year for a duty to investigate all reportable incidents in the large firm; £120 in the medium size firm; and £10 in the small firm. These costs will of course vary by industry. If the duty was to include within its scope all workplace accidents, diseases and dangerous occurrences then costs would approximately double.

7 Research findings (see paragraph 12) identify three broad classes of investigation. The assumptions about what each would involve are as follows:

- Simple investigation. This describes an investigation into a minor accident that required first aid only, or involved a short absence. The research found that around 70% of companies indicated that the total number of staff hours spent on an investigation into a minor accident would be less than 1 hour. Allowing for under-estimation, we assume that a simple investigation will involve a line manager interviewing the injured party and other witnesses. A written record of the incident and investigation may be kept in an accident book and the formal risk assessment may be amended if appropriate. This is estimated to take an average of one hour of the line manager's time and a total of thirty minutes time of other personnel involved in the accident.
- Standard investigation. This describes an investigation into a reportable accident or a minor accident where there was potential for more serious harm. This is assumed to involve a 'checklist' approach using a standard proforma which would be kept as a record of the investigation. For standard investigations, results from the survey indicate that an average of around 5 staff hours would be spent on the investigation procedure. Allowing for under-estimation we assume an average of 6 ½ hours.
- Elaborate investigation. This is likely to involve several personnel. In large organisations, both a safety specialist and safety representative are likely to be involved. In smaller organisations, an external safety adviser may be involved. The investigation is likely to be structured using an established proforma. Research findings indicate that this may be the same form as in a standard investigation, but with more detailed responses. Witness statements, photographic evidence, and technical descriptions (including reconstructions) may be employed. From the research findings, we assume an elaborate investigation as involving an average of 27 staff hours.

8 It is estimated that the unit costs of the simple, standard and elaborate investigations are around £19, £80 and £490 respectively. These costs may vary slightly depending on the wage rates in different industries.

10 There may be some disproportionate impact on small and medium sized businesses. Research findings (see paragraph 12) indicate that they are less likely than larger firms to currently investigate accidents etc. They are also less likely to have standard procedures for accident investigation which may increase their time and costs. It is estimated that the cost per worker of a duty to investigate in a small and medium sized business will be around two to three times as much as that in a large firm.

11 On the other hand, when small and medium sized businesses were asked what the implications would be of a statutory duty to investigate accidents etc, some 60% considered there would be few implications for them - either because they already undertook investigations or they did not foresee any problems with complying with a statutory duty. Some 20% of such businesses considered that there would be additional resource implications in complying with a statutory duty. The figures for large companies were around 70% and 28% respectively.

12 These figures are approximate, and are only intended to illustrate the likely scale of costs and benefits given full compliance with the proposals. They are based on the findings

of an HSE commissioned study of the way that companies investigate the causes of workplace accidents, dangerous occurrences and diseases. The study was undertaken by Human Reliability Associates. It provides an overview of current investigation practice across the spectrum of commerce and industry, including micro-businesses, small and medium sized businesses and larger companies. A summary of the findings is at Annex 4.

EXECUTIVE SUMMARY

In July 2000, Human Reliability Associates was commissioned by the Health and Safety Executive (HSE) to carry out a study of current industry practice in incident investigation, with particular emphasis on the resources expended and the quality of the investigations. The study was initiated to provide background information for the proposed new legislation requiring employers to investigate the causes of work-related accidents and ill health, and to provide guidance for HSE as to the type and level of practical support which industry may need to successfully implement the new requirements.

The study design consisted of two separate but complementary stages: a large-scale telephone survey (1500 cases) followed by a smaller face-to-face interview survey (100 companies). The purpose of the telephone survey was to obtain a comprehensive and nationally representative overview of investigation practices and procedures. The interview survey was designed to provide general verification of the information obtained via the telephone survey, to provide further details of typical investigation processes and procedures and, lastly, to generate some exemplar case studies which could be used to illustrate these processes and procedures. This report covers the second stage of the study – the interview survey. It describes the technical approach adopted in the survey, a comprehensive summary of all the key findings, a comparison of these findings with the output from the telephone survey and, finally, the implications of the findings for the HSE.

In general terms, the interview survey demonstrates that companies employ a range of approaches to incident investigation, from a largely unstructured and ad-hoc approach, to one that is well supported in terms of clear procedures and associated analysis tools and techniques. However, most companies were found to either have no support or only the minimum level of support for incident investigation. The likelihood of using a more sophisticated approach to incident investigation increased with the size of the company. Approaches to investigation were underpinned by a number of different causal models from system-based (which examine all potential contributory factors) to more traditional models (that focus on the individual concerned and most immediate cause). However, the majority of companies were found to operate closer to the traditional end of this continuum. It was also found that the individual driving the investigation has a major impact on the approach that is adopted, although this influence is moderated by the presence of a robust structure to support the investigation process.

The findings of the interview survey also suggest that the majority of companies do not effectively discriminate in the investigation process between immediate and underlying causes. However, the recommendations that follow from the investigation often reflect a more system-based approach than would be expected given the dominance of the traditional model. Despite the limitations of many of the investigations examined in the study, the vast majority of companies still consider they have a structured approach to incident investigation.

The interview survey also covered details of resources (in terms of personnel and associated time) used in investigation. This showed that the most common investigation team consisted of a health and safety specialist and a line manager. Safety representatives or other employee representatives were involved in only a relatively small percentage of cases. Some differences in the composition of the investigating team were identified between the telephone and the interview survey. The interview survey also suggested that the investigation process takes longer than the estimates of time that were reported in the telephone survey. The possible sources of these differences are considered.

