NATIONAL 2024 FORKLIFT SAFETY DAY

National Forklift Safety Day Campaign

Learn

Now that the accident investigation has been completed and work has resumed, it is important to ensure we have learned lessons and applied corrective actions to any lapses found.

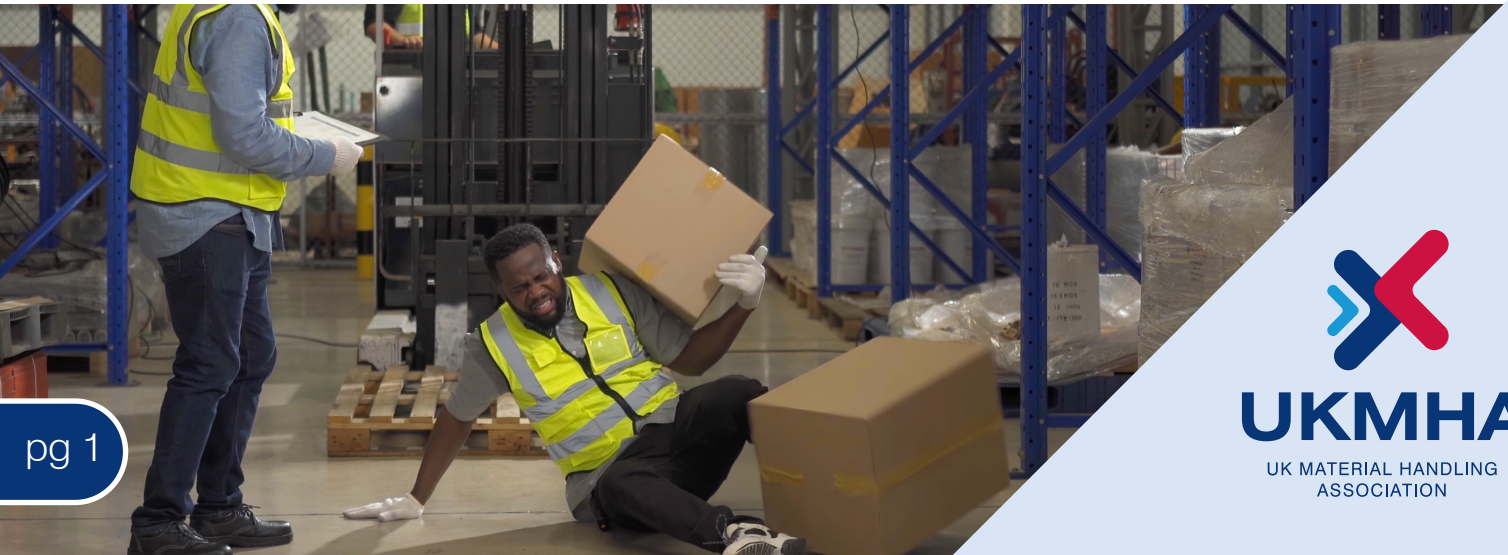
This is not about apportioning blame; it is about trying to prevent the same or similar incident happening again.

Whilst apportioning blame to an individual or group of individuals is not the aim, it is important to remember that everyone has a responsibility for health and safety.

Create an action plan to clearly define the requirements identified, including who is responsible for implementation and a time for completion.

The accident investigation should have highlighted immediate, underlying and root causes. The Action Plan should include all of these. It can be uncomfortable for employers/senior managers to look inwards, however it is often the case that the root cause sits at this level.

Corrective actions may need to be applied to equipment, machinery, training, safe systems of work, communication, emergency preparedness and monitoring processes. Make sure you take a broad view of the organisation and include all areas that can affect and/or be affected by the findings and associated corrective actions.



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Emergency Preparedness

How did the employees act and perform at the time of the accident? Did responders have suitable knowledge of what to do, who to contact etc when the event happened?

These points must be considered as in the event of a serious accident, speed and appropriate response could have a major impact on the outcome of any personal injury or equipment/building damage.

Ensure employees have the competencies to act accordingly when an incident occurs.

Equipment and Machinery

Confirm with your service provider that your material handling equipment is suitable for the work activity (PUWER). Assess if it is the right tool for the job or is there something else that can do the task more safely. Finally, check that Preventative Maintenance & Thorough Examination (TE) frequencies are correct for the work application (PUWER & LOLER). Note that the minimum levels of TE set by regulations may not be sufficient for the work application. Remember to check with the competent persons completing TE's on your behalf.

