

# **The Young Farmer's Clubs of Ulster**

## **INVESTIGATING ACCIDENTS AND INCIDENTS GUIDELINES**



## **Introduction**

The management of Health and Safety Regulations (Regulation 4) places the requirement on all organisations to have in place the means to measure their performance in relation to health and safety. The guidance from the Health and Safety Executive describes an effective measurement system as having two components.

1. Active Measurement
2. Reactive Measurement

Mostly efforts are directed to active measurement by means of inspections, assessments etc., as this helps to prevent accidents from happening in the first place. Reactive measurement however, involves investigations conducted into accidents and incidents, which have occurred.

This is only part of the duty, there is also a moral obligation to investigate accidents in order to, as far as possible, prevent any reoccurrence. It is also necessary to gather information at an early stage where accidents or incidents may result in claims or other litigation against the organisation.

People are inclined view accident investigations and investigators with suspicion perceiving their remit to be one of apportioning blame to one individual who can then be held responsible. This is based on a basic understanding of the purpose of investigations, as the primary objective is the prevention of any reoccurrence. Notwithstanding this it must be accepted that in reality any organisation that failed to take appropriate action, including disciplinary proceedings, would be open to criticism for failing to take appropriate action. Balancing this out however is the knowledge that employment tribunals would be very critical if action was taken against an individual when subsequent investigation/s found that there were procedural and/or management failures which also contributed to the event. It is therefore paramount to carry out structured and systematic investigations which take into account at all aspects of the incident and produce balanced and accurate findings.

## **Monitoring**

As part of the monitoring process the Executive Officer will provide an analysis of all accidents on an annual basis to the Executive Committee.

## **Promoting a Culture to Encourage Support**

It is a proven fact that when major accidents, injuries and incidents occur, there is less resistance to investigations even if they are viewed with suspicion and fear. Everyone accepts that they must report:

1. Injuries and cases of ill health.
2. Loss events e.g. damage to property or equipment.
3. Incidents (including all those which could have resulted in injury, ill health or loss).
4. Hazards.
5. Weaknesses or omissions in performance standards.

Obtaining these reports is usually possible even if the purpose is not understood or supported by everyone involved. Furthermore, more minor events, injuries and loss incidents are usually not reported or are even covered up. Ironically it is these minor accidents and incidents, which provide an organisation with the greatest opportunity to identify hazards and potential risks and take remedial action thus preventing a more serious injury or loss.

The answer is to report all accidents and incidents whatever the scale. This will be supported by having open and genuine support for reporting and investigating accidents and incidents. This culture can be fostered and supported by promoting:

1. Training which clarifies the underlying objectives and reasons for reporting and investigating all relevant events.
2. Providing training in accident/incident investigating to personnel at all levels and encouraging them to actively participate in or lead investigations.
3. Support from the Executive Committee for a culture which emphasises a responsive approach to reporting and investigating events along with the critical importance of improving systems of control before harm occurs, and which encourages open, honest communication.
4. Cross referencing and checking first-aid treatment, health records, maintenance reports, fire reports, and insurance claims to help to identify trends and otherwise unreported events.

### **Type of Investigation**

The level and nature of an investigation will depend on a number of factors such as the significance of the injury, nature of the ill health, magnitude of the loss and the potential to cause serious loss or injury. It is important that personnel at all levels are trained to conduct investigations which will mean that they can quickly and effectively deal with the more minor incidents and events. The more serious the incident the more senior the investigator will need to be.

Determining the levels of investigation and investigator will be determined taking into account the size and scope of operations of the organisation and the levels of management available. Regardless of the level of investigation the emphasis should be clearly focused on identifying the reasons for any substandard performance, underlying failures in health and safety management systems, to learn from events and to prevent any re-occurrences.

Investigations are also required to:

1. Satisfy legal obligations to report record and investigate events.
2. Collect information, which may be needed if legal action is taken.
3. Collect information for potential claims.
4. Maintain the organisations own specific records.

In the most serious cases or, where the size and design of the organisation does not facilitate major investigations, it may be necessary to bring in specially trained investigators or investigation teams.

### **Conducting the Investigation**

Any investigation must seek to establish not only the immediate causes of the event but also the underlying organisational issues, which allowed the circumstances to arise. In order to achieve this the investigator should consider organisational as well as human factors such as:

1. Policies, procedures, standards of performance, and local rules.
2. The task and the subsequent plant premises, substances and procedures for their use.
3. Members or employee(s), their behaviour, training, selection and history of performance to standards.