The report also examines barriers to improving the current standard of incident investigation. Issues considered include: the current and developing legal environment; the potential isolation of incident investigation from risk assessment; the lack of a common model and structure to underpin and support incident investigation; the currently low level of competence and the lack of available training; the general level of complacency in many companies about their standard of investigation and the resource implications of improving standards, particularly in small companies.

Lastly, the report considers the implications of these findings for the work of the HSE. These include the need to reinforce the links between risk assessment and incident investigation, the need to provide industry with additional technical support and better access to information already held by the HSE, the provision of better support for training in incident investigation and lastly acting as a key 'change agent' in improving the current legal climate. A fuller summary of the results of the interview survey is provided in section 7 of this report.

Full details of the 100 case studies documented in the interview survey are included in Appendix A. Appendix B includes the interview schedule used in the survey and the telephone protocol used to arrange the interviews. The results of the telephone survey were reported to the HSE in December 2000. The report consisted of two volumes: Volume 1 provided a review of the study methodology and a commentary on the most significant findings; Volume 2 consisted of the tabulated data. For completeness, these reports are appended to this report as Appendix C and Appendix D.

3 KEY CONCLUSIONS AND STRUCTURE OF REPORT

In this section of the report the key conclusions reached in relation to the overall aims and objectives of the study (as laid out in section 1) are first briefly summarised. This summary integrates the key results from both the telephone survey and the interview survey. The structure of the remainder of this report, which specifically covers the results of the interview survey, is then outlined. Readers who require a more detailed summary of the interview survey results and their implications for the HSE can refer directly to Section 7 of this report.

3.1 KEY CONCLUSIONS FROM THE TELEPHONE AND INTERVIEW SURVEY

In the following summary, and throughout this report, the term ‘incident’ is used as a generic description for all injuries, diseases and dangerous occurrences reportable under the RIDDOR regulations.

In interpreting the following it should be borne in mind that the data from the telephone and interview surveys differ in two respects. First, the former employed a large statistically representative sample, whilst the latter was based on a small sample of 100 companies. Second, the methodologies differed; whilst the telephone survey asked for estimates based on the general experience of investigating incidents, the interview survey focused on the actual practice involved in the investigation of a specific set of 100 incidents. The data referred to below therefore needs to be interpreted in the light of these differences in approach.

3.1.1 General approach to incident investigation

The telephone survey identified the overall pattern of incident investigation in companies of different sizes. For example, it demonstrated that whilst 74% of companies have standard rules for the composition of the investigation team, fewer companies have a standard set of questions or protocol that has to be completed in an investigation (from 18% in small companies to 73% for large companies). By examining the actual investigation process in a sample of 100 incidents, the interview survey provided a much richer picture of what happens in practice.

The level of structure and support provided by the 100 companies in the interview survey was classified into four main categories representing increasing levels of formal structure and sophistication of approach: Approach 1, Approach 2.1 and 2.2 and Approach 3. In general terms, in Approach 1 there is a complete absence of any documented structure or support for incident investigation. In Approach 2.1 there is minimum formal support with the focus on identifying immediate cause. Approach 2.2 is more structured, with a more sophisticated approach to identifying immediate and underlying causes. In Approach 3 the causal analysis is supported by further analysis tools and techniques.

The general findings in relation to the provision of structure and support for investigations are summarised below:

- Approach 2 is the most commonly used
- Within Approach 2, most companies use only the minimum level of structure and support
- A large percentage of companies still use Approach 1, i.e. a largely informal unstructured approach. This includes smaller companies with the least resources, but also includes a relatively large proportion of bigger organisations

- The likelihood of using a more sophisticated approach increases with the size of company
- Approaches 2.2 and 3 represent the best practice identified in the interview survey. Where incidents are potentially complex, the tools and techniques used in Approach 3 may be valuable
- These approaches are driven by a number of different causal models from system-based (which examine all potential contributory factors) through to wholly traditional models (that focus on the individual concerned and most immediate cause). However, the majority of companies still operate closer to the traditional end of this continuum rather than using a system-based approach
- The individual driving the investigation has a major impact on the approach that is adopted, although this influence is moderated by the presence of a robust structure to support the investigation process. Hence companies that employ Approaches 2 and 3 are more likely to maintain a consistent and through investigation process

3.1.2 Who typically carries out the investigations?

The analysis of the 100 cases in the interview survey suggests that the company health and safety specialist is involved in the overwhelming majority of cases, usually having overall responsibility for carrying out the investigation. Line management is involved in approximately half of all incidents and senior management in roughly one quarter of incidents, the latter are least likely to be involved in a minor incident. Technical experts are also involved in approximately one quarter of all incidents.

However, the most common team composition is a health and safety specialist together with a representative of line management. Safety representatives or other employee representatives are only involved in 11% of incidents. Although those individuals involved in an incident and co-workers (where relevant) are nearly always asked to contribute by describing ‘what happened?’, they are rarely formally involved in the investigation process.

The composition of the investigation team is most likely to change as the incident increases in severity; this change would typically involve the addition of a more senior manager to the team. Team composition may also change dependent on the exact nature of the incident.

A number of differences were observed between the findings of the interview survey and the telephone survey in respect of the above; these include the following:

Safety specialists were involved in a higher percentage of cases in the interview survey than in the telephone survey. This can be partly explained by the fact that the interview sample was skewed towards larger companies and more severe cases. Line managers were also involved in more incidents in the telephone survey compared to the interview survey. There was also a difference between the data on senior management involvement in incident investigation between the two surveys. Senior management was involved in a much higher percentage of cases in the telephone survey than in the interview survey. This result may be partly explained by the nature of the interview sample, in that it involved a much greater proportion of larger companies with a greater likelihood of having safety specialists. It may also indicate that telephone survey respondents over-estimated the involvement of senior management. Safety representatives were also more likely to be involved in investigation in the telephone survey compared to the interview survey.

