

REPORTING OF ACCIDENTS AND INCIDENTS

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INTRODUCTION

This paper is a personal view set against the background of trying to improve the reporting of accidents, incidents and dangerous occurrences in EPC-UK.

BACKGROUND

There is a growing appreciation of the importance of incident reporting and investigation as an accident prevention tool. According to various authors accidents are only the tip of the iceberg and for each reported major injury there may be hundreds of minor injuries, incidents and potential risks, many of which can go unreported. Therefore an increase in reporting should result in an increase in investigation with resultant removal of hazardous situations and ultimately a reduction in the number of injuries. Bird arrived at his famous triangle after the analysis of thousands of incidents and accidents.

Accident Frequency Triangle



(Bird 1969)

METHODS

This paper looks at reporting frequencies for accidents and incidents and possible reasons for under reporting, and strategies for increasing reporting frequency.

Accidents

There is a wide range of definitions of accident.

A Lost Time Accident is a result of failure to return to work on the shift following the accident.

Other definitions of Lost Time Accidents include –

An accident that results in medical treatment at a General Practice or hospital;

Failure to return to work some time subsequent to the accident;

Failure to be available to work on the usual job on the day following the accident;

Failure to be available for work for three consecutive shifts after the accident.

All of these definitions allow room for interpretation, and therefore possibilities for under-reporting.

As far as EPC-UK is concerned an accident is an unplanned and uncontrolled event which results in personal injury or ill health and/or plant and equipment damage (including environmental damage).

An incident is an unplanned and uncontrolled event which could have resulted in personal injury or ill health and/or plant and equipment damage (including environmental damage).

Recordable Injuries

Again, there are several definitions of recordable injuries –

Defined injuries such as scalds, abrasions, cuts, broken bones etc

First aid treated – bear in mind that if you report the accident to a First Aider you will almost certainly receive first aid treatment.

Minimum treatment time; this avoids the obligatory First Aid as mentioned above eg if set at 30 minutes this would screen out most of the sticking plaster accidents.

Potential Risks

Again, several definitions are commonly used –

Unsafe situations or conditions;

Near hits;

Near misses;

Dangerous occurrences – these are legally defined in UK Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR). These tend to be for incidents that have actually happened rather than for near-misses that had potential e.g the observation of a weak

link in a lifting chain would be a near-miss, or unsafe situation; a failure of the link and falling of the load would be a dangerous occurrence i.e. the potential has happened.

All of these have the potential to lead to accidents and incidents.

Policies and Mission Statements

Policies and mission statements frequently contain phrases such as –

Zero harm;

Zero accidents;

Safety is number one priority;

Accidents are not acceptable;

Target zero;

No blame culture.

These are all meant with the best of intentions and are genuinely thought to be achievable, but are they realistic or even accurate?

Is safety the number one priority or should it be company survival is the number one priority and good safety management is an integral part of that strategy?

Zero accidents is an aspirational target that we'd all like to achieve but is it realistic?

Most would agree that "accidents are not acceptable" but how does writing it help? What does it mean and what are the consequences? Does it mean "we won't accept accidents"? If so, this leaves the manager with operational responsibility with nowhere to go and puts all levels of staff in an impossible position.

Not many companies would say that they have a blame culture so what does a "no blame culture" mean? It is usually only put to the test when things go wrong.

Statements of this type make the reporting of accidents and incidents very difficult.

Reporting Frequencies

The percentage of reported accidents versus actual numbers of accidents decreases as you move down from the apex to the base of Birds triangle. This is not just because the numbers of accidents/incidents have increased but also because the seriousness of the accidents/incidents decreases and therefore the likelihood of a report decreases.

It could be said that –

Fatalities are always reported;

Lost Time Accidents are usually reported;

Recordable injuries are quite often reported;

Anything else is sometimes reported.

Reporting

Reasons For Not Reporting

Every company has a policy that all accidents and incidents must be reported.

However an accident report is an admission of failure and no-one likes to report failures, especially to the outside world.

How many organisations adopt the following approach?

Accidents and incidents **MUST** be reported internally

Accidents and incidents **SHOULD** be reported to the authorities

Accidents and incidents really **OUGHT** to be reported to SAFEX.

There are several reasons why we fail to report –

Fear – my job is stake. If managers feel that this is the case then reporting an accident is career-threatening and therefore is less likely to be reported.

Fiddle (manipulation of the figures) – For the inventive manager this can be a Godsend. Was it really a Lost Time Accident? Was the victim really at work or just travelling to work? Did it happen during a lunch break? Can the victim be given alternate employment – stocktaking, data inputting, manning the reception desk etc to avoid the time off?

Can they take holidays or time in lieu of previous unpaid overtime?

