Fisher Broyles

A word from Anne and her team...

Why incident investigations matter in the boardroom.

Hello and a very warm welcome to A word from Anne and her team. I do hope you are keeping well. For the first edition in 2022, I'm going to concentrate on a subject that I believe is of paramount importance to today's boardroom, and that's the process around incident investigations. I am increasingly finding in my work that simply not enough attention is being given to reviewing the root cause of an incident and the steps that should be involved in preventing a similar incident happening again.

I hope you find my thoughts informative and thought-provoking. As always, if you'd like to discuss what I talk about and how it might affect your organisation, I'd be only too happy to speak with you.

The context

There's no easy way to say this. I am increasingly involved in cases where the quality of investigations after an incident is awful. A lack of details, a lack of action and, subsequently, a lack of proper recommendations worryingly seems to be the status quo. Given the often-frightening commercial implications of poor Health & Safety, this presents a serious risk to a business's sustainability in the long term.

The importance of the board's role

As you would expect, I spend a lot of time trying to get into the detail on incidents and understanding the actions that will take place after them. When I discuss with board members and senior leadership teams how they assess the quality of their investigations, the vast majority of them tell me they don't. The general feeling is that they assume that those they appoint to lead investigations will do so with rigour and competency, relying on the training they have previously received. Whilst, no doubt, in some cases this will prove to be correct, it simply cannot be assumed. Think for a moment. All too often an investigator may only have a couple of cases to deal with annually. This can result, if you'll excuse the pun, in a competency slip.

I find that most organisations I work with produce reports on incidents, but that they are dreadfully sparse in two key areas: the actual findings and the root causes. Incidents are looked at in unison, but invariably not as part of a wider, deep dive into key themes. The board reports often include statistics on the number of incidents, details on injuries, the age of the injured person, their experience in the environment they operate in. Yet rarely do they have meaningful details on the bigger picture.

Ultimately, successful people and businesses learn from their mistakes. Because they take the time to understand them, implement change and then, crucially, monitor that change. And that last part is key for me. Measuring the success of remedial action is what really makes the difference.

My experience

If often helps to put my thoughts into context with some real-life examples, so here are a couple that really struck a chord. While working with a client recently I read a report that stated a piece of equipment had been adjusted to enable better visibility for one of their drivers. However, when I pressed for more detail and asked if this had been corroborated by the driver, I found out it had not. It was an assumption that the reason for the adjustment was to improve visibility. I would argue that this should not have got to the "lawyer" stage before it was asked. Anyway, the upshot was that the investigation team had made an assumption. And one that fundamentally affected the whole flow of their subsequent actions and planning, as well as their understanding of root causes.

Another case I was involved in centred around a fall a customer had on a slippery floor at a restaurant. The reason provided for the fall was a lack of slip resistant testing being carried out because, although the test had been commissioned, it had never actually allegedly been carried out. And that was it, no more detail.

But why did the report not consider why the test result had not been chased up? Why did it not review the process for testing? Why did it not look at the Construction Design and Management (CDM) Regulations? After all, the property was a new build. There was basically no review of how the building process was supervised and in what state it was handed over to the owners upon completion.

Without a hint of facetiousness, the detailed consideration was reserved for how it looked and how it felt – "we're all about the perfect first impressions and a great customer experience for our valued clients". To be fair, absolutely no expense was spared in the aesthetics of the restaurant, it looked delightful. But, alas, no similar level of detailed analysis was given to the safety of the surface of the floor. When I spoke with the manager he was brave enough to admit that the project team were entirely focused on the customer experience, but had failed to acknowledge that all the expensive hand cream in the world was of little consequence to their notion of customer experience when someone fell and broke their elbow.

It's a statement of the obvious, but customer experience is the sum total of every possible interaction. Not just how expensive the hand cream is. In this example, the restaurant was immediately on the back foot, with serious financial implications hanging over their head. Given the vast initial investment required to build restaurants, it doesn't take a rocket scientist to work out that incidents like this can have incredibly serious consequences for management. But how much of the detail around such an incident reaches the Boardroom? Is there a tendency to report fatalities or near fatalities in detail, yet a broken elbow has little air time? Next time the unfortunate guest may hit their head as they fall, and the outcome could be very different? A lost opportunity to learn a lesson.