3.1.3 Time spent on investigation

Based on the analysis of 100 cases the interview survey showed that overall some 42% of incidents took less than 5 hours of investigation time, 35% took between 5 and 20 hours and 18% over 20 hours. The data from the telephone survey indicated that less time than the above was usually committed to investigation. Since companies rarely monitor the amount of time spent on investigations, and respondents in the telephone survey also indicated difficulty in making time

estimates, it is likely that the interview survey provides a more accurate picture of resources used. However, the difference may also be partly explained by the selection of more severe incidents for the interview survey.

The general trend that emerged was that investigation time increases with the severity or potential severity of the incident. This finding is consistent with the pattern that emerged from the telephone survey in that the amount of effort and resources applied in an investigation is strongly related to severity of outcome.

3.1.4 Identification of immediate and underlying causes

The depth of causal analysis was not explicitly addressed in the telephone survey. The findings of the interview survey however suggest that the majority of companies do not effectively discriminate, or indeed understand, the distinction between immediate and underlying causes. However, despite the limitations of many of the investigations examined in this study, the vast majority of respondents felt that their current approach had led them to identify the underlying cause of the relevant incident.

There is also a tendency for incident reporting and incident investigation to be conflated. Companies that perceive themselves as having effective systems and skills in reporting often overestimate the quality of their investigations.

3.1.5 Recommendations and actions taken

The interview survey identified the specific recommendations and actions that were taken following the investigations. In general terms, the results obtained indicate a more system-based approach than was apparent in the interviews or in the causal analysis documented in the case studies.

In the telephone survey companies rated their effectiveness in monitoring the impact of actions following an incident investigation at 4 out of 5. In the context of other scores recorded in the survey this was judged to be a relatively poor result. This finding is confirmed by the results of the interview survey. These results suggest that companies that employ Approaches 1 and 2.1 (that is the majority of companies) tend not to have formal systems to ensure that recommendations are acted upon. In addition, only a small number of companies have a formal system in place to ensure that recommendations have been effective in reducing the likelihood of similar or related incidents.

3.1.6 Training in incident investigation

The results of the telephone survey indicate that there is little training in incident investigation with over half the organisations in the survey reporting a lack of training in incident investigation. Such training as there is, is mostly part of more general management training or concerned with the recording of accidents. The level of training is somewhat higher in larger organisations.

These findings are generally confirmed in the interview survey. Although some two thirds of investigation teams in the interview survey have some training in incident investigation, with the percentage of individuals trained increasing by size of company, the bulk of this training relates to generalised health and safety training such as NEBOSH or IOSH courses. In practice, even if demand were high, there is currently a lack of easily accessible and affordable training courses on incident investigation.

3.2 STRUCTURE OF THIS REPORT

The results of the interview survey are discussed in four main sections:

Analysis of the case study material (section 4 of the report)

This forms the substantive part of the report. The case study data have been used to illustrate:

- Inputs to the investigation and resource implications
- The investigation process and different approaches to investigation
- Actions taken following the investigation
- Storage and use of incident data

Where appropriate, and where data are available, comparisons are made with the results obtained within the telephone survey.

A full description of each case study is provided in Appendix A. Each case study is described in terms of the following:

- A brief narrative description of the incident
- The consequences of the incident
- The individuals involved in the investigation and the time involved
- A brief description of the investigation process
- The conclusions reached and the actions taken
- The lessons learnt by the company

To illustrate the range of incidents that were followed up, a brief summary of each case study classified by type of incident is shown in .

General evaluation of company approaches to incident investigation (section 5 of the report)

This section summarises the extent to which the approaches adopted by companies generally meet the requirements of a 'good incident investigation process' as previously defined within the report. The advantages and disadvantages of the different approaches are also identified.

More general issues covered in the interview (section 6 of the report)

This section includes a discussion of the following issues:

- Training issues
- Near-miss reporting
- Changes companies would make if incident investigation were made mandatory
- Support requested from the HSE

Summary of findings and their implications for the HSE (section 7 of the report)

This section provides a detailed summary of the major findings of the interview survey and their implications for the HSE.

7 OVERVIEW OF THE STUDY FINDINGS AND IMPLICATIONS FOR THE HSE

The main findings of the interview survey, and key differences between these and the comparable results of the telephone survey, are first briefly summarised. The major barriers to improving the current quality of incident investigation are then discussed. Lastly, the implications of these findings for the HSE are then considered.

7.1 SUMMARY OF MAIN FINDINGS

The following does not aim to provide an exhaustive summary of results but is intended to highlight those findings that are considered most significant for the HSE policy and practice. In general terms, the summary covers the extent to which companies currently meet the main requirements of a successful incident investigation as identified in Section 4 of the report. For reference these requirements are listed below:

- A causal model that represents a system-based approach to incident investigation
- The involvement of relevant individuals within the investigation
- Procedures or protocols to structure and support the investigation
- The identification of both immediate and underlying causes
- The development of recommendations that address both immediate and underlying causes
- The implementation of these recommendations and the updating of relevant risk assessments
- Follow up to ensure that actions taken are successful in reducing the risk of further incidents
- Feedback to relevant parties to share immediate learning
- The development of an accessible database

It should be noted that whenever comparisons are drawn between the results of the two surveys, there are two potential sources of discrepancy. First, the telephone survey was based on a large, statistically representative sample of 1500 respondents; in contrast the interview sample was small and not statistically representative of the target population. Second, the methodologies are completely different and variations in findings could be attributable to the greater time available and level of personal contact within the interview survey. It is also important to recognise that the data from the interview survey is mainly based on an analysis of 100 actual incident investigations, whilst the data in the telephone survey are estimates based on a company's general experience of investigating incidents. Any points made in the report in respect of differences in findings between the two surveys need to be interpreted in the light of the above.

