

# YOUR GUIDE TO ACCIDENT INVESTIGATION



SOUTHALLS  
STAY SAFE, STAY COMPLIANT

Designed to give an overall outline of accident investigation, this guide is for businesses and individuals looking to better understand the accident investigation process, or fine-tune the way they currently investigate accidents.

The guide will help you to view accident investigations from all sides, and encourage you to ask questions that you may not have previously considered.

# WHO IS THIS GUIDE FOR?

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# WHY INVESTIGATE ACCIDENTS?

- ✓ To meet the **requirements of RIDDOR**.
- ✓ To **notify your insurers** and to gather information in event of a future insurance claim.
- ✓ To **boost employee morale** and attitude towards Health & Safety.
- ✓ To **prevent further similar accidents** – in event of an accident, investigating officers take a very dim view of companies who have ignored previous warnings and will use this against you in court.

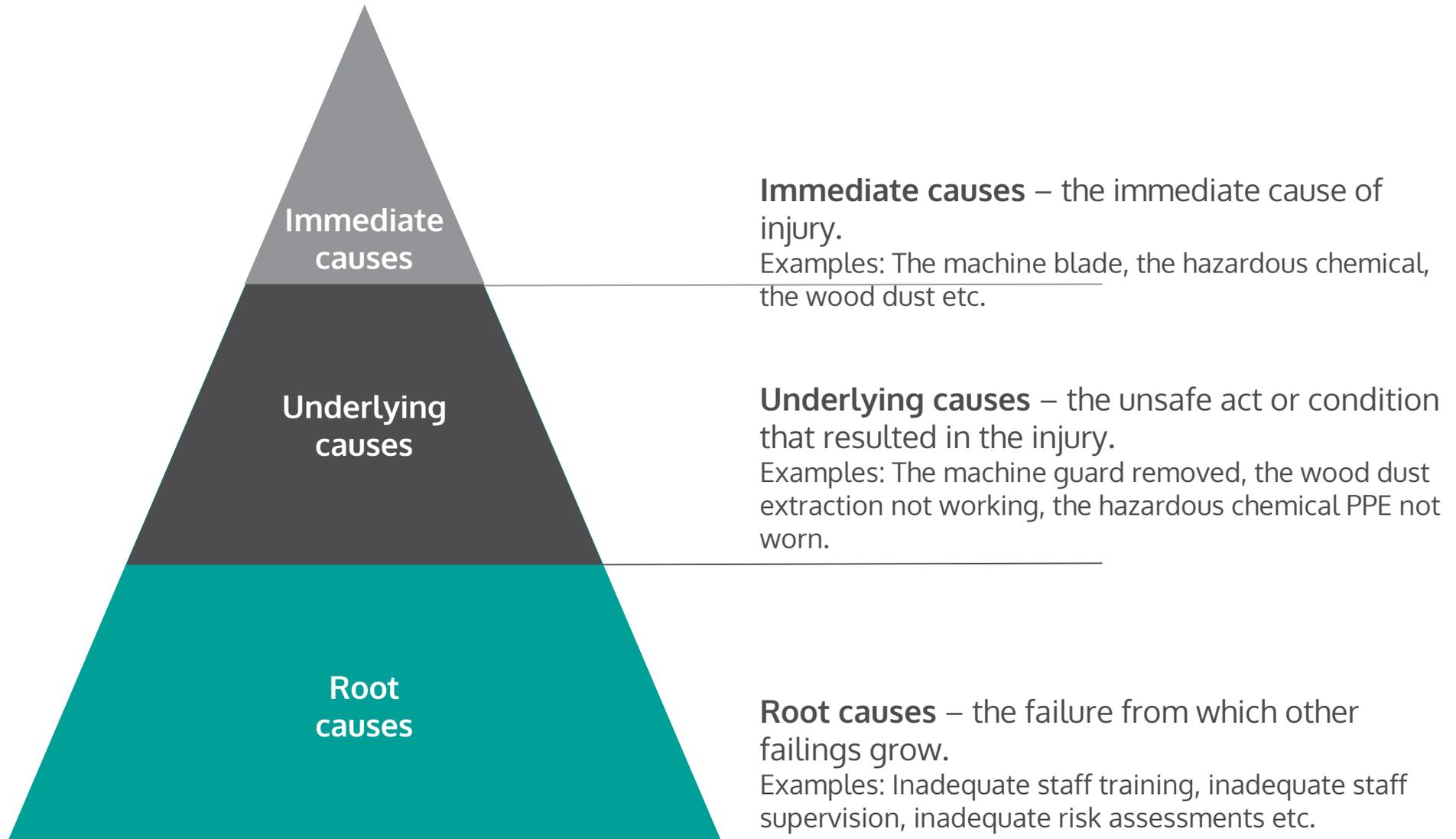
## TIP

A thorough accident investigation should identify all **immediate, underlying and root causes**, thereby providing a foundation for developing control measures to eliminate these causes.

