The Moray Council

APPENDIX 1

HEALTH & SAFETY ANNUAL REPORT (January to December 2014)

1. Purpose

1.1 The purpose of this report is to provide information on health and safety issues at both a Council and a national level, and to define how the Council is dealing with them. It is also to give an overview of the Council's health and safety performance corporately up to the end of December 2014 and to raise awareness of any major risks we are facing and risk control improvements deemed necessary in the Council's systems to eliminate or mitigate these risks.

2. Summary of Key Themes

Some key themes have emerged from this report, mainly around ensuring that what should be happening is happening in practice, day to day. These are expanded on in the report with specific action proposed to address them and can be summarised as:

a) Learning and adapting – recognising that the way we work does have a bearing on accidents and that this needs to deliberately change when an incident occurs;

b) Spreading the change – the learning needs to filter through all service areas and be followed up to ensure it sticks

c) Responsibility – managers in particular need to ensure safety is prioritised and that they ensure appropriate measures are in place in their operations. Employee responsibility is also an issue.

3. Introduction

"If you always do what you've always done, you'll always get what you've always got."

3.1 There is no doubt that improvements in the attitudes towards safety have occurred since the Council started the culture change process in 2012. There are more engagement activities in the form of meetings and written communications on safety related topics and there is more focus on accountability. More training opportunities in the way of both formal events and toolbox talks are also in place and there is more emphasis on integrating safety into new developments. Also, the statistics demonstrate more reporting of incidents than was previously carried out. However, the information in this report indicates that there is still some way to go on the journey towards being in the desired state as regards health and safety.

3.2 There have been a number of serious accidents during the last 12 months that

have been investigated and as noted above, some common themes emerge. A recent fall from height accident in Building Services has added weight to the argument for the need for further change. The incidents reported have caused a critical re-examination of the approach of the last few years towards trying to change the safety culture of the council. Evidence suggests that the genuine desire of senior management to keep everyone safe and have a zero tolerance to people wilfully exposing themselves and others to unacceptable risks has not been fully understood or acted upon at all levels within all services. Underpinning actions are proposed in the final section of this report aimed at continuing the culture change required and making it more likely to be embraced and sustained.

3.3 The past year has been challenging in terms of maintaining focus on improvement plans due to constant pressures to deal with emerging issues. The changes and thinning down of management structures across the authority has caused a knock on effect of more direct contact being requested from the Health and Safety (H&S) team on specific problems and more support being required. Some potentially serious accidents within the higher risk areas of the Council have also required input from the H&S team which in a small unit is difficult to factor in within the service delivery structure. Ensuring that any improvement activity in one operational area is reflected out to all services where relevant is an obvious way to ensure an organisational improvement when an operational weakness is discovered but this is difficult to achieve in practice.

3.4 The overarching goals of the council's health and safety system remain the same. In the last year the points below have been added to the Health and Safety Policy statement of the Council. The intention of these was to give clearer direction to all, taking account of the issues we face in the current climate of restraint.

- Reduction of risks to all people's health and safety
- Minimisation of all losses
- True engagement with the workforce in securing improvements

4. Review and Monitoring of Council Performance.

4.1 Statistical Review

4.1.1 **Appendix A** sets out an analysis of the Health and Safety incidents that were reported during the year January 2014 to December 2014 and compares these to the previous 2 years. In total 288 incidents were reported. The statistics show a rising trend of around 15% each year with 30% more incidents in 2014 than the 221 reported in 2012.

4.1.2 The main points to note are:

i) When the incidents are broken down by service, the greatest number is in Education. While this is new in the 2014 statistics with there having been a significant 75% increase in the number of incidents reported for this service, it is closer to what would be expected given the size and nature of council services.

ii) In contrast, the number of incidents reported in Social Care has reduced by more than a third, largely due to a reduction in slips and falls but the reduction may also suggest a degree of under-reporting based on comparison with previous years.

iii) When looking at the severity of incidents, although there is a higher number in Education and Social Care these do not have as high a potential to cause serious liability for the council as those in other services.

iv) There has been a significant increase in the number of incidents classified as “other” and this needs to be addressed for future reporting.