7.1.1 Causal model adopted by companies

- There is a range of approaches to incident investigation, from system-based through to wholly traditional models. However, the majority of companies operate closer to the traditional end of this continuum rather than using a system-based approach
- The individual driving the investigation has a major impact on the approach that is adopted; in the absence of any formal approach or training, the direction the investigation follows is totally dependant on an individual. Even where there are formal investigation systems in place, the

disposition of the individual will still have a significant impact on the process and output of the investigation

7.1.2 Composition of the investigation team

- The company health and safety specialist is involved in the overwhelming majority of cases; in 46% of cases the health and safety specialist is also seen as having overall responsibility for the investigation
- Line management is involved in approximately half of all incidents
- Senior management is involved in approximately 26% of incidents; they are least likely to be involved in a minor incident
- Technical experts are involved in approximately one quarter of all incidents
- The most typical team composition is a health and safety specialist together with a representative of line management
- The person involved in the incident is rarely involved in the process of active investigation
- Safety representatives or other employee representation are only involved in 11% of incidents
- Although those individuals involved in an incident and co-workers (where relevant) are nearly always asked to contribute by describing 'what happened?', they are rarely formally involved in the investigation process
- The composition of the investigation team is most likely to change as the incident increases in severity; this change would typically involve the addition of a more senior manager to the team. Team composition may also change dependent on the exact nature of the incident

A number of differences were observed between the findings of the interview survey and the telephone survey in respect of the above; these include the following:

- Safety specialists are involved in a higher percentage of cases in the interview survey than in the telephone survey. This can be partly explained by the fact that the interview sample was skewed towards larger companies and more severe cases
- Line managers are involved in more incidents in the telephone survey compared to the interview survey
- There is a difference between the data on senior management involvement in incident investigation between the two surveys. Senior management is involved in a higher percentage of cases in the telephone survey than in the interview survey. This result may be partly explained by the nature of the interview sample, in that it involved a much greater proportion of larger companies with a greater likelihood of having safety specialists. It may also indicate that telephone survey respondents over-estimated the involvement of senior management
- Safety representatives are also more likely to be involved in investigations in the telephone survey compared to the interview survey. The likeliest explanation here is that the telephone survey respondents overestimated their involvement

7.1.3 Time spent on investigation

- Overall some 42% of incidents took less than 5 hours of investigation time, 35% took between 5 and 20 hours and 18% over 20 hours. The general trend that emerged was that investigation time increases with the severity or potential severity of the incident
- It is difficult to carry out a valid comparison with the data from the telephone interview survey because of the relatively small number of incidents in most categories within the interview

survey. However, when investigation time on ‘over-three-day injuries’ are compared (the biggest category in the interview survey), there is a discrepancy between the results. The data suggest that the telephone survey respondents tended to underestimate the time involved in the investigation

- Since companies rarely monitor the amount of time spent on investigations, and respondents in the telephone survey also indicated difficulty in making time estimates, it is likely that the interview survey provides a more accurate picture of resources used

7.1.4 Structure and support for investigations

The level of structure and support provided for incident investigation was classified into four main categories representing increasing levels of formal structure and sophistication of approach: Approach 1, Approach 2.1 and 2.2 and Approach 3

The specific characteristics of each approach are described in the Section of the report. However, in general terms, in Approach 1 there is a complete absence of any documented structure or support for incident investigation. In Approach 2.1 there is minimum formal support with the focus on identifying immediate cause. Approach 2.2 is more structured, with a more sophisticated approach to identifying immediate and underlying causes. In Approach 3 the causal analysis is supported by specific analysis tools and techniques

The general findings in relation to the provision of structure and support for investigations are summarised below:

- Approach 2 is the most commonly used (55% of all companies employ Approach 2.1 or 2.2)
- Within Approach 2, most companies use only the minimum level of structure and support (44% of all companies employ Approach 2.1)
- A large percentage (38%) of companies use Approach 1, i.e. a largely informal unstructured approach. This includes smaller companies with the least resources, but also includes a relatively large proportion of the bigger organisations
- The likelihood of using a more sophisticated approach increases with the size of company
- All the companies that use Approach 3 are either large or high-risk organisations, and typically both large and high-risk
- About half the companies in the interview survey would be prepared to use a more structured approach with qualifications about value and the need for simplicity. Those 30% who said they would not be prepared to incorporate more structure tend to be satisfied with their current approach or feel that a different approach would involve too much time or resources. The larger the company, the more receptive it would be to using a more structured approach
- There are variations in what happens, and who is involved in an investigation, if the incident involves a contractor, a member of the public, violence or has potential for further litigation
- Approaches 2.2 and 3 represent the best practice identified in the interview survey. Where incidents are potentially complex, the tools and techniques used in Approach 3 may be valuable. An overall evaluation of the four main approaches against the requirements listed above concluded that, in relative terms, Approaches 2.2 and 3 were most likely to result in the identification of both immediate and underlying causes, to result in recommendations that address these causes and to ensure that such recommendations are implemented and subsequently followed up. However, as indicated below, the results of the interview survey suggest that, even when a high level of support for incident investigation is in place, this does not guarantee that companies always meet these requirements to a satisfactory standard

7.1.5 Identification of immediate and underlying causes

- The findings of the interview survey, and the impression gained from the respondents, suggest that the majority of companies do not effectively discriminate, or indeed understand, the distinction between immediate and underlying causes
- The vast majority of companies also feel that they currently have a structured process in place to identify the underlying causes of accidents; respondents are less confident about their approach to identifying the underlying causes of ill-health (only 53% were happy with their current approach)
- Despite the limitations of many of the investigations examined in this study, the vast majority of respondents felt that their current approach had led them to identify the underlying cause of the relevant incident