Work equipment should have a documented daily/pre-shift check defined by the risk assessment and a process in place for employees to highlight defective equipment to supervision.

Ensure all equipment and tools associated with the accident (and throughout the organisation) have suitable maintenance regimes and checking processes in place.

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Training

The investigation may have identified lapses in training of employees. This is not specific to 'shop floor' workers and should also include supervision, including the most senior managers to ensure all are aware of their responsibilities.

Operators of material handling equipment should be trained by appropriately qualified trainers and have refresher training scheduled. This can be defined by risk assessment but should not exceed five years.

All employees should have a level of safety training appropriate to their role. The organisation's internal safety professional or external safety consultant should advise what training is suitable.

It is important to make sure the training is understood and that all those being trained can correctly apply what has been taught. Good training will include assessments either throughout or at the end (or both) of a training course and will be checked through the monitoring process.

Do not forget, training is not a 'one off'. It should be refreshed regularly and developed further with organisational and/or equipment/technology changes.

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Communication

Share the findings of the investigation with all relevant employees. It may not be necessary to share all information with employees, but steps should be in place to ensure it is targeted. Remember not to be defensive and hide appropriate information. An organisation with a good safety culture will share information with employees through a consultation process such as a Safety Council where Safety Representatives (Union appointed) or Representative of Employee Safety (non-union) can discuss accidents and their findings and then share with other employees.

Communication of safety information such as risk assessments, safe systems of work, safety alerts, minutes of Safety Council meetings etc should be clear and easily accessible. Try to decide which format of communication is best for your business, whether that be via notice boards, emails, intranet systems or other forms of electronic communication.

Monitor via audit or other checking process that all employees have access to relevant information, that they understand it and have the ability to implement what is needed. Do not forget language or other difficulties which may prevent employees following due process.

Including employees via two-way communication makes them feel part of the decision making process, reassuring them their views have been listened to and considered. This can positively influence behaviour and develop an improved safety culture.

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Near Miss Reports

Ensure the near miss/unsafe circumstance report process is as effective as possible, always making sure the report process is clear and straight forward. Do not be tempted to dismiss any reports as this will only encourage employees not report incidents in the future. An organisation with a good safety culture will not have blame apportioned to these reported incidents, only good investigation with the intention of prevention. Employee safety training should outline what near miss reporting is for, how it is used and how beneficial it can be to individuals and the organisation.

Tracking of near miss reports is important and can help define trends with a particular work process, work area, work equipment etc. The accident investigation should look at whether any near miss/ unsafe circumstance reports had been previously submitted which, if investigated at the time and acted upon properly could have prevented the accident happening.

Risk Assessment and Safe Systems of Work

These documents and processes will have been included with the investigation and should always be reviewed in the event of an accident. It is likely there has been a lapse in this process if an accident has occurred.

Ensure RA's and SSW's are reviewed on a frequent basis. Do not make it so frequent though that it becomes a paperwork exercise. All reviews should be thorough and in-depth, ideally carried out by a team (certainly more than one person) and include employees who actually complete the work being assessed. A RA carried out by a person who 'thinks' they know how a job is carried out is not suitable.

SSW's should be agreed with the employees completing the work and should not include processes which the author(s) know will be disregarded as over complicated and short cuts developed. SSW's must be recognised as the definitive way to complete a job safely and can and will be adopted by employees. If this is not carried out it is likely bad practice/short cuts will become the norm and lead to the potential for accidents in the future.

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Your risk assessment should include any human factors which may be present. The main human factors are: lack of communication, complacency, lack of knowledge, distraction, lack of teamwork, fatigue, lack of resources, pressure, lack of assertiveness, stress, lack of awareness and norming.

The SSW should ensure that suitable supervision is in place, including knowledge, resource and conformation that it is available when needed.

Once the review has taken place, make sure changes are communicated to all relevant employees.

Monitor and Review

Now that the organisation has investigated the accident, found the cause or causes and implemented changes, it is important to have a process in place to check that lessons have been learned and the corrective actions have been applied and will be subject to monitoring on a regular basis to ensure they are understood and being enforced. This monitoring process will help the organisation understand its safety culture and pinpoint where further action may be needed.

Remember, no matter how good a process is there is always room for improvement.

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