Training is not just for Christmas

I briefly touched on the importance of regular and systematic training and having mechanisms in place that ensure the training has been properly absorbed and implemented. But it's worth exploring this in a little more detail. What I increasingly find is that all too often, organisations conclude that if someone has been trained then that's that. What more can they do? Yet, when I have probed further, I find this general lackadaisical approach permeates everything. A living example of this can be found in one business I worked with who regularly sent emails out to staff asking them to not "take short cuts". But there was no detail on what the shortcuts were. And what was leading to it? Was it ineffective

supervision? Or ineffective monitoring? Or, most worryingly, was it because they were effectively encouraged to take short cuts for commercial reasons? Initial training and then infrequent reminders to behave are simply not good enough.

I know of a good number of organisations who conduct mock trials as part of their training approach. There's no doubt that this can be a worthwhile exercise, after all they can often be informative, are invariably fun and can create significant impact. But they are merely the starting point. What happens next is crucial. Management and the board need to ensure they are asking the right questions after these take place. Most fundamentally, how do they check that those who have attended mock trial training are putting into practice what they have learnt? And can you really, truly learn how to investigate an incident and take a witness statement based on attending a mock trial. In my view, you can't. They have their place, but as a part of a suite of training and learning.

So, what should the board do differently?

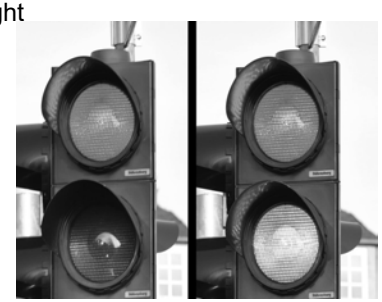
As with most organisations, a good boardroom is awash with governance. And good governance starts with asking questions. Are they receiving regular reports of leading indicators and, if not, are they asking why? Are they seeing summaries of incidents and being provided with meaningful details of the root cause and remedial actions? Are they seeing tracking documents of those remedial actions and details on when actions will be completed? Are wider audits and inspections required to include specific reviews of actions that have been recommended after an investigation? And, if something is presented as a root cause, is it really that?

Which leads me to another important point. And that's whether people really understand the difference between immediate causes and root causes. A good grasp of this is incredibly important when it comes to reviewing incidents and implementing change. For those of you who would like some more detail on this, the Health and Safety Executive has produced a detailed paper that is certainly worth looking through (and there's specific detail on page 10 on causes) – I've provided the link at the end of this article.

Trying to sum it up succinctly, it's very easy to note that an incident occurred because an area hadn't been cleaned and leave it at that. But the question should be why it wasn't cleaned. What prevented that simple action and how can we ensure it doesn't happen again. Identify the root cause and then eliminate the risk of a similar incident occurring in the future.

Those businesses that do this well often adopt the simple process of the five whys as a process to get to the root cause. To give you some idea of how this works, an easily relatable example is best.

The problem: I ran a red light
Why: I was late for work



Why: I woke up late
Why: My alarm didn't work

Why: The battery was dead
Why: I forgot to check
And that's the root cause

Behaviour plays a big part

I think one of the final things that I recommend should be very much on the mind of board members is behavioural issues and whether the reports they are presented with take these into account. Let's provide an example. A forklift truck overturns due to driver inattention which is caused by fatigue which, in turn, was caused by working too much overtime. The safety alert in this case is all to often pointed firmly at the driver. But arguably, it shouldn't be.

And that's because it needs to be evaluated at a higher level. Is this a practice that is prevalent throughout the workforce? Is it culturally engrained? What have HR teams done to address this? Have they, by default, encouraged it? Should they be doing more to raise awareness of the consequences of working excessive hours? It's also worth noting as an aside that given the rising cost of living crisis and labour shortages that this may well become increasingly more likely.

So, what to do now?

I'm hopeful that I have provided food for thought for the boardroom. Yet, there are two underlying themes that you should take and ensure you imbed in your working practice.

The first is easy; never take anything for granted. Probe, challenge, ask questions, follow the train of thought right down to the very root cause of issues and potential issues and do all you can to address them.

The second is to ensure that this approach is embedded throughout your organisation. Encourage people to look beyond the immediate and help them understand the importance of doing this. Incidents and accidents are often awful things, but they present an opportunity to eliminate future risks. I've spoken before about the importance of sustainability for businesses. After all, it's a commercial imperative. True sustainability doesn't come from just good green credentials. It comes from ensuring that your business is aware of all its risks and does everything it can to mitigate and, ultimately eliminate them. And that requires a ruthless focus on the detail. Because that's where the devil is.

I wish you all a Happy Easter and hope that you remain safe and well.

With my very best wishes,
Anne

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Link to Health and Safety paper on Investigating Accidents and Incidents: https://www.hse.gov.uk/pubns/hsg245.pdf