7.1.6 Recommendations and actions taken

- The most common recommendations and actions taken following an incident were changing equipment or modifying procedures, and/or further training and awareness-raising
- Changes to equipment and procedures were more common in companies employing Approaches 2 and 3
- Raising awareness and further training were more common in companies employing Approach 1.
- Risk assessments were revised in 24% of the cases; this was most common in companies employing Approach 3

The above results indicate a more system-based approach than was apparent in the interviews or in the causal analysis documented in the case studies. However, when respondents were asked to indicate what they considered to be the most common recommendations made following an incident investigation, the results indicate a stronger bias towards more person-centred recommendations. In general terms, the study results also suggest that companies that employ Approaches 1 and 2.1, tend not to have formal systems to ensure that recommendations are acted upon. Only a small number of companies have a formal system in place to ensure that recommendations have been effective in reducing the likelihood of similar or related incidents.

7.1.7 Feedback to relevant parties

- In the majority of companies, senior management are informed about the results of the investigation; the likelihood that this will happen increases with the size of the company
- In small companies safety representatives and safety committees are rarely involved; in medium size companies approximately three quarters (74%) are likely to inform the health and safety representatives or safety committee; the equivalent percentage in large companies is 64%
- A smaller percentage of companies than would be expected inform relevant line management of the results of the investigation, although these are generally involved in the investigation team
- Results are only communicated to the workforce in a small percentage of cases
- The results of the comparison between the interview and telephone survey show that:
 - The percentage of companies informing senior management are generally similar; the telephone survey identified a higher percentage of medium sized companies involving senior management (91% compared to 79% in the telephone survey)
 - The results are also similar for safety committees within medium sized companies, but the telephone survey identified a greater involvement in companies of over 200 than was found in the interview survey. However, if the involvement of health and safety representatives is added to the interview survey results, this increases the percentage to 64% making the results more similar

- The telephone survey identified a much stronger pattern of reporting to head office than was identified in the interview survey

7.1.8 Storage of data in an accessible database

- About 40% of companies use a primarily paper-based system; 15% primarily use a computer-based system and about 40% use a combination of both to store information on incident investigations. The reliance on a paper-based system is more common in smaller companies, although about 30% of larger companies still use a paper-based approach. Companies that are less structured in their approach to incident investigation are more likely to rely on paper-based approaches.
- Some 80% of companies use the data for monitoring the frequency of different types of incident; companies that are less structured in their approach (and therefore, by definition smaller companies in which incidents are themselves less frequent) are less likely to carry out this type of analysis
- Companies are less likely to use their data to monitor patterns in underlying causes, although nearly 60% of companies suggest they do use the data for this purpose. Even this figure may be over-inflated since there is some doubt over the understanding of the concept of ‘underlying causes’

7.1.9 Training

- Some two thirds of investigation teams in the interview survey have some training in incident investigation, with the percentage of individuals trained increasing by size of company; the bulk of this training relates to generalised health and safety training such as NEBOSH or IOSH courses
- In practice, many of the individuals who have responsibility for leading or supporting incident investigations are not dedicated safety professionals. Their exposure to any training in incident investigation is minimal and the time available for such training is restricted
- In small companies incidents and even near-misses are rare events and maintaining appropriate awareness and skills in incident investigation becomes a real issue
- There is no real way in which competence in incident investigation is routinely externally or internally evaluated; individuals or companies are likely to get little or no feedback on the quality or effectiveness of their investigations
- In practice, even if demand were high, there is currently a lack of easily accessible and affordable training courses on incident investigation
- There is tendency for incident reporting and incident investigation to be conflated. Companies that perceive themselves as having effective systems and skills in reporting often overestimate the quality of their investigations

7.1.10 Near-misses

- Nearly all companies recognise the potential value of following up near-misses and the majority of companies attempt to investigate them, if incidents are brought to their attention
- Companies are generally aware of the difficulties in obtaining good levels of reporting, but do little proactively to encourage such reporting. There is an assumption that, because there is an incident reporting system in place, this means that they address near-misses

7.1.11 Perceived implications of forthcoming legislation

- In the majority of cases companies already assume there is a legal requirement to investigate accidents and ill-health
- Approximately 40% of companies feel the legislation would make no difference to their companies; this percentage drops to 18% for those companies that currently have little structure or support for their incident investigation. This group see the major implications as being the need for additional time and more training
- Companies that employ more structure also identify the need for training and more time as the main implications of any change in requirement
- Companies that have been classified as most sophisticated in their approach, generally feel they are currently adequately resourced for any new demands
- Respondents felt unable to cost the implication of these changes without further clarification of what will be required by the legislation

7.2 SUMMARY OF MAIN BARRIERS TO IMPROVING THE QUALITY OF INCIDENT INVESTIGATION

On the basis of the results summarised above, this section now briefly summarises the main barriers to improving the general quality of incident investigation.

7.2.1 Current and developing legal environment

Many companies readily acknowledge that the increasingly litigious business climate makes them more conscious of the need to protect themselves from potentially unfair and punitive employee claims. In such a climate it is possible to argue that there is a powerful disincentive to both identifying, and subsequently documenting, management and organisational factors that may have contributed to an incident.

Although the interview survey did not directly address this sensitive issue, there are a number of results that suggest that legal pressures could become a significant issue. Nearly a quarter of companies suggested that they would change their investigation process, if it were likely that an incident could lead to a legal claim. Often, these changes, which appeared primarily to be driven by the requirements of insurers, resulted in what was described as ‘a more thorough’ investigation, but not necessarily a more system-based investigation.

