



Investigating excellence

Accident investigation toolkit

Contents

Accident & incident investigation



An accident can be defined as an unplanned, unexpected, or unwanted event resulting in death, injury, ill health, or incident. Notwithstanding substantial business case benefits, there is a moral and legal duty to investigate the circumstances of accidents. Robust accident and incident investigation is essential to any effective Health and Safety management system.

This Risk Insight has been produced to aid the thorough investigation of incidents and accidents and the effective management of claims. This document is designed to aid the collection and collation of pertinent information and evidence during the investigation process. Should an accident or incident give rise to a claim, this will aid liability decision-making.

In trying to prevent accidents in the first instance the implementation of the following points are essential:

- Clear and understood procedures
- Good supervision and inspection
- Compliance with procedures
- Delivery of suitable training
- Creating a positive culture
- Safety-critical communication
- Prevention of problems caused by workload and fatigue.

Organisations must measure how well they implement their health and safety management system. Simply accepting low accident rates may hide the fact that risks are not being controlled. Effective monitoring will look at reactive issues, such as accident statistics and safety deficiencies, and active issues, such as compliance with health and safety standards. Active monitoring can also include periodic examination of documents, environmental monitoring and inspection of premises and plant.

Why do we investigate accidents?

Effective accident investigation has many benefits, including legal, moral, and financial reasons. Preventing or minimising the risk of injury to employees, contractors and members of the public is essential and effective accident and incident investigations can identify areas and controls that may require alteration or improvement and thus potentially prevent reoccurrence. This may also be a client requirement in some instances, particularly in hazardous industries such as rail, energy, highways, etc. This can reduce insured and uninsured costs and provide evidence supporting claims liability decision-making. Benefits include:

- Identification of the underlying and root causes of accidents to prevent the same or similar accidents or incidents from happening in future.
- Complying with statutory requirements.
- Facilitating data collection and analysis.
- Helping to plan and target risk management initiatives.
- Enabling timely and informed decisions in personal injury claims.

The depth of an investigation and amount of evidence collected will depend on several factors, including the actual and potential worst consequences of the event, the severity, the type of incident and the frequency of the incident or accident. Fatalities, Specified Injuries, and Near Misses that constitute a Dangerous Occurrence will naturally require a detailed investigation; however, there may be other, less serious incidents where detailed investigations are still warranted, such as:

- The incident relates to a company's key risk exposures.
- Trend analysis identifies a significant cause of accident or claim, e.g., slips or trips, manual handling, work at height, etc.
- The individual involved may warrant a more detailed accident investigation due to being involved in several similar accidents.
- Near-miss incidents with potentially serious consequences should also be investigated thoroughly.

When to investigate – the Golden Hour

The importance of timely investigation cannot be overstated. As a rule, investigations should commence within "the Golden Hour," a term that describes the immediate phase following an accident or incident. Taking appropriate action to obtain evidence during the Golden Hour will help to ensure that the main accident investigation can be conducted effectively enabling the investigator to reach the correct conclusions concerning why the accident happened and what action needs to be

taken to prevent any recurrence. Initial response to an accident or incident should include:

- Commence investigations as soon as possible after the accident.
- Ensure that the area has been made safe and emergency action has been taken, such as first aid response organised.
- Preserve the scene – make the area secure and preserve the accident scene.
- Appointed person to take control.
- Bring communication processes into action – who needs to know – internal/external.
- Establish early evidence collection. The process for the collection of vital early evidence will include:
 - Names of those involved
 - Plant/equipment details
 - Features of the site
 - Key documents
 - Recording of contemporaneous notes.

Collecting evidence

Witness statements

- Statements should be taken as soon as practicable after the event whilst remaining sensitive to a serious accident's impact on witnesses and colleagues. Evidence that is gathered as soon as practically possible after an incident or accident is generally the most reliable rather than obtaining statements, days, weeks or months post-incident or when memories have faded, or observations have been challenged by others casting doubt in the witness' mind.
- Identification of potential witnesses as soon as possible and their evidence should be recorded. It is also important to identify and confirm individuals who were in the vicinity but did not see the accident, these people are usually referred to as negative witnesses.
- Depending on the severity and circumstances of the accident or incident, this may require sensitive handling, and a full interview may need to be scheduled for another time.
- Witnesses should be interviewed separately and not collectively (including negative witnesses who may not have seen or heard anything).
- Open questions should be used to encourage detailed answers e.g. who, what, where, when and how.