This should result in a continual improvement in health and safety management.



# IMMEDIATE, UNDERLYING AND ROOT CAUSES



# WHAT TO DO IMMEDIATELY AFTER AN ACCIDENT

Your immediate goal is to help the injured party to prevent further injury to themselves or anyone else.



Call for the necessary first aid treatment, or an ambulance, for the injured party .



Isolate the area using tape, barriers or personnel to restrict access to the area and preserve the scene.



If any immediate danger is presented to you or others (e.g. risk of racking collapse), then all personnel must be kept a safe distance away.



# WHAT TO DO IMMEDIATELY AFTER AN ACCIDENT



If possible, take steps to make the area safe where necessary – for example isolating gas supplies (in some cases this may need to be done first).



Note names (and contact details) of the people involved and any witnesses.



Note the details of any equipment involved (including model type, model number, machine number, year of manufacture and any mods made to the equipment).



Note the position of machine controls.

The HSE defines the investigation process as a four-step process:

- 1 Gather the information
- 2 Analyse the information
- 3 Identify risk control measures
- 4 Implement the action plan

# THE INVESTIGATION PROCESS

# STEP 1: GATHER THE INFORMATION



**Physical**  
(The scene)



**Verbal**  
(Witness statements)



**Written**  
(Procedural)

- Ask the witnesses and injured party questions (statement gathering)
- View the scene
- Review CCTV footage
- Take measurements (e.g. deflections in racking or heights of goods being reached for etc.)
- Take photographs of the scene, check-sheets, permits to work etc.
- *(This can be obtained in note form with a full report compiled later.)*
- Consider environmental factors – recording weather conditions or lighting/noise levels as relevant.
- Analyse relevant procedures – risk assessments, safe system of work, training, instructions etc).

# WHO SHOULD INVESTIGATE?

A team investigation is often more productive than a one-man investigation.

A supervisor, for example, is unlikely to want to consider a 'lack of supervision' a factor contributing to an accident occurring.

Depending on the size of your organisation you may want to involve:

- supervisors
- line managers
- directors
- union safety reps
- employee reps
- health and safety professionals

# STEP 2: ANALYSE THE INFORMATION

Look at the sequence of events to **establish the facts**. What happened and why. Try to identify the immediate, underlying and root causes that lead to the accident.

## Consider:

- Human errors\*
- Procedural violations
- Task/job specific issues
- Organisation issues
- Plant or equipment issues
- Environmental factors

# HUMAN ERROR

If human error or failings are identified as a contributory factor, this needs to be handled carefully. Human error may be skill based (a slip or lapse or memory), a mistake, or a violation.

Slips and lapses can be reduced by various techniques like colour-coding, checklists, interlocks etc. Training, safe systems of work, and equipment design are important in preventing mistakes.

Violations (deliberate rule breaking) can be reduced through training, supervision and monitoring. Disciplinary action should only be taken in event of a deliberate, malicious violation or sabotage of workplace safety precautions.

If you create a 'blame culture' you risk alienating the workforce and undermining the safety culture.

When investigating, consider that the following factors can influence human behaviour:

- Distractions
- Time pressures
- Physical size and strength
- Competence
- Fatigue, stress, morale, alcohol or drugs
- Production pressures
- Long hours/shifts
- Supervision
- Safety culture.
- Equipment design, controls and ergonomics.
- Workplace layout.

# STEP 3: IDENTIFY RISK CONTROL MEASURES

**Ask yourself the following questions when investigating:**

- What risk control measures were missing, inadequate, or misused?
- How should the activity, condition, or process been undertaken to follow safe systems of work, legal requirements, or best practice?
- What risk controls need to be put in place to prevent a recurrence and improve the OSH management system?
- How can you eliminate the risk? For example, can you change chemicals used to safer products. If that is not possible, can you reduce the risk at source (e.g. machine guarding)? If that is also not possible, how can you minimise risk through procedures and PPE?
- Do any other similar risks exist in the business? What and where?
- Have similar accidents occurred before? What and where?