There was also a noticeable discrepancy between the profile of causes identified in the case studies and the profile of interventions subsequently made. Typically, companies tend not to identify and document work-related issues as immediate or underlying causes but paradoxically, are prepared to make secondary recommendations that directly address these issues. This suggests a tacit acknowledgement that these are significant contributory factors but a reluctance to formally highlight management or organisational deficiencies.

The likelihood either of companies failing to fully investigate potential management or organisational deficiencies, or of failing to document or disclose such findings, also needs to be considered in the light of the Lord Woolf’s Final Report on Access to Justice. In the case of potential litigation, the Woolf Report makes recommendations that aim to ensure that litigation will be less adversarial and more co-operative. In particular, there is an expectation of openness and co-operation between parties from the outset. This move to more openness is supported by pre-litigation protocols on disclosure and expert evidence.

If successfully implemented, this should increase the likelihood that all critical aspects of an incident are brought to light at the earliest possible opportunity. It should also ensure that there is a deterrent against the suppression of, or failure to disclose, significant information.

7.2.2 Isolation of incident investigation from risk assessment

In most companies proactive risk assessment, performance monitoring and audit and near-miss reporting are effectively de-coupled from the process of incident investigation which is typically perceived as a stand alone process. However, in practice, all these processes can inform a company about accident drivers and potential mitigating measures. Conceptually they can be seen as a continuum as illustrated in Figure 5, with each process potentially providing feedback into risk assessment and the development of risk control measures.

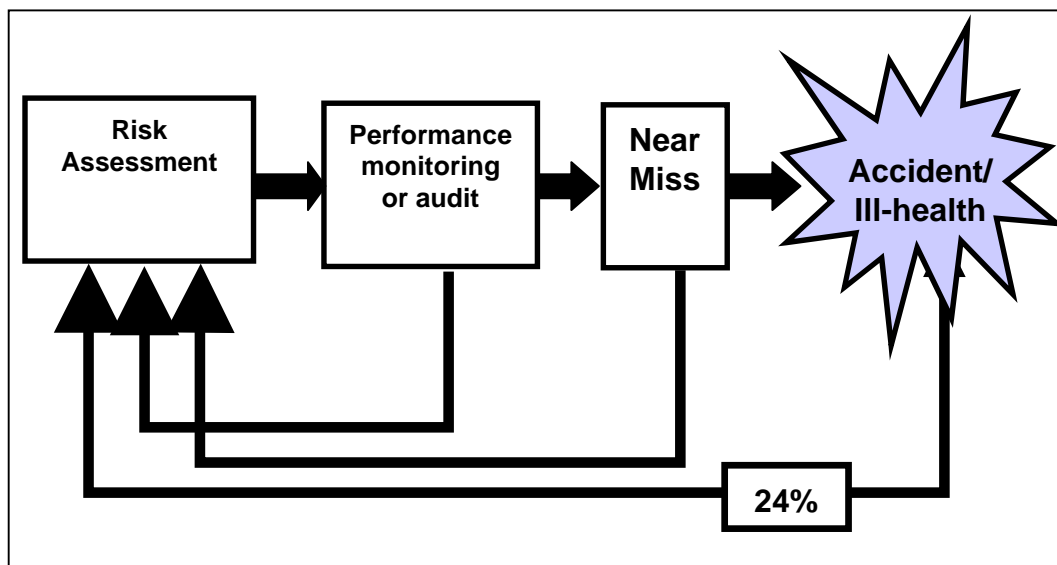


Figure 5 An integrated approach to Risk Assessment and Accident Investigation

In reality, only a small proportion of companies have comprehensive near-miss reporting, reducing the effectiveness of this feedback loop. The interview survey also showed that only 24% of companies used the output from their incident investigation to update their risk assessment, suggesting that even the use of this feedback is far from standard practice. There is also a more fundamental problem, because companies do not see these processes as an integrated whole, each separate process is based on a different model or structure, with little consistency in the taxonomy or approach used. In practice, this means that risk assessment and performance monitoring and audit may use one set of factors and incident investigation a completely different set of issues. This further undermines the effectiveness of any feedback loop.

7.2.3 Lack of common model and structure

The interview survey revealed that companies have a wide range of approaches to incident investigation, from those that are totally unstructured to quite formal and well-supported systems. It has also highlighted the importance of the individual driving the investigation, the focus on incident reporting rather than investigation, and the general failure to distinguish or understand the difference between immediate and underlying causes. These results suggest two further barriers. First, there is a significant lack of awareness and understanding of system-based rather than the more traditional

accident models, and the value of using such models. Second, there is a lack of practical support, in terms of usable systems and documentation, to encourage the application of such models.

7.2.4 Current levels of competence and availability of training

It has already been noted that many of the individuals who have responsibility for leading or supporting incident investigations are not dedicated safety professionals. Their exposure to any training in incident investigation is minimal, and the time available for such training is restricted. Moreover, in small companies, incidents and even near-misses are rare events and maintaining appropriate awareness and skills in incident investigation becomes a real issue. These findings therefore reinforce the need for comprehensive support in terms of advice, guidance and documentation to encourage effective incident investigation.

7.2.5 Current level of complacency

One of the main barriers to overcome is the overall level of satisfaction with current approaches. Despite the limitations of many of the investigations examined in this study, the vast majority of respondents felt that their current approach had led them to identify the underlying cause of the relevant incident. The majority of companies also feel that they currently have a structured process in place to identify the underlying causes of accidents, although they are less confident about their approach to identifying the underlying causes of ill-health. Many companies also feel that the forthcoming legislation will make little or no difference to them. This finding implies the need for a significant shift in awareness, so that more companies recognise the need for, and value in, moving from an approach that focuses on merely describing the chain of events that happened to one that tries to identify why these events happened.