Risk Insight – Accident & Incident Investigation

- Keep interviews factual. Opinion, hearsay and second-hand information should be avoided.
- Questions and answers should be written down when a Q&A process is being used. The statement should be signed and dated by the witness and include a statement of the truth (compliant with Civil Procedures Rules – PRACTICE DIRECTION 32 – EVIDENCE – Civil Procedure Rules ([justice.gov.uk](https://www.justice.gov.uk))).
- Keep the contact details of witnesses in case they move on. Also keep the details of those who attended the witness interview, for example, Trade Union Representative or Representatives of employee safety.

Photographs, video, sketch plan and CCTV

Accident investigation reports can be enhanced by good-quality photographs, videos, and sketches. The essential criteria for such supporting evidence are:

- Photographs of the accident scene should be taken as soon as it can be done sensitively. The date and time the photograph is taken should be recorded (often done automatically on a smartphone, tablet, etc). The first photographs are usually general views (including reverse angles), also take a photograph from the point where the accident occurred to obtain the injured parties view. Before taking any photographs, always ensure it is safe to do so.
- Photographs should show the accident scene clearly. Including an everyday object in the photograph may be helpful to illustrate perspective and scale.
- The use of plans and sketches should also be considered where relevant, particularly to show the layout of a workplace, position of witnesses or machinery, transport etc. Again, these need a signature to validate their origin and purpose.
- It would be useful, if possible, to invite the injured party to agree on the site layout at the investigation stage.
- CCTV can provide very useful evidence. A process should be in place for the collection, validation, and secure retention of CCTV footage. It is vital to view CCTV footage for the period prior to the accident, to observe employee behaviour and whether any hazard situation was created which may have contributed to the accident. Remember, there may be valuable CCTV evidence that was captured by neighbour's premises CCTV footage so asking them to check and share their footage may be valuable.

Document collection and collation

Efficient and consistent collation, collection, and submission of relevant documentation as part of an investigation is essential for the management of claims. Claims decisions on legal liability may be determined by the presence or absence of good-quality documentation. Where there has been a more serious incident with Police/HSE/Local Authority/Environment Agency involvement, legal advice should be sought and followed from your legal representatives or QBE panel legal representatives regarding legal privilege.

Environmental factors

Environmental factors such as workplace design can be both natural and man-made. Environmental conditions in the workplace are frequently overlooked as causes or contributory factors of accidents and can include:

- Poor lighting
- Ambient temperatures
- Air pollution
- Sound pollution
- Visibility.

Root cause analysis

When concluding an incident or accident investigation, there should be a root cause analysis undertaken, to fully understand the immediate, underlying, and root causes, and from this an action plan can be devised to enhance the prospects of avoiding a further similar occurrence.

Occupational health

Accidents and equally workplace ill health, can and often do happen. With this in mind, an effective occupational health provision should form part of every company's risk management strategy. Managing the long-term consequences of an injury can often prove difficult, particularly where this involves significant personal injury and absence from work due to physical or psychological injury.

Engaging occupational health support at the earliest opportunity will help to ensure that disruption to the business is minimised and that the associated future claim and the costs associated with that claim are minimised. When an employee receives the best possible care at an early stage, it can facilitate a successful and sustained return to work.

There are a variety of benefits for an organisation with a well-established occupational health provider, including:

- Commercial benefits for the organisation
- Health and wellbeing benefits for the employees
- Successful and sustained early return to work.

Risk Insight – Accident & Incident Investigation

QBE have an award-winning Rehabilitation service team comprising case management experts from a wide range of clinical backgrounds – physiotherapy, occupational therapy and psychology – and are supported by a network of specialist service providers. They provide bespoke, cost-effective services – from workplace assessments to specialist medical care – to help injured people and employees recover and return to work promptly. The team can manage a very broad range of injuries, from minor ankle sprains to significant spinal injuries, as well as injuries resulting from major incidents and accidents.

Claims notification

Organisations will have their internal processes for handling claims notifications and will have agreed Claims Handling Procedures with their insurance broker and QBE. However, to protect your position fully, you should make sure that the agreed procedures are fully briefed to all relevant staff and followed.