Forget – this is particularly true of incidents and potential risks. People often fail to report what they consider is trivial, especially if it results in no harm – a slip in snow, a trip over a computer cable, unstable files on a high shelf etc.

Improving Reporting Performance

EPC-UK are focussed on trying to improve our accident/incident reporting success. We have been looking at this particularly from the point of view of the perceived failure modes listed above.

Our policy statement states that “we will assess the level of risk from all significant Health & Safety hazards and so far as reasonably practicable, ensure that they are eliminated or adequately controlled”.

Fear – we are trying to develop a genuine no blame culture. This does not happen overnight and is a long term process. So far there have been no instances where disproportionate blame has been attributed, but it does take time to neutralise natural suspicions. Obviously in cases,

for example, when someone runs into the back of another car the law blames the driver for driving too fast or too close. In cases like these we have concentrated on retraining rather than blaming. People make mistakes and can directly cause an incident. They may be clearly at fault and must take their share of the responsibility, not actual blame, but very close to it. The blame approach is often about historic management style.

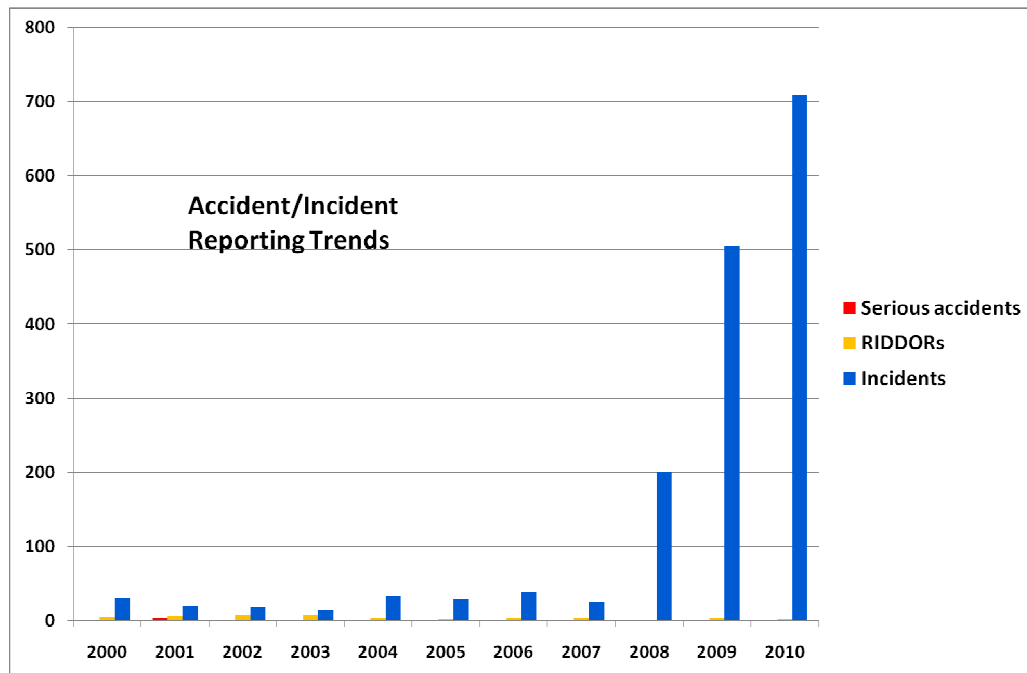
Fiddle (manipulation of the figures) – the only defence against this is to have clear definitions and monitoring of what constitutes accidents and incidents. This may vary from organisation to organisation but internal consistency is essential.

Forget – organisations should constantly remind people of the need to report accidents and incidents. Some companies have reward schemes that encourage reporting. In these situations it is important to take care that employees don't "save" reports until rewards are offered. It also helps if you make it easy to report accidents and incidents – no-one wants to have to fill in pages of paper to report what they may consider as trivial. We have a dedicated phone line for accident and incident reporting that records from all levels of staff messages allowing safety managers to document and follow up. This is particularly useful for employees who are not factory-based.

It is also extremely important that all reports are investigated and the originator of the report is given feedback on the outcome of the investigation to avoid the perception that reports are not acted upon and therefore are a waste of time.

RESULTS

So far we have seen a marked increase in the frequency of reporting accidents and incidents (admittedly, from a very low initial baseline) and our employees have begun to see the value. To date, we have succeeded in achieving a no blame culture.



The responsibility for investigating accidents and incidents lies with the line managers but they are usually assisted by divisional safety managers (three, within EPC-UK).

Take Home Messages

Make it as easy as possible for employees to report accidents and incidents. Yes.
Try not to attach blame. Yes, but identify personnel responsibilities.

Accurately and consistently define the meanings of accident, incident, Lost Time Accident etc
Monitor the reporting of accidents and incidents to look for trends such as area, type of incident/accident, shift patterns, season etc.

Follow-up on all reports and communicate the findings.