7.2.6 Resource implications

Although, in general, companies already assume that they have a legal responsibility to investigate accidents, it is likely that the new requirement will still have resource implications for many companies, both in terms of training needs and time expended on investigations. This conclusion is supported by both the survey findings on training needs, and the finding that companies actually spend more time on investigations than was estimated in the telephone survey. In order to persuade companies to allocate these resources, the HSE will therefore have to demonstrate that improving incident investigation will be of benefit to a company.

7.2.7 Particular problems of SMEs

Lastly, there are particular challenges to be faced in improving the quantity and quality of incident investigation in small to medium sized companies. These include:

- The difficulty of allocating appropriate time and resources for training and investigation
- Maintaining skill and awareness levels when incidents are rare events
- Convincing companies of the need to identify and monitor underlying causes when incidents are rare events
- Convincing companies that they have a responsibility to address underlying causes even if to do so would have significant short and medium term cost implications

7.3 IMPLICATIONS FOR THE HSE

Although the previous section focused on the more negative results from the interview survey, there are also a number of positive messages for the HSE. For example, there are some illustrations of

good practice, and many of the interviewees were professional and diligent in their approach to incident investigation. They were also positive about the contribution the HSE could make to improving company policy and practice.

It is also clear that line and senior management are increasingly involved in investigations, although the results are less optimistic than those of the telephone survey (the telephone survey also appeared to overestimate the involvement of health and safety and employee representatives). Companies were also ready to consider changing the work environment many cases. They were also aware of the need to follow up near-misses, although they were not addressing some of the fundamental issues that deter reporting of such incidents. Lastly, virtually all companies maintained formal records of the incident, investigation and outcome.

This final section of the report now considers some of the practical ways in which the HSE could support companies in improving incident investigation.

7.3.1 Reinforce links between risk assessment and incident investigation

In line with the arguments made in section 7.2 above, HSE should reinforce the links between risk assessment, performance monitoring and audit, near-miss and incident investigation through the further development and dissemination of integrated models, assessment and investigation tools. In particular it should reinforce and further promote the value of near-miss reporting as an essential risk assessment tool. In the context of the legal pressures discussed above, near-misses have powerful advantages. They provide almost equivalent learning opportunity without the legal and liability implications. HSE field staff have a significant part to play here by ensuring that risk assessment policy and procedures, and near-miss reporting, are routinely reviewed when incidents are being investigated.

In order to achieve change at these fundamental levels, there also needs to be a shift in the understanding of the importance and value of addressing both immediate and underlying causes. This requires a major awareness and educational initiative.

7.3.2 Provide additional technical support

There is also a range of more practical support and advice that could be provided by the HSE, and which was specifically requested by respondents in the interview survey.

- The provision of a more structured and standardised approach to incident investigation based on a clear set of accident causation models, so that companies can make the best use of their time and resources, and compare their findings and performance with those of other relevant companies. It was also noted by some respondents that HSE inspectors were themselves not consistent in the way they investigated incidents. Although there may be perfectly legitimate reasons for these differences in approach, given the legal context within which inspectors may be working, it is still important that companies receive a consistent message in terms of what constitutes a good investigation process
- The provision of industry specific guidance and support so that the incident investigation systematically covers issues that are already known by the HSE to be important within that industry context
- The provision of clear examples and case studies to illustrate appropriate standards of investigation and different approaches which may be applicable in different situations
- The standardisation of forms and documentation to comply with the HSE requirements and compatibility with RIDDOR; the provision of enhanced electronic access to, and linkage with,

RIDDOR so that immediate feedback can be obtained from the HSE on related incidents, factors which should be investigated in that category of incident, and guidance to prevent reoccurrence

In all of the above, the emphasis should be on the need for simplicity and clarity to avoid too much bureaucracy and burden on small companies. There were also a number of more general comments made about the service provided by HSE. These are summarised below:

- There were a number of interviewees (about 10%), who felt that companies are still reluctant to contact the HSE for advice and help, either because they still see the organisation in the role of legislator and enforcer or because the organisation is not sufficiently responsive
- Several interviewees complained about lengthy delays in the response from the HSE following the reporting of a specific incident. This has the effect of undermining company confidence in the HSE, and in some cases, delaying the circulation of information about an incident within the relevant company
- A small number of interviewees were also explicitly opposed to the principle of more legislation and greater prescription on health and safety issues

7.3.3 Provide better access to information already held by the HSE

Individual companies will, by definition, tend to have access to details of only a small number of cases and a limited database. The HSE should develop a more interactive relationship with companies to share information on similar incidents that may have been reported, both to improve the quality of subsequent investigations, and also to identify any obvious patterns or trends.

7.3.4 Provide better training in incident investigation

Respondents identified the need for training or other support, such as software or videos, developed and endorsed by the HSE. This reflects the both the lack of confidence in the currently available commercial products and a desire to ensure that company methods and approaches will satisfy the requirements of future health and safety legislation.

7.3.5 Act as a key 'change agent' to improve the current legal climate

Lastly, there is the critical issue of how the HSE can be influential in de-coupling issues of blame and liability from the process of objective investigation. It has already been noted that the increasingly litigious climate may deter companies from identifying, and documenting, management and organisational factors that may have contributed to an incident. It is therefore important that the legal system is perceived as encouraging and not penalising companies that adopt a system-based approach to incident investigation. It may be also appropriate to think of developing more practical incentives to improve investigation and risk management by introducing relevant insurance incentives.