Always ensure that the claims handling procedures agreed upon are followed. These usually include:

- In the case of Employers' Liability, immediate notification of any RIDDOR incident, including an absence of seven or more days, is likely to give rise to a claim or any other incident likely to give rise to a claim.
- In the case of Public Liability, immediate notification in the event of an incident likely to result in a claim.
- Electronic acknowledgement of any Claims Notification Forms and immediate referral to the QBE claims team.
- A review of all cases and proactive desk-top handling will take place within QBE, liaising with you to obtain relevant documentation, including investigation reports and witness statements to ensure compliance with the response timescale requirements.
- A decision will be made as to whether a site visit is required, and a loss adjuster will be appointed if appropriate.
- Be prepared for, and co-operate fully with, the ensuing investigation.
- Ensure that all relevant personnel, including witnesses, are available for interview during the investigation visit.
- Locate and collate all documents, in preparation for the insurers/loss adjusters' investigation, including all sickness absence and return to work documentation.

→ Full disclosure to the claimant of documents in the preliminary stages of any claim is required, if legal liability is denied, so it is vital that these are submitted. Having immediately notified the incident you should also:

- Avoid delay in forwarding any correspondence or documents that you receive in relation to the incident, in accordance with policy conditions.
- Avoid engaging in discussion on the merits of the case with the injured person or their representative.
- Make no admissions of liability.

Conclusion

Implementing an effective incident and accident investigation policy can have many benefits. By taking the relatively simple steps of ensuring that accident or incident investigation is thoroughly undertaken, by competent people, who are well supervised by management with the right equipment, the benefits to an organisation are multiple.

When developing an accident investigation process for your management system, there are a number of documents in the QBE Accident Investigation Toolkit that can be referred to.

If you have any further queries about developing an accident and incident Investigation module for your management system, please get in touch with your QBE Risk Solutions contact.

Guidance and useful information

- The Health & Safety at Work Act 1974
- The Management of Health and Safety at Work Regulations 1999
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

For further information the HSE has also produced excellent guidance in the form of HSG 245 and HSG 48:

www.hse.gov.uk/pubns/books/hsg245.htm

www.hse.gov.uk/pubns/books/hsg48.htm

Different types of supervision and the impact on safety in the chemical and allied industries, HSE Research Report 292, 2004 ISBN 0 7176 2929 5:

www.hse.gov.uk/research/rrpdf/rr292.pdf

Other references

www.justice.gov.uk/courts/procedure-rules/civil

(1) Lardner, R. & Miles, B. (1998). Supervision, self-management and safety. *The Chemical Engineer*, Jan 1998, 650, 28–31.



The Golden Hour

Every accident or incident needs to be managed, and the extent will depend on its nature and severity. Information and evidence obtained during the “Golden Hour” period immediately following an accident is essential for use in the subsequent accident investigation. If evidence is not obtained during this critical first hour, it may never be available for investigation again, and the effectiveness of the investigation could be compromised.

Taking appropriate action to obtain evidence during the Golden Hour will help to ensure that the accident or incident investigation can be conducted effectively, enabling the investigator to reach the correct conclusion concerning why the accident or incident happened and what action needs to be taken to prevent any recurrence.

Good practice

The following 10 steps highlight the focus the investigator needs to gain the most from the Golden Hour period:

-
- 01 Ensure that the accident scene is safe and can cause no further harm to individuals or property before entering the area.

 - 02 Provide first aid and emergency treatment as appropriate to the injured party or parties.

 - 03 Notify the emergency services authorities as necessary, such as the Ambulance Service, Fire Brigade, Police, Coastguard, etc and provide clear information on location, injuries and any hazards they may encounter on arrival.

 - 04 Secure and maintain the accident scene to ensure that nothing is disturbed, and evidence is preserved and retained.

 - 05 Understand the work practices being undertaken at the time of the accident or incident; if you are unfamiliar with the location and activities, speak to someone who has such knowledge.

 - 06 Take as many photographs and videos of the accident scene from a variety of angles as is necessary and prepare a sketch plan diagram of the accident or incident scene noting the relevant constituent parts, e.g., the position of machinery, plant, vehicles, tools, products, and distances. For further information, see [Risk Essentials – CCTV, Physical Evidence, Photographs and Video Footage](#).

