

Incident Investigations

Background

Current approaches to incident investigation are inconsistent and reports are of variable quality with inadequate senior-level review. Investigations also struggle to understand root causes and therefore we miss opportunities to properly address these to prevent future incidents and share lessons learnt.

Vision

To improve the quality and consistency of investigations such that we understand the root causes and are able to avoid repeat occurrence.

Principles of Approach to be Adopted (incl Application of Hierarchy of Control)

As a supplier community we have agreed to adopt the following approach as a **common standard for all incident and accident investigation and reporting** (including work-related road traffic accidents). This common standard is intended to address Health, Safety or Environmental incidents and accidents such that recurrence is avoided.

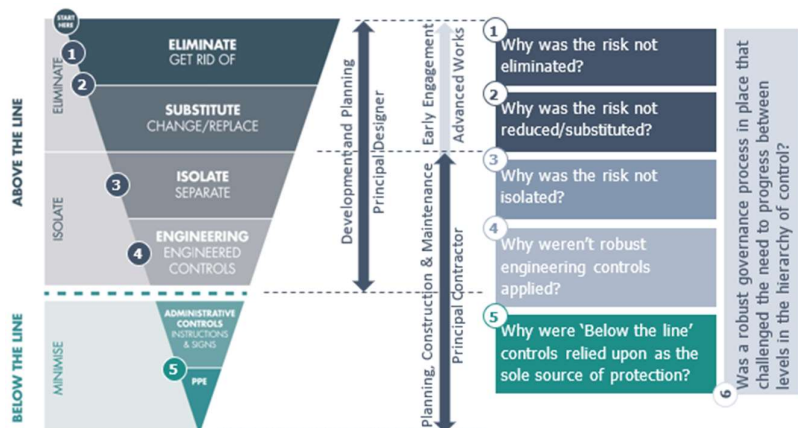
This common standard provides a baseline for good practice in effective and fair investigations and determining root causes following an accident/incident. It promotes application of policies to improve investigation activities and outcomes and requires **the level of all investigations to be based on the highest reasonably foreseeable potential impact** and not on the actual outcome.

Openness and transparency is critical for us to learn as an industry and avoid future incidents therefore, **as Suppliers to Highways England, we will share as much as we can, as early as we can.**

Consideration of Root Causes will not stop at on-site processes and procedures but will also consider how designs could have been improved so that we are learning fully from the event. To assist in this, **we will involve a design and Highways England representative in all investigations for improvement projects**, unless it can be demonstrated that design could not have contributed.

We will use a **suitable and effective** (& preferably industry-recognised) **method for analysing the information and determining root causes** such as “5 whys?” or Incident Cause Analysis Method (ICAM) framework. We will consider causes that emanate from both design and construction stages (for improvement projects), drawing on specialist expertise as required. **We will consider what and why decisions have been taken to move through each of the levels in the Hierarchy of Control.**

As a minimum, we will consider: task & environmental conditions; organisational factors; human factors (eg errors & violations model), including individual or team actions; and absent or failed defences. **The act of an individual will rarely, if ever, be the root cause**, so we will continue to ask “why” to determine root causes for behaviours, and not seek to apportion blame.



We will specify the approach we take in our procedures and will include (as a minimum):

1. Roles and Responsibilities
2. Requirements for Immediate Response
3. Requirements for Notification and Reporting Internally
4. Requirements for Notifying and Reporting to Highways England
5. Social Media Policy
6. Categorisation of Events
7. Specific Investigation and Reporting Requirements for each Category type
8. Requirements for Working with the Principal Contractor (for sub-contractors and suppliers)
9. Requirements for Working with Sub-Contractors and Suppliers Skills/Qualifications/Experience of Lead Investigators for each Category type
10. Methodology for determining Root Causes
11. Specific Requirements for Investigations for each Category type
12. Human Factors/Behavioural Safety Considerations
13. Review of Quality of Investigation and Reporting
14. Requirements for AIRSWeb Reporting
15. Requirements for Joint Ventures/Alliance/Multi-party arrangements

Reports will include a high-level summary of events, causes, actions, lessons learnt and plans for communications, followed by more detailed documentation of these. We will define **SMART actions** that will be undertaken as a result of the findings and will follow through within the times specified.

Specific Areas that We Will Better Address

- **We will categorise all events based on the highest reasonably foreseeable potential severity** (rather than actual severity) to determine the level of investigation, reporting and governance, aligned to GG128.
- **We will use AIRSWeb to report incidents to Highways England.** We will record (as draft) incident cause on AIRSWeb as soon as practically possible. During investigation we will update AIRSWeb and we will review/amend as appropriate before submission as final, upon investigation completion. **We will not let time requirements for reporting limit investigations**, seeking extensions to the 10-day requirement as appropriate, providing sufficient evidence of progress.
- **We will implement a clear Incident Protocol** following an incident, including: reporting content, **involvement of all organisations**, timescales and appointment of **a suitably experienced and (for HIPOs and RIDDORs) qualified lead investigator** who will be ultimately responsible for identifying the root cause(s) of the incident and driving recommendations to ensure the causes are not repeated. They will be, or will report to, someone with the authority to make decisions and act on any findings. We will approach all investigations without prior bias to ensure we determine true root causes, including underlying management / organisational factors.
- Reports produced following investigation will be **reviewed and signed off by a manager of appropriate seniority (Managing/Sector/Operations Director or equivalent Level for HIPO and RIDDOR incidents)** prior to sharing the findings with/submitting to HE/others.
- We will **report all incidents to the Principal Contractor** as soon as is practicable and within the timescale required by the Enforcing Authority and Highways England, and no later than 24 hours.
- We will **comply with requests for investigations by others** and support any investigation by being open, honest and promoting a just culture.
- We will **regularly brief/share any lessons learnt** via the Safety Hub, the Engagement Council, live operational maintenance contracts and Major Projects, as appropriate, and integrate into our working practices any improvements identified during investigations.
- We will produce a **SMART action plan** for implementation of risk control measures, including *Local* SMART actions aimed to prevent reoccurrence on the same project and *Wider* SMART actions aimed at preventing occurrences elsewhere. We will ensure that proposed additional risk controls are reviewed by, and assigned to, people at appropriate levels for timely completion and monitoring.
- **For high potential investigations** (serious, major or fatal potential) Managing/Sector/Operations Directors (or equiv.) will be involved with the investigation throughout the process. The same Senior Director will ensure that agreed risk control measures are implemented within appropriate timescales and ensuring findings from investigations are shared throughout the supplier community.
- **We will have a suitable process in place to review the effectiveness of the investigation** and will conduct regular audits to ensure that recommendations are adequately considered/applied.

Additional Documentation/Detailed Guidance



GG128 remains the definitive document for specific requirements for reporting incidents, events and undesirable circumstances: health, safety, wellbeing, structural and environmental.

This *Common Intent* sets broader expectations in the way in which we will adopt approaches that go beyond simple compliance and help us to reduce accidents and incidents.

Guidance/advice on interpretation of requirements and the common intent, including best practice examples, are being added to the Raising the Bar Documents:

(<https://www.gov.uk/government/collections/health-and-safety-for-major-road-schemes-raising-the-bar-initiative>)

Document Approval Record

	Name	Signed	Dated
Working Group Chair	Lesley Waud		31 July 2020
SCSLG Chair	Phil Clifton		31 July 2020