4.2 Review of Incidents/Accidents

4.2.1 A number of serious accidents have occurred this year with roads, waste and building services figuring strongly on the more severe end of the spectrum as regards actual or potential seriousness of outcome. Some examples are provided below to indicate the range and nature of incidents that occurred.

i. Mobile plant continued to cause injury in the roads section with two tipping rollers being reported. The one which caused the more minor injury to the worker had the higher potential to have caused a serious outcome. This is a reminder that the actual outcome of an accident is not a good indicator of the accidents which demand the greatest effort to avoid. In the first incident a roller tipped over down an embankment – the driver had to jump off and roll down the banking to escape potentially being trapped and crushed by the roller if it had followed him. In the other incident a driver trapped his foot under a tipping roller resulting in him suffering broken bones in his foot. Actions agreed within the department aim to ensure an improvement of the Council’s record in this regard.

ii. A dumper truck driver lost control of a vehicle and ran over the foot and ankle of a colleague working close to his intended path.

iii. A waste operative fell from a ladder on his vehicle’s body due to the ladder being damaged. Later in the year another operative fell and injured himself whilst climbing on the same vehicle body as the ladder had not been replaced

iv. A JCB radiator hose burst in the cab spraying hot steam and water over the driver. This could have had more serious consequences if the driver had lost control of his vehicle.

v. A digger tipped and had to be recovered because the bucket was overloaded and digger arm over-stretched while moving earth. Stabilising devices were not positioned. The driver pitched forward out of the front window of cab and suffered bruising injuries.

vi. A load of concrete ($3m^3$) slid in the back of the truck when the body was being tipped off the back of the lorry. The back door was broken off and the concrete landed in road. This is reported as a near miss which had the potential to cause serious injuries to employees or passers-by.

vii. A van driver did not see the warning lights or hear the warning alarm when approaching the level crossing at Forres. He crossed onto the railway line and was trapped by the descending barriers. The oncoming train had to be stopped.

viii. A number of accidents in physical education have occurred causing more injuries than usual. Work is underway to ascertain whether the increase is due to better reporting, a change in activity or a statistical anomaly.

ix. A refuse collection vehicle reversed into a parked car and pushed it into a wall.

4.3 Review of Policy and Development Work

4.3.1 A programme of inspections of higher risk areas has been undertaken and common themes from the inspections have been discussed with the management of these areas for action. These inspections have uncovered practices that managers have not been aware of (e.g. poor welfare facilities; poor practices where equipment was inadequate). It may be that people on the ground are more willing to pass concerns to safety officers than via their supervisors to management, or that the opportunity is taken when the questions are asked. For safety to become part of the culture and to be fully embedded in operational practice, ways of reporting and taking action through the management structure must become a priority.

4.3.2 The training of staff carried out so far in health and safety management has been well received but needs to be developed to be more practice based and accessible. Due to the level of H&S resource available, the number of training events that can be offered is limited and so only relatively small numbers of managers have attended to date. It should be noted that separate job and task specific safety training and briefings are provided within services and general safety awareness is part of the induction process. The Council's new e-learning system is hoped to be one vehicle to opening training opportunities to a wider audience.

5. National Developments.

5.1 The HSE continues to emphasise their mission to only impose reasonable expectations upon us. The courts, however, are imposing penalties where failures result in injury or death. This is especially true within Educational and Care settings.

5.2 Some recent prosecutions of local authorities are worthy of note.

- Lake District council fined £150k for refuse collection vehicle reversing fatalities
- Cornish council fined £14k for injury to contractor during roof work

- Suffolk council fined £48k with costs of £44k after 2 accidents in schools and vibration related injury to roadworkers
- Fife council fined £20k after janitor injured whilst using a chainsaw
- Gateshead council fine over £40k for worker hit by a train whilst trying to clear tracks of a tree he had cut down.
- Birmingham council fined £10k for bin lorry reverse accident
- A Welsh council fined £24k with £13k costs after a worker crushed by inappropriately stacked concrete barriers.
- Lothian council fined £80k after elderly tenant falls down hatch left up in her house during central heating upgrade. She died from her injuries.
- Lanarkshire council fined £50k after worker crushed by lifter device on recycling vehicle. He was trying to fix the lifter which had been jamming.

5.3 The Construction Design and Management regulations (CDM), the legislation that governs how contractors building or maintaining our estates must be managed, has been modified after the HSE review of construction activity. The amendments implement a move away from development of highly detailed plans with no actual safety improvement outcome towards making sure that designs are safe to build, to use and to maintain. The legislation allocates this responsibility to a new position of “Principal Designer” along with some changes to the client role. Within the Council examples have been found of approved plans not being comprehensive or not detailing how certain risk elements of a job will be managed. This is what the amendments to the Regulation are trying to address to ensure a more realistic outcomes focussed approach.