 - 07 Speak to the injured party to record a basic short account/statement of their version of events, but only if he/she is comfortable doing so. Be respectful of how they are feeling, and if they are in distress, both emotionally and physically, or if they are in severe pain, leave until later when they are more comfortable. See [Risk Essentials – Witness Evidence](#) for further information.

 - 08 Identify witnesses, especially eyewitnesses but also witnesses who have knowledge of the lead up to the accident/incident but did not see the accident/incident and record their evidence. Also, not forgetting those “negative witness statements” who confirm they did not see or hear anything which could be crucial if their evidence changes at a later date. See [Risk Essentials – Witness Evidence](#) for further information.

 - 09 Identify, review, capture and retain CCTV footage. Remember that this can include CCTV footage from other parties, not just your own, such as neighbouring properties with a shared view and third-party transport that may have been in the area and stopped to help. For further information, see [Risk Essentials – CCTV, Physical Evidence, Photographs and Video Footage](#).

 - 10 Identify and retain the relevant documentary evidence pertinent to the accident or incident (see Standard Claims Disclosure Documents). For further information, see [Risk Essentials – Standard Claims Disclosure Documents and Evidence](#).
-

Accident & incident reporting and RIDDOR



Accident and incident reporting is critical to an organisation's health and safety management system. Understanding accidents and incidents and setting up procedures and processes to report them is vitally important for any organisation. These procedures and processes will enable organisations to fulfil their statutory obligations and support the civil liability claims management process if a claim is made. Most importantly, having robust systems around accident and incident reporting can support accident elimination strategies within the workplace, resulting in a safer, healthier and more productive workforce.

Near misses

A near miss is defined as “an event that, while not causing harm, has the potential to cause injury or ill health, including dangerous occurrences”. Near misses also include undesired circumstances which are “a set of physical conditions or circumstances, in the workplace, that have the potential to cause injury or ill health”. Near-miss reporting is critical to an organisation’s health and safety management system. In addition to implementing robust reporting processes, the promotion of positive intervention from employees is vital to the overall accident prevention strategy.

Proactive near-miss reporting can help an organisation identify negative trends and better understand how to protect employees, contractors and visitors. This, in turn, can help reduce workplace accidents overall and improve company safety culture, as well as helping to prevent potential future claims for negligence from both employers’ liability and public liability exposures. Depending on the potential severity of the near-miss event, the same level of diligence should be applied as an actual loss event regarding the investigation process.

Reviewing near miss incidents over a period of time can identify any weaknesses in operational procedures or safety systems. An example of a near miss incident could be a roof tile falling from a roof and narrowly missing a person who was standing underneath.

Further information regarding near-miss reporting can be found within the following link: www.hse.gov.uk/pubns/near-miss-book.htm

Accidents

Accidents are commonly defined as “Adverse events that result in injury, or ill-health.” Accidents tend to be unexpected, unplanned events in a sequence of events, that occur through a combination of causes resulting in physical harm (injury or disease) to an individual. The importance of accident reporting and the recording and gathering of information on all causes of work-related accidents, dangerous occurrences and incidents, can assist in risk assessment generation and future accident prevention strategies.

RIDDOR – the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

These regulations, commonly referred to as RIDDOR, specify in detail which work-related injuries, cases of ill health and dangerous occurrences must be reported to the Enforcing Authorities. Accidents that result in a death, a specified major injury or an employee being unable to carry out their normal duties for more than seven days, exclusive of the day of the accident, must be notified to the Health and Safety Executive.

Only ‘responsible persons’, including employers, the self-employed and people in control of work premises, should submit reports under RIDDOR. The report can be made online via the HSE website or by telephone for fatalities or

specified incidents. The RIDDOR report should be restricted to factual knowledge, without blame or accusations and reference to any deficiencies on the part of individuals or organisations.

Certain specified cases of work-related ill health and dangerous occurrences must also be reported under RIDDOR. Reporting under RIDDOR will be carried out by the nominated person, usually the Health & Safety Manager. Managers must, therefore, ensure that the Health & Safety Manager is immediately notified of any accidents that may need to be reported under RIDDOR.

