



# Wilkins Safety Group

Monday, 15<sup>th</sup> September 2014

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## *Welcome to our latest Update E-Newsletter*

As ever, please feel free to share this with friends and colleagues. You will also find PDF versions of all our other newsletters on our website: [www.wilkinssafety.co.uk](http://www.wilkinssafety.co.uk) with lots more useful information and a wealth of leaflets covering Health and Safety topics.



### **This week we are looking at Accident Investigation.**

I was out on my little tractor at the weekend driving around the field, thinking about a new accident case I was asked to look at on Friday, and I thought “why are these accidents happening and are people investigating them properly?”

Many accidents happen when staff are away on holiday and often the work was unrelated to the injured parties' normal job function, because **“they were just filling in whilst the usual person who does this job was away”**

**This week's 2 recent HSE cases also look at accidents that could and should have been avoided.**

- **23-year-old**, from Holbeach, was helping to clear a blockage on an unguarded woodworking machine and lost the top of his finger
- **A Kidderminster carpet company** and a Surrey-based firm have been fined after a large pressure vessel exploded, propelling the vessel's quarter-tonne lid **six metres into the air**

We hope you learn from the mistakes of others that are highlighted in our weekly newsletters and, as a result, do not have similar accidents at your workplace.

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## Accident Investigation

Unfortunately if there is an incident and it is serious enough, you - the employer - will have to complete the necessary reports and on-line RIDDOR forms, maybe have staff off work due to the injury. Therefore we thought we would highlight the requirements for Accident Investigation.

### Incident and accident investigation

#### Employers' duty

Employers have a duty to investigate incidents and accidents at work and a duty to revise risk assessments in the light of investigations. The Management of Health and Safety at Work Regulations 1999, Regulation 5, "Health and Safety Arrangements", states that: ***"Every employer shall make and give effect to such arrangements as are appropriate, having regard to the nature of his activities and the size of his undertaking, for the effective planning, organisation, control, monitoring and review of the preventive and protective measures."***



The associated Approved Code of Practice (ACOP) says that: ***"Employers should measure what they are doing to implement their health and safety policy, to assess how effectively they are controlling risk, and how well they are developing a positive health and safety culture."*** Monitoring includes:

- Adequately investigating the immediate and underlying causes of incidents and accidents to ensure that remedial action is taken, lessons are learnt and longer term objectives are introduced.

Employers are required under MHSW Reg 3(1) (a) to ***"make a suitable and sufficient assessment of the risks to the health and safety of his employees to which they are exposed at work"***. Reg 3(3) requires risk assessments to be reviewed where there is reason to believe they are no longer valid, or there has been a significant change in the matters to which it relates. The associated ACOP at paragraph 26(a), draws attention to near misses and defects in plant or equipment, and identifies **accidents, ill health and dangerous occurrences as events that should trigger a review of risk assessments**.

### Accident Investigation

Accidents, cases of ill health, dangerous occurrences, near misses and property damage can have high human and financial costs. They often cause unnecessary misery, threaten someone's livelihood and may affect the viability of the company. It is vital therefore that employers put in place arrangements for identifying, recording and investigating **all** relevant incidents.

#### These should:

- ascertain both immediate and underlying causes (there is rarely a single cause)
- put in place measures to prevent a recurrence; this may need to be done straightaway
- reappraise existing risk assessments
- review control standards and success in meeting them

- identify activities or jobs causing the greatest number of incidents - of particular value in larger firms and groups
- satisfy legal reporting and recording duties
- obtain details which might be needed if the incident becomes subject to an insurance claim or legal action

These arrangements should be set out in the company health and safety policy. They form part of the firm's monitoring system and are an essential feature of successful health and safety management.

Early priorities after an incident are of course to treat the injured, deal with the immediate emergency and make the workplace safe. During rescue, clearing up and investigation care must be taken to avoid the destruction of any evidence which might be required during investigation.

## Why investigate?

The main aims of investigation are to pin-point the causes of incidents and take prompt and effective action to prevent recurrence. Key points to consider during investigation are-

- the organisation including relevant policies, standards, procedures and rules
- the job including, where relevant, the substances, procedures, equipment and premises in use
- personal factors including people's behaviour, suitability and competence to carry out the work

Incidents need examining in sufficient depth so that immediate causes and the underlying failures of systems for managing health and safety are identified. As well as immediate and early remedial action it may be necessary to make longer-term changes.

### Improvements might include:

- giving training in manual handling techniques
- substituting a wash-up solvent with something less hazardous
- changing a make-ready procedure or other system of work
- instituting health surveillance, e.g. for people working with UV curable materials
- providing an interlocking guard
- amending the health and safety policy and risk assessments

## Which incidents?

Be guided by the significance of the incident when deciding what to investigate and on the type and depth of the investigation. Consider not only the actual consequences but also the potential outcome. The more serious the event or greater its potential, the greater is the effort to be applied.