5.4 Fees for Intervention which are levied by the HSE will continue despite objections and seem unlikely to be removed. This will be of interest to the Council in the coming year as, outwith the reporting period of this annual report, there has been a serious incident that could lead to HSE intervention in Moray.

6. Conclusions and Proposed Developments

6.1 Over two years ago, the Council formally acknowledged that a major factor in many of the more serious accidents experienced in the Council had at their root an element of poor safety culture. The practices that have developed through increased emphasis on safety, improved communication and better reporting of incidents demonstrate that the safety culture is improving. However, the range of incidents reported and some of the common features suggest that there is still room for improvement. Defects in systems, plant, equipment, buildings and people are still evident and these leave the Council potentially exposed to liabilities of a legal, financial and moral nature.

6.2 Cultural issues which expose the Council in that they can lead to accidents have been found at various organisational levels. Based on an overview of the issues and incidents presented to the Health and Safety team and referred to in this report, it is suggested that the following cultural issues are tackled to generate a sustainable improvement in performance.

- **Senior management**
    - omissions in defining potential safety issues and their control when projects and changes are at the planning stage

- inadequate risk assessment of the known and unknown hazards
- more emphasis on sorting the immediate problem rather than adopting and ensuring a long term safe solution

- **Managers and Supervisors**

  - competing priorities
  - not feeling empowered or able to intervene when unsafe situations are observed
  - inability to get to the root causes of accidents, the default is to instruct victim to "take more care."
  - unwillingness to report failures in systems or resource issues
  - regarding subordinates who report safety issues in the same way as they imagine they would be regarded if they reported safety issues to their superiors
  - not being specific enough when defining a safety message to employees

Actions Recommended:

i) Workshop for supervisors and managers in high risk services
ii) Supervisors and managers held to account for ensuring safe practices used
ii) Health and Safety service reports produced 6 monthly
iii) Health and Safety added as agenda item to team meetings
iv) Senior manager overview fed back to CMT/SMT by Heads

- **Employees**

  - not appreciating the level of danger they are exposed to
  - a fatalistic approach to the potential outcomes of undertaking high risk activities
  - not wanting to cause any bother or be thought of as rocking the boat
  - seeing safety as a hindrance

Actions Recommended:

i) Series of communications to enable all staff to see their health and safety responsibilities as necessary obligations
ii) Review employee survey questions to gather safety information for a bottom up approach;
iii) Consideration of a safety specific "climate survey" for particular service areas to measure progress over time
iv) Employees held to account for not following safe practices

6.3 To move the council from the current position, there are a number of existing critical elements which need to be developed and sustained.

- A specific safety action matrix introduced from top down.

- Are all significant health and safety risks assessed and controlled?
- Are all staff competent to manage the risks?
- Does a safe system of work exist for high hazard tasks?

- Assurance checks introduced from bottom up.

  - Are robust checks in place to ensure continued control of risk?
  - Are reports being submitted and acted upon?

- Good quality safety information for all staff available in real time.

- Involvement of Health & Safety at the early stages of all major projects where hazards exist and through the life of the project as required.

Actions Recommended:

i) Managers and supervisors encouraged to proactively discuss safety issues with their employees
ii) Health and Safety team to undertake more topic specific audits*
iii) Health and Safety team to have increased presence and direct contact with operational services*

*(*achieved by reducing focus on general audit and fire risk assessment work)*

7. ACTION PLAN

The actions above have been taken to create the action plan to address the main findings from this report. These will become the work that the Health and Safety service will be focusing on and require services to support over the coming months.

ACTIONS	TARGET FOR COMPLETION
1. Workshop for supervisors and managers in high risk services	Sept 2015
2. Supervisors and managers held to account for ensuring safe practices used	Ongoing
3. Health and Safety service reports produced 6 monthly	Dec 2015
4. Health and Safety added as agenda item to team meetings	May 2015
5. Senior manager overview fed back to CMT/SMT by Heads	Jan 2016
6. Series of communications to enable all staff to see their health and safety responsibilities as necessary obligations	Mar 2016
7. Review employee survey questions to gather safety information for a bottom up approach;	June 2015
8. Consideration of a safety specific “climate survey” for particular service areas to measure progress over time	Dec 2015
9. Employees held to account for not following safe practices	Ongoing
10. Managers and supervisors encouraged to proactively discuss safety issues with their employees	March 2016

11. Health and Safety team to undertake more topic specific audits	March 2016
12. Health and Safety team to have increased presence and direct contact with operational services	May 2015