



Learning from health and safety - failure



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The Royal Society for the Prevention of Accidents

Learning from health and safety - failure..

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THE ROYAL SOCIETY FOR THE PREVENTION OF ACCIDENTS



RoSPA's Mission & Vision

Mission
To save lives and reduce injuries

Vision
To lead the way in accident prevention



Health and safety failure: UK PLC

- 229 notified fatal injuries to workers (07/08)
- 100+ members of the public
- 1,000 fatal WoRRIs?
- 328,000 reportable injuries (LFS 06/07)
- 6k to 12k deaths (?) due to work related health damage
- 1 million injuries (all severities)
- 2 million cases of work related ill health
- 36 million working days lost
- £20 – 30 billion or between 2 –3 % of GDP!



Or...

- One crashing every fortnight (fatals/early death)



- Twenty landing every day (injuries/ill-health)



RoSPA Key Issues



- Directors
- MORR
- SMEs
- Accident investigation



Why focus on investigation?



- OS&H management supposed to be proactive via risk assessment
- In reality much new action is still reactive
- BUT many organisations fail to extract full value from investigation
- Accident investigation remains an underdeveloped part of OS&H management.

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Accidents wreck lives and cost everyone

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Accidents test your organisation

- ✓ First aid/rescue
- ✓ Making safe
- ✓ Preserving/managing the scene
- ✓ RIDDOR
- ✓ Informing/liaising
- ✓ Dealing with authorities
- ✓ Investigation, learning and remediation
- ✓ Coping with the aftermath

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Accidents test your relationships

- HSE,
- Lawyers
- Other public authorities
- Families,
- Insurers,
- Workforce,
- Trades unions
- Customers/clients,
- The media

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You have live with the consequences

- Damage costs
- Sick pay
- Replacement staff/equipment
- Business interruption, delays, lost contracts etc
- Loss of workforce morale
- PTSD
- Reputational loss
- Fines
- Compensation payments
- Higher insurance premia
- Career damage?

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Enforcer intervention

- Investigations by Police HSE, LAs etc
- Interviews under caution
- Seizure of evidence
- Enforcement action
- Notices
- Prosecutions

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Prosecution options

- HSW ACT Sections 2, 3 etc
- Section 7
- Section 37 ('consent, connivance or neglect')
- MHSW regs (risk assessment etc)
- Specific regs (COSH, MH, LOLER)
- Corporate Manslaughter
- Manslaughter

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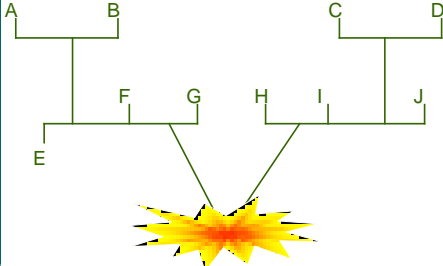
An accident aftermath is not a comfort zone



- Trauma?
- Liability?
- Threat?
- Prosecution?
- Anger?
- Bad PR!!

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Necessary and sufficient conditions



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The essence of investigation

1. Reporting, Making Safe, Emergency Action, Preserving the scene
2. Initial appraisal, commissioning, agreeing terms, scale etc
3. Gathering evidence (witnesses, debris, documents, photos etc etc)
4. Integrating evidence (structured methods?)
5. Constructing and testing hypotheses
6. (Searching for more evidence?)
7. Reaching conclusions
8. Making recommendations
9. Securing closure

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Common failings

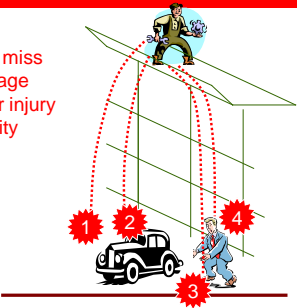


- No investigation at all
- No reporting or investigation of 'near-misses'
- No procedures
- Lack of clarity about purposes
- No scaling

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Same unplanned event, different outcomes

1. Near miss
2. Damage
3. Minor injury
4. Fatality



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Common failings




- Little/no managerial or worker involvement
- Concluding the investigation too early
- Automatically blaming the victim
- No examination of underlying organisational factors
- No/poor communication of lessons learned

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Common errors



- Uni-causal view of events
- Focus on fault and blame
- Weak understanding of human error
 - 'Slips' and 'lapses'
 - 'Mistakes' – skill and/or rule based
 - 'Violations' – exceptional, routine and situational
- Stop rules and biases
- *GIGO (garbage in, garbage out!)*

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What we have done

- Advice from reference group
- RoSPA discussion document (1998)
- Congress presentations
- 'One-to-one' discussions (TUC, CBI etc)
- Partner in HSC discussion exercise (1998)
- 'High performers' review (1999)
- Response to HSC consultation
- RoSPA 'Challenge' (2002)
 - Input to new Annex G in BS 8800 (2002)
- Input to HSE Guidance (2003)
- DOR/PRIA (2005/6)

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HSE's CRR 344: Main findings

- Current and developing legal environment
- Potential isolation of accident investigation from risk assessment
- Lack of common model & structure to support incident investigation
- Current low level of competence, lack of training and complacency in companies
- Resource implications of improving standards, particularly for small companies