Incidents needing investigation include:

- **all injuries, dangerous occurrences and cases of occupational ill health;**
- **fires and spillages;**
- **Near misses and property damage** - these incidents, which can also cause loss and may be potentially very serious, merit investigation; the remedial action taken may help prevent an injury in the future.



## How do you find out about such incidents?

A robust approach to learning from incidents rests on not only on a positive safety culture but on having an environment in which people are actively encouraged to report incidents including near misses are thanked by managers for doing so and are informed about what action has been taken as a result. It is also important to check other sources such as first-aid treatment and health records, maintenance reports etc. to help identify incidents.

Effective procedures need to be in place so that managers at the appropriate level can be notified and decisions made about any immediate remedial action and about the nature of the investigation.

## Who should investigate?

Normally line managers will investigate with help as appropriate from the health and safety adviser/competent person, medical or nursing adviser and technical staff such as in-house engineers and equipment or materials suppliers. The level of management involved will generally be related to the actual or potential significance of the injury, ill health or loss but, in most cases, there will be an immediate inspection, possibly by the supervisor who can ensure that important evidence is not lost.

Safety representatives are entitled to carry out inspections where there has been a reportable accident or dangerous occurrence or where a reportable disease has been contracted. Employers or their representatives may be present during these inspections. Employers need to provide reasonable facilities for independent investigation by safety representatives and private discussions with the employees they represent.

In practice the best approach is normally a joint inspection between employers and safety representatives. The main purpose is after all to determine the causes so that the necessary remedial action can be taken. The advantages of a 'team' approach to investigation, involving safety representatives, are that this brings practical experience to the process, team members learn about investigation techniques and about general principles of health and safety management and they can become powerful advocates for securing implementation of any resulting recommendations for action.

Training in incident investigation techniques is necessary, including, for example, gathering witness evidence via interviews and using structured methods to put evidence together and to test hypotheses about what happened and why. In practice the bulk of evidence used in investigations comes from witness interviews. Managers and safety representatives need to understand how to approach witnesses, for example, using 'open' not 'closed' questions and recognising that they may have been traumatised, particularly where the accident involved serious injuries.

## Checklist for incident investigation

Use the following checklist to structure investigations and written reports. It is intended as a guide and is not comprehensive. Be sure to establish at an early stage whether immediate action is needed. For example, it may be necessary to withdraw a machine or substance from use or stop an activity. The most important first step is to gather key facts about the event and circumstances surrounding it by: interviewing witnesses before their recollection of events alters; gathering all necessary physical evidence; and identifying and securing key documents (for example, recent inspection records, training records etc.).



### Obtain basic facts

- names of injured employee(s)/witnesses/ people early on the scene

- condition of plant
- substances in use or present
- layout
- place, time, conditions
- exactly what happened just before the event and as it unfolded
- injury/ill health damage/process disruption
- make use of cameras, sketches, measurement to record the undisturbed scene

### **Establish circumstances**

- What was being done at the time and what happened?
- immediate causes
- events leading up to the incident
- any evidence linking case of ill health to work
- Competence, e.g. what instructions and training were given before the event and how much experience in the job did the people involved (including managers and supervisors) have?
- What were the established methods of work and procedures?
- behaviour and actions of individuals
- role of supervision and management
- Has something similar happened (or nearly happened) before?

### **Identify preventive measures**

- assess/reassess the risk
- question the adequacy of existing physical safeguards and work methods and discrepancies with those intended
- Reappraise the intended safeguards and work methods - do they satisfy the intentions of the company health and safety policy and do they meet the standards given in authoritative guidance?

### **Establish whether initial management response was adequate**

- prompt and appropriate action such as making safe and dealing with any continuing risks, electrical isolation, suitable firefighting, effective first-aid response and correct spillage procedures

### **Identify the underlying causes**

These might include:

- management or supervision failure
- lack of competence
- inadequate training
- shortcomings in original design
- inadequate performance standards set by firm
- absence of a system for maintenance

### **Determine action needed to prevent a recurrence**

In deciding on the right course of action, employers need to think whether the outcome could have been more serious and what prevented this from happening. Examples of action are:

- improve physical safeguards
- provide and use local exhaust ventilation

- use mechanical handling aids such as pile turners and mobile lifts
- introduce better test and maintenance arrangements
- improve work methods
- provide and use personal protective equipment
- make changes to supervision and training arrangements
- review similar risks in other departments
- set up a system to assess the risks from new plant and substances at the planning stage
- review procedures involving contractors
- update standards and policies
- introduce monitoring and audit systems

### **Implement, analyse, and review**

Once the initial action is taken, management need to:

- identify underlying causes and corrective action
- implement follow - up action promptly
- check that follow - up action has been taken (standard report forms can help)
- analyse data systematically to identify trends and features - safety representatives and company safety committees will find this useful
- Question the overall response - did it fully reflect the risks?
- review performance periodically

They can then make sound decisions for the future.



