

Health and Safety Bulletin

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Accident Investigation

There is no specific legal requirement to investigate accidents – even those that have to be reported under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR). However, the Health and Safety at Work etc. Act (HASWA) places a general duty on employers to (so far as is reasonably practicable) protect the health, safety and welfare of their employees and most people accept that learning from any incident or accident – where it is likely the event has occurred because an element of the health and safety management system has failed – is fundamental to achieving this requirement.

The first steps

The first steps in investigation (once the immediate risks have been controlled and any injured persons have been provided with treatment) is to gather all the evidence that might help the investigation. Depending on the circumstances this may include risk assessments, training records, safe systems of work (such as permits or work instructions), and maintenance records. It is this evidence that can be analysed to identify how the incident or accident occurred.

Identifying the causes

The immediate causes of the event are easy to identify – these are the ones that led directly to the injury or damage. Unfortunately, some employers prefer to stop their investigation at this stage because it's easier to blame the injured person than find the management-related causes.

However, analyzing the immediate causes should pinpoint the unsafe conditions and/or unsafe acts that led to the accident – these are known as the underlying causes. Finally the root causes – those which allowed the event to occur - can be ascertained. Root causes are commonly associated with the failure of management systems such as recruitment, training or supervision, correcting them provides an opportunity to prevent many more accidents from occurring in the future.

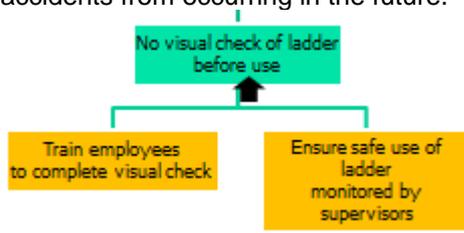


Figure 2: Using fault tree to identify corrective action

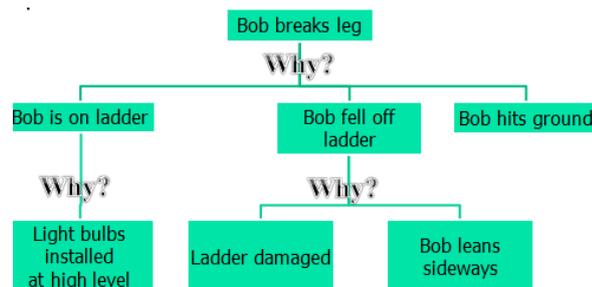


Figure 1: Start of fault tree analysis investigation

For simple accidents, fault tree analysis can be used as shown above to identify the three cause types (this diagram only shows immediate and underlying causes). Fault tree analysis is very similar to the “five why?” process used in quality investigations.

Working down to the root causes makes it easy to identify the corrective actions that, if implemented, would prevent further management failures – see figure 2.

Conclusion

HSE has just issued the provisional fatalities for 2014/2015 – 142 compared to 136 in 2013/2014. Many think this upward trend is likely to continue with the improvement in the economy.

Incidents and accidents are not pleasant – we know when they occur that they are proof of failures in our safety management systems. However, by investigating thoroughly and identifying the root causes, there is a real opportunity to prevent further negative events.

Recently issued health and safety information:

- HSG279: Making paper safely
<http://www.hse.gov.uk/pubns/priced/hsg279.pdf>
- Updated guidance on Safety Signs and Signals Regulations
<http://www.hse.gov.uk/pubns/priced/l64.pdf>
- HSE's dust hub
<http://www.hse.gov.uk/dust/index.htm>
- Epilepsy in the workplace - a TUC guide
<https://www.tuc.org.uk/sites/default/files/EpilepsyInTheWorkplace.pdf>
- Breathe Freely website
<http://www.breathefreely.org.uk/>
- Back to basics: Building a better workstation to lessen pain
<http://marshfield.wickadlocal.com/article/20150608/NEWS/150607517/?Start=1>
- Posture guidance for sedentary workers
<http://www.ergoergo.info/>

Changes to IOSH courses

IOSH has announced that they are combining their IOSH Directing Safety and IOSH Safety for Senior Executives course into one - Safety for Executives and Directors. The new course is aimed at those who have overall operational or strategic accountability, responsibility for determining and implementing effective safety and health management, and monitoring its effectiveness.

The syllabus will include the moral, legal and financial case for safety and the structure of effective health and safety management systems. It provides an opportunity for senior managers to focus on their health and safety strategy, taking into account both internal and external pressures.

Clwyd Associates has provided IOSH Safety for Senior Executives training since 2009 and will be developing their current successful material to meet the new criteria – for more information, please see our website at http://www.clwydassociates.co.uk/1_iosh.htm

Case Law update

This issue focuses on cases that occurred after numerous near misses or incidents that were not investigated effectively

A steel foundry has been sentenced after a worker was killed when he was struck in the face by a shard from an abrasive disc that exploded from a hand-held grinding machine. As he used the machine, the disc fitted to it suddenly exploded catapulting fragments across his workbay and a shard went straight through his visor and hit him in the mouth. HSE found the abrasive disc was nine inches in diameter although the grinder had a maximum permissible tool diameter of only two inches unless guarded. It was also attached to the grinder using a non-proprietary tool. In addition the disk was rated for 6,650 rpm

but the grinder was running at 12,000 rpm. The court was told that HSE's investigation had uncovered a number of previous incidents when discs had come off grinders, however, none of these had been mentioned in monthly minutes of the company's health and safety meetings for the site. The company was fined **£150,000** and ordered to pay **£24,000** costs

A 61 year-old employee was left in a coma after he was crushed during an accident that occurred while he was repairing a hopper unit on top of a continuous batch washer. His employer carried out an internal investigation into the incident and almost all the blame fell on a number of employees on the site, including the victim who was disciplined. Despite the HSE subsequently prosecuting them, the company's own

internal investigation made little criticism of the company's policies or of senior management. The company were fined **£80,000** and ordered to pay **£33,059** costs – the judge stated that the fine would have been **£40,000** more if the company had not pleaded guilty.

McDonalds were fined **£3,000** with **£18,880** costs after an employee required reconstructive surgery on her arm after she slipped and submerged it in scalding oil. It is thought the employee slipped on a piece of cardboard placed by a filter machine to catch leaks – this was common practice because the floor was slippery. After the accident, the company installed a self-filtering frying vat, replaced the flooring and retrained staff in the cleaning procedure.

IOSH Managing Safely

Clwyd Associates will be running a three day public course in Coalville from **21st - 23rd September 2015**. We are one of the few providers that are licensed to complete this course over three days rather than four.

Course costs:-
IOSH Managing Safely **£525**
These costs include course notes, IOSH fees and refreshments. VAT is excluded.

Contact us to find out more or to book a place!

About Clwyd Associates...

We are a management consultancy, focusing on health and safety, and SAP based in the Midlands.

We employ consultants with at least 15 years practical experience backed up by recognised professional and academic qualifications - ensuring our clients receive first class service.

Clwyd Associates Ltd
www.clwydassociates.co.uk



Contacting HSE

HSE has introduced an alternative 0345 phone number to report fatal and specified injuries, helping to cut the cost of telephone calls for the public.

The new number for the RIDDOR Incident Contact Centre is 0345 300 9923



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