When conducting an investigation it is essential to be clear from the outset what information you wish to collect. This enables the investigator to proceed in a systematic manner. Information needed will include:

1. Details of any injured employee including age, sex, experience, training etc.
2. Where and when the event took place i.e. the exact location, date, time of day, and prevailing conditions.
3. An accurate history leading to the event including:
  - actions which led directly to the event.
  - the immediate causes of the event.
  - the direct causes of any injuries or other loss.
  - details of any witnesses and their account of the event.
  - the underlying causes, i.e. failure of management systems, lack of or ineffective training, lack of supervision etc.
4. A detailed account of the outcomes including:
  - The nature of the outcome i.e. injuries, damage to property or equipment, disruption to business etc.
  - The severity of the harm caused especially injuries and losses.
  - The immediate response to the event and an evaluation of the adequacy of the response.
  - Whether the event was preventable and how.

Whilst the investigator and the investigation must concentrate on facts, be totally impartial and neither offer nor add opinion at this stage, it is necessary to consider fully the possible consequences of the event including:

1. What was the worst that could have happened?
2. Why did the worst not happen, what prevented it?
3. Could the event re-occur and if so how often?
4. What was the worst injury or loss/damage that could have happened?
5. How many people could have been affected by the event?

Once all the facts have been gathered it is possible to take an overview of the whole event and look at the management systems that were in place at the time. The investigator should seek to establish:

1. The circumstances at the time of the event.
2. Comparison of these with the relevant performance standards relating to the event.
3. Any inadequacy between the performances standards and the reality.
4. Reasons for any disparity between intention and reality.

With all this information at hand it is now possible to establish the exact and underlying causes of the event. It will also be possible, using this information to identify where failings occurred and where and what remedial action is required to prevent any reoccurrence. The physical method used to collect this information can be tailored to suit the organisation and/or the investigator and can range from written statements to pre-prepared pro-formas or even computerised systems. Whichever method is used, it should be effective in collecting the right information quickly and accurately.

Appendix 1

# Accident Recording Form



Complete this immediately or as close to the time of the accident as practically possible. Delaying may cause facts and important details to be forgotten.

<b>Reporting person</b>
Name:
Position:
<b>Injured Party's details</b>
Name:
Associated Club
Connection to Club (ie. member, parent, sibling of member etc)
Date of birth:
Address:
Parents / Carers names(if injured person under 18)
Address:
<b>Location of Accident</b>
Place:
Address
<b>Witnesses</b>
(1)
(2)
Please attach witness statements/accounts to this form (if appropriate)

**Please complete the reverse side of this form**

**Record What Happened & Nature of Injury** (use additional paper, as required)

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**Record Action taken:**

Reported to YFCU Headquarters (yes/no)	How was it reported
Who to, Name:	Date & Time:
Details of advice received:	

Signed by the reporting person: ..... Date: .....

This copy of this form should be kept in a secure place. If requested YFCU Headquarters will do this for you. Irrespective of this a copy or the original must be forwarded to the YFCU Executive Officer or Executive Officer at YFCU Headquarters, 475 Antrim Road, Belfast BT15 3BD Telephone 028 90370713.

Do not fax this document unless arrangements have been made to receive it securely.  
Appendix 2

# YFCU ACCIDENT/INCIDENT INVESTIGATION REPORT



Name of injured party: \_\_\_\_\_

Connection with YFCU: \_\_\_\_\_

Location of accident: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Accident/Incident: \_\_\_\_\_ Time: \_\_\_\_\_

	Yes	No
Is the injured party a member of staff?	[ ]	[ ]
Was an accident report completed?	[ ]	[ ]
If yes are they on file at Headquarters?	[ ]	[ ]
Was the incident reported under RIDDOR?	[ ]	[ ]
Was medical treatment offered/given?	[ ]	[ ]
Did the injured party go to hospital	[ ]	[ ]
Were there witnesses to the accident/incident?	[ ]	[ ]
Are witness statements available?	[ ]	[ ]
If yes are they on file at Headquarters?	[ ]	[ ]
Is a current risk assessment available?	[ ]	[ ]
If yes is it on file at Headquarters?	[ ]	[ ]
Are personal training records available?	[ ]	[ ]
If yes are they on file at Headquarters?	[ ]	[ ]
Are relevant maintenance/service records available?	[ ]	[ ]
If yes are they on file at Headquarters?	[ ]	[ ]

Witnesses \_\_\_\_\_  
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## History

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Description of injury

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Findings

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Recommendations

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Investigating Officer

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_