Remember we are more than happy to run an in-house course for those companies that want to have more than one person competent in undertaking '**Accident Investigation**'.

If you need further information please call us on [01458 253682](tel:01458253682) or send us an email at [info@wilkinssafety.co.uk](mailto:info@wilkinssafety.co.uk)

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**Now to the latest HSE cases:**

## ***A Lincolnshire timber firm in court after worker's finger amputated***

**A Lincolnshire timber company has been fined after an agency worker lost the top of his finger in an unguarded machine.**

Grantham Magistrates' Court heard today (11 September) that the 23-year-old, from Holbeach, was helping to clear a blockage on a woodworking machine at Select Timber Products Ltd's premises in Mill Lane, Donington, when the incident happened on 15 July 2013.

An investigation by the Health and Safety Executive (HSE) found two of the machine's guards had been removed. The machine operator had lifted the main guard to clear the blockage, while a fixed guard on one of the machine's six cutting head had also been taken off to make cleaning easier.

However, the machine was still under power, so when the agency worker reached in his left hand came into contact with one of the moving cutting heads. Surgeons had to amputate the top of his middle finger on his left hand. He also suffered severe lacerations to two other fingers and only has partial movement in these and his middle finger.

Select Timber Products Ltd was fined a total of £9,900 and ordered to pay a further £1,193 in costs after pleading guilty to three separate breaches of the Provision and Use of Work Equipment Regulations 1998.

After the hearing HSE inspector Neil Ward said:

*"About 30 to 40 similar incidents are reported to HSE every year. Nearly all result in amputation injuries and most, including this one, could have been prevented if the cutters had come to rest before operators approached them."*

*"Neither the machine operator nor the injured man had been trained to a suitable standard by Select Timber Products. HSE publishes free guidance for this type of machine but that guidance was not followed."*

*"Workers should not have been clearing blockages with any of the cutters turning and the fixed guard should never have been removed from one of the heads."*

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## ***Exploding vessel leads to court for carpet company and engineering inspection firm***

**A Kidderminster carpet company and a Surrey-based firm have been fined after a large pressure vessel, in which carpet fibres are dyed and processed, exploded, propelling the vessel's quarter-tonne lid six metres into the air.**

No-one was injured in the incident at Brinton Carpets Ltd's site at Halesfield, Telford on 4 June 2013, but the dangerous incident could have been prevented.

The Health and Safety Executive (HSE) carried out an investigation and today (10 Sept) prosecuted Brintons Carpets Ltd, the owner and user of the pressure vessels and Allianz Engineering Inspection Services Ltd, who were contracted to carry out periodic thorough examinations of the dye vessels.



Telford Magistrates' Court heard that each of Brintons Carpets' four stock dye vessels, each described as industrial pressure cookers, were pressurised while in use.

During a production run, one of the vessels exploded. The lid, which weighed approximately 250kg, was torn off its locking mechanism and hinges and hit the roof of the factory six metres above. Such was the force of the collision that it left a dent in one of the factory roof girders.

One worker was standing just a few feet from the where the lid came to rest.

The explosion was found to have been caused by a failure of the vessel's regulator and pressure relief valve. HSE found Brintons Carpets Ltd had not ensured that suitable and sufficient maintenance of the vessel's safety devices was being carried out. In addition to this, the periodic statutory thorough examinations had not been completed for three years.

A Written Scheme of Examination was in place at Brintons Carpets Ltd, which included the stock dye vessels in question. Although Allianz Engineering Services Ltd were carrying out periodic thorough examinations on the other pressure equipment on site, the HSE found that the four stock dye vats had been overlooked for a number of years. Allianz Engineering Services Ltd, therefore, failed to carry out the required examinations on the vats properly.

Brintons Carpets Ltd of Stourport Road, Kidderminster, Worcestershire, pleaded guilty to breaching Regulation 12 of The Pressures Systems Safety Regulations 2000 and was fined £10,000 and ordered to pay costs of £1,174.

Allianz Inspection Services Ltd of Ladymead, Guildford, Surrey, pleaded guilty to breaching Regulation 9(2) of The Pressures Systems Safety Regulations 2000 and was fined £13,000 and ordered to pay costs of £1,111.

Speaking after the hearing, HSE inspector Lyn Mizen said:

*"If a piece of pressure equipment fails and bursts violently apart, the results can be devastating to people in the vicinity. It was a matter of pure luck that no one was seriously injured in this incident.*

*"There are clear standards set out in the regulations and strict inspection regimes whereby the user has a duty to ensure that equipment, and its safety devices, are properly maintained. This is backed up by the periodic thorough examinations by competent persons to ensure this is happening and is appropriate and suitable.*

*"Sadly in this case the user of the pressure system and their competent person both failed in their duties."*



If you have any queries on any health and safety matter, please contact Jon Wilkins on [01458 253682](tel:01458253682) or by email on [jon@wilkinssafety.co.uk](mailto:jon@wilkinssafety.co.uk)



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