The HSE could play a strategic role in facilitating such change by generating an active and high-level dialogue between industry, legal and insurance representatives, with a view to identifying and committing all parties to a coherent and productive approach to this difficult challenge.

HSC

HEALTH AND SAFETY COMMISSION

CONSULTATIVE DOCUMENT

PROPOSALS FOR A NEW DUTY TO INVESTIGATE ACCIDENTS, DANGEROUS OCCURRENCES AND DISEASES

Name of Respondent:

Address:
.....
.....
.....
.....

Position (if any):

(please tick relevant box)

- | | | | |
|-----------------|--------------------------|-----------------------------------|--------------------------|
| company | <input type="checkbox"/> | employer organisation | <input type="checkbox"/> |
| local authority | <input type="checkbox"/> | trade union/employee organisation | <input type="checkbox"/> |
| voluntary body | <input type="checkbox"/> | health and safety consultant | <input type="checkbox"/> |
| Public Body | <input type="checkbox"/> | private individual | <input type="checkbox"/> |

other (please specify)
.....

If you are an employer, how many employees do you have?

- If you are not an employer, are you an:
- | | |
|------------------------|-----------------------------------------|
| employee | <input type="checkbox"/> |
| self employed | <input type="checkbox"/> |
| other (please specify) | <input type="checkbox"/>
..... |

Summary of questions:

Q1 Do you agree that the duty to investigate should be incorporated in the MHSWR?

Yes

No

No opinion

Q2 If you answered “no” to question 1, what would be your preferred legislative route?
Please give reasons for your answer.

Q3 Do you agree that the duty to investigate should apply to those accidents reportable under RIDDOR?

Yes

No

No opinion

Q4 If you answered “no” to question 3, what range of accidents do you think we should include within the scope of the duty?
Please give reasons for your answer.

Q5 Do you agree that the duty to investigate should apply to “near misses”, but limited to those dangerous occurrences reportable under RIDDOR?

Yes

No

No opinion

Q6 If you answered “no” to question 5, what scope do you think the duty should encompass?

Please give your reasons for your answer.

Q7 Do you agree that the duty to investigate should apply to diseases, but limited to those reportable under RIDDOR?

Yes

No

No opinion

Q8 If you answered “no” to question 7, what scope do you think the duty should encompass?

Please give reasons for your answer.

Q9 Do you agree that the duty holder should be the same person as the one who has the legal duty under RIDDOR to report accidents, dangerous occurrences and diseases?

Yes

No

No opinion

Q10 If you answered “no” to question 9, who do you think should be responsible for carrying out the investigation?
Please give reasons for your answer.

Q11 Do you agree that an investigation should commence within the timescales set out in paragraph 32?

Yes

No

No opinion

Q12 If you answered “no” to question 11, what time limits do you think should be set for the commencement of investigations?
Please give reasons for your answer.

Q13 Are the draft regulations' proposals for keeping a record on investigations sensible and workable:

Yes No No opinion ; or

would you prefer to align any record keeping requirements on investigations with:

- the record-keeping requirements in the MHSWR; or
- the record-keeping requirements in RIDDOR; or
- link them to the requirements in regulation 5, as well as Regulation 3, of MHSWR?

Q14 What arrangements do you currently have in your workplace for record keeping in respect of the investigation of accidents etc?
(see also question 18)

Q15 Do you think that the legal duty should be extended to include providing the investigation findings to others, eg the person(s) involved in the event, or the employers' liability insurers?
Please give reasons for your answer.

Yes

No

No opinion

Q16 Do you have any general points you want to make about the approach we have adopted in these proposals?

Q17 We would welcome comments on the assumptions made in compiling the draft RIA and on its conclusions.

Q18 We would also like to hear from you about the arrangements you currently have in place for the investigation of accidents, dangerous occurrences and diseases. In particular, we would like to hear from you about the amount of time currently spent on the investigation of accidents, dangerous occurrences and diseases in your workplace.

(i) Do you currently investigate:

- all workplace accidents, dangerous occurrences and diseases
- some workplace accidents, dangerous occurrences and diseases
- no workplace accidents, dangerous occurrences and diseases

(ii) What is the **average** amount of time, in hours, your organisation spends on the investigation of:

each accident.....hrs	annual total on accidents.....hrs
each dangerous occurrence.....hrs	annual total on dangerous occurrences.....hrs
each disease occurrence.....hrs	annual total on disease occurrences.....hrs

Q18 cont.

comments on above;

Q19 In your view, how well does this document represent the different policy issues involved in this matter?
(please tick one box)

- very well
- well
- not well
- poorly

If you answered “not well” or “poorly”, how do you suggest things might be improved for the future (please add extra sheets if you wish).

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Comments on this consultative document should be sent to:

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Health and Safety Executive,
Policy Division, SASD,
8 South Wing, Rose Court,
2 Southwark Bridge, London, SE1 9HS.

Tel: 020 7717 6426 (messages)

Fax: 020 7717 6891

By 3 September 2001

Glossary of acronyms

ACoP	Approved Code of Practice
CD	Consultative Document
DD	Discussion Document
HSC	Health and Safety Commission
HSE	Health and Safety Executive
HRA	Human Reliability Associates
HSWA	Health and Safety at Work etc. Act 1974
MHSWR	Management of Health and Safety at Work Regulations 1999
RIA	Regulatory Impact Assessment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

CONSULTATIVE DOCUMENT



The full text of this and other Consultative Documents can be viewed
and downloaded from the Health and Safety Executive website on the Internet:

www.hse.gov.uk/condocs/

Consultative Documents are available from:

HSE Books, PO Box 1999
Sudbury, Suffolk CO10 2WA
Tel: 01787 881165
Fax: 01787 313995