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RoSPA's view

- Performance improvement not possible without organisational safety learning
- AI is a 'window on OH&S management reality'
- Accidents are unparalleled organisational learning opportunities
- Accidents are emotionally charged and the adversarial basis of litigation is a barrier to effective AI
- Easier to learn from incidents than accidents
- Poor AI practice due to failure to popularise OH&S management
- HSE must place higher value on investigation

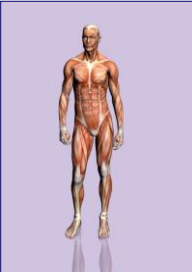
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HSE Guidance

- 'Investigating accidents and incidents - a workbook for employers, unions, safety representatives and safety professionals' (HSG245) July 2004
- ('the gathering of information; the analysing of information; identifying risk control measures; and the action plan and its implementation')

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Investigating health damage?



- MSDs
- Stress
- Skin disease
- Noise
- VWF
- Occupational cancer
- Respiratory disease
- Zoonoses
- etc

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Some key lessons

- Effective investigation rests on strong reporting culture
- Informal minor problem solving sets pattern for more structured investigation
- Tackling the aftermath of accidents requires maturity and robust relationships
- Team based investigation offers significant advantages
- Investigation needs board ownership

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Advantages of a team approach



- Learn how to investigate
- Different perspectives
- Learn about OS&H management
- Builds trust
- Creates ready-made champions for change

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See accidents/incidents as opportunities



- ✓ See accidents as an investment
- ✓ Exploit unique learning/change opportunities
- ✓ See accidents as 'windows on reality'
- ✓ Build trust through team based investigation
- ✓ Learn from near misses/hits

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RoSPA's 'Ten Point Challenge'

www.rospace.com/occupational-safety/learning/tenpoints.htm

1. Commitment to learning from safety failure?
2. Prompt reporting?
3. Scaling and terms of reference?
4. Team based approaches?
5. Training, guidance and support?
6. Information gathering?
7. Use of structured methods?
8. Immediate and underlying causation?
9. Communication and closure?
10. Reviewing investigation capability?

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Ideas for new inputs

- Updated training courses?
- Better guidance?
- Review of policy and practice in EU Member States/USA etc?
- Facilitation/review services?
- An investigation standard?
- Monitored self investigation
- Extending SADIE (http://step.steel-sci.org/SADIE/main_sadie_fs.htm)?
- **Project DORI !**

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Project DORI

- Defining Operational Readiness to Investigate
- Partnership between RoSPA and NRI Foundation
- Proposed Outputs:
 - functional analysis of investigation
 - criteria for readiness to investigate
 - list of phases for developing readiness
 - basis for subsequent RoSPA project, "PRIA" (Programme for Readiness to Investigate Accidents)
- Report published as a 'White Paper' on the NRI Foundation website (www.nri.eu.com)

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Operational readiness means..

- Creating an organisation that
 - ➔ places the right people
 - ➔ in the right places
 - ➔ at the right times
 - ➔ working with the right hardware
 - ➔ according to the right procedures and management controls
- At a secondary level, readiness implies that the needed elements are functioning in a conducive physical and psychological environment

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If not ready...

- Threat to the relationships between stakeholders
- Response not geared to requirement to learn
- Lack of clarity about what happened
- Poor handling of evidence, including witnesses
- Uneven analysis and interpretation
- Tendency to allocate blame
- Poor rates of near-miss/hear hit reporting
- Lack of continual improvement
- Poor quality of remedial change and learning

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Elements of readiness

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Readiness check

- 1) The ability of staff to recognise that something significant has happened
- 2) Rescue, first-aid & making safe
- 3) Notifying occurrences
- 4) Informing families (initial, plus updates)
- 5) Preserving/managing the scene
- 6) Collecting (early) statements
- 7) Assigning the level of investigation
- 8) Selecting the team
- 9) Informing workforce (initial, plus updates)
- 10) Informing customers (initial, plus updates)
- 11) Informing insurers and regulators
- 12) Informing the public and media
- 13) Develop terms of reference
- 14) Enabling/advising/protecting the Team

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Readiness check .. Cont'd

15) Managing the team	25) Evaluate/testing hypotheses
16) Liaising with other investigation teams	24) Identifying controls and barriers
17) Cataloguing evidence	25) Identifying root causes
18) Recording visual data	26) Writing reports
19) Collecting documents and logs	27) Developing remedial actions
20) Collecting equipment and material evidence	28) Reviewing the investigation
21) Collecting environmental evidence	29) Debriefing the team
22) Interviewing witnesses	30) Debriefing affected staff
23) Structuring what happened and how	31) Managing recommendations
24) Developing alternative lines of enquiry	32) Returning, archiving or disposing of evidence

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Some useful websites

- RoSPA www.rosipa.com
- NRI www.nri.eu.com
- HSE www.hse.gov.uk
- NEBOSH www.nebosh.org.uk
- Safety Groups www.safetygroupsuk.org.uk
- IOSH www.ioosh.co.uk
- IoD www.iood.com
- TUC www.tuc.org.uk
- CHAS www.chas.gov.uk
- CIEH www.cieh.org

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But please..

**don't have
nightmares...**

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Thank you