# CREATING AN ACTION PLAN

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OBJECTIVES

**Specific** - ensure the action plan is specific enough to understand whether or not it has been achieved.

**Measurable** - setting criteria and specific goals will allow you to measure how effective your plan has been.

**Agreed** - the goals set in your action plan should be as a result of a team discussion that has been thoroughly considered.

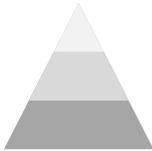
**Realistic** - setting unachievable goals will not only set you up for failure, but negate the usefulness of the action plan entirely.

**Timescaled** - ensuring you have timescales for specific actions will allow you to track progress and measure results.

# STEP 4: IMPLEMENT THE ACTION PLAN



The results of the investigation should be shown to all concerned. It should highlight the action plan, timescales and responsibilities, how the plan will be implemented, and how improvements will be monitored.



You need to provide risk control measures to address the immediate, underlying and root causes of accidents.



The plan should detail short, medium, and long term improvements as well as which risk assessments require review.

# STEP 4: IMPLEMENT THE ACTION PLAN

A cost analysis should be undertaken to establish both the insured and uninsured cost of the accident and the cost of the associated control measures.



In multi-site businesses, consider issuing safety memos or alerts company-wide to ensure that any necessary improvements can be made throughout the company and not just at branch level.



Morale boost – keep staff informed that an in-depth accident investigation is ongoing.



PR control – ask for staff cooperation in confidentiality whilst the investigation is ongoing – i.e. to refrain from discussing outside of work.



# REPORTING UNDER RIDDOR

Seeking further professional H&S advice is vital if you are unsure whether an accident falls into the category of a reportable under RIDDOR.

Alerting the authorities to an accident unnecessarily may lead to a lengthy investigation and potential for FFI or prosecution!

# SENTENCING GUIDELINES

With penalty costs now reaching new heights, and the number of company director prosecutions having trebled since the introduction of the new sentencing guidelines in February 2016, it has never been more crucial to have a strong handle on health and safety risks and manage culpability.

## Watch

Law firm Gowling LLP, and Health and Safety Consultancy Southalls discuss the impact of the guidelines so far:



# AN INSIGHT INTO ACCIDENT INVESTIGATION



**John Southall,  
Director, Southalls**

Ex-local enforcement officer, turned Health and Safety Consultancy Director, John Southall will be speaking at the Safety and Health Expo at the Excel on 22<sup>nd</sup> June, giving a unique insight into incident investigation.

Coming from a background in enforcement, John understands how inspectors operate and what they look for when investigating major incidents, including the compliance issues that result in the biggest penalties for businesses.

John will discuss how businesses can prepare and protect themselves from accidents and fines, as well as prevent recurrence.

**[Click here to find out more and register to attend.](#)**

# ACCIDENT INVESTIGATION QUESTION CHECKLIST

- Where and when did the accident happen?
- Who was injured/suffered ill health?
- What was damaged?
- What and where was the injury i.e. bruise, crush, burn to right upper arm midway between elbow and shoulder.
- Who was involved?
- How did the accident happen?
- What activities were being carried out at the time?
- What did witnesses see, hear, smell, feel, taste?
- Was there anything new or different about the working conditions?
- Were there adequate safe systems of work and did people stick to them?
- Was the activity being properly supervised/managed?
- What were the outcomes of the accident - injury, disease, damage, death, near miss, loss?
- What was the cause of any injury?
- What were the immediate and underlying causes of the accident?
- What does the relevant risk assessment say?
- Was the risk known? If yes, why was it not controlled? If no, why not?
- Did the work organisation (or lack of it) impact on the accident?
- Was the maintenance and cleaning adequate?
- Were the people involved suitable and competent? Under 18?
- Did the workplace layout influence the accident?
- Did the nature, shape or form of the materials influence the accident?
- Did the work equipment influence the accident? Was it difficult/awkward to use?
- Had the people involved received adequate information, instruction and training?
- Was this clearly documented?
- Was adequate safety equipment provided and used correctly?
- Was maintenance and cleaning/housekeeping sufficient?
- What other conditions influenced the accident? i.e. high production targets or piece work?

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