Organisations should be familiar with these regulations to ensure their statutory duties are met. Further information on the RIDDOR regulations can be found within the following link: www.hse.gov.uk/riddor/

Arrangements

Employees have a duty to cooperate with their employer so that they can perform and comply with their duties. Employees should report any work-related accidents that result in an injury to themselves, a work colleague, a contractor, visitor, or others effected by their activities as per their employer’s management system requirements.

An injury may be dealt with by a first aider or appointed person. However, if the extent of injuries is beyond those treatable by a first aider, an ambulance should be called at the first opportunity. If any accident results in a serious injury or the injured person being taken to hospital, an appropriate emergency response procedure should be followed to ensure the correct escalation is followed.

Incidents or dangerous occurrences that could potentially cause injury must be reported so that the incident can be investigated to prevent a similar event from occurring in the future. Depending on the circumstances of the event, notification to the HSE may be required under the RIDDOR regulations if the event meets the criteria of a dangerous occurrence.

Nominated people are responsible for ensuring that the details of any accidents or incidents reported to them are recorded in either an accident book or a similar method of recording without delay. The Accident and Incident Report should be completed either electronically or using a paper-based system, depending on the organisation’s procedures. Where a serious accident (i.e. major injury) has occurred the Health and Safety Advisor, Senior Manager or Nominated Director responsible for health & safety must be notified immediately. When conducting this process, organisations must consider compliance with the Data Protection Act (GDPR); further information on this topic can be found at the following link: www.gov.uk/data-protection

Summary

By reporting workplace accidents and incidents, employers then have the opportunity to investigate and identify immediate, underlying, and root causes of the event. Through trend analysis, organisations can implement remedial measures to prevent reoccurrence and ensure employees are kept safe from harm. Organisations must also meet their statutory duty to report specific types of events to the HSE under the RIDDOR regulations; not doing so could result in regulatory enforcement action. In addition, having robust accident and incident reporting systems can help support the civil liability claims management process if a claim were to be made.



Witness evidence

Witness evidence is often critical to understanding how an accident or incident occurred; it can provide a chronological order of events and sequences that lead up to the accident or incident, confirm or dispute other evidence being put forward (both verbal evidence and physical evidence) and witnesses can be critical in both criminal (Police, HSE, Environment Agency) investigations as well as civil claims for damages.

Risk Essentials – Witness Evidence

Statements

Witness statements need to reflect the purpose for which they are being prepared, cover all the elements required for the witness statement's purpose, and have a clear structure that is easy to follow and understand.

The statement should contain only those matters in which the witness can properly sign a statement of truth at the end of the statement. The statement may include the witness' opinion if firmly held and within their area of experience and knowledge.

The intention is that a witness statement should coherently support the investigation in general, fitting as well as possible with the statements of the case and with the other evidence.

The PEACE model is a helpful framework to help support the witness statement-taking process; further information can be found within the following link:

www.college.police.uk/app/investigation/investigative-interviewing/investigative-interviewing#peace-framework

Prepare and plan

Before commencing an interview with the intention to compile a witness statement, the interviewer should prepare and plan their interview beforehand. Consider the most suitable environment for an interview, such as a quiet office, and ensure that they cannot be interrupted or disturbed.

Engage

They should engage with the person to be interviewed and explain thoroughly the reason for the statement, why and how it can help the investigation and potentially help prevent future similar accidents or incidents but also that the statement might be required for internal disciplinary hearings and potential civil claims for damages.

Account

In recording the witness's account of the accident/incident, the interviewer needs to extract the fullest possible account from the interviewee and capture the maximum amount of information using open questions to elicit the best response.

Some witnesses may prefer to write their own statements, but these statements can lack critical information, and an additional statement is often required to cover key areas of information.

It can sometimes be helpful to have two investigators, one to ask the questions and one to write the answers.

Statements are key evidence in an investigation, but they need to be produced in the correct format if they are to be effectively used in root cause analysis, criminal or civil legal processes and internal disciplinary hearings. Remember to get any corrections initialled and cross through any blank spaces so it's clear that no further information can be added to the statement.

Closure

When the interview is completed, the notes and statement should be reviewed together and summarise the account taken. It should be ensured that what is written is the witness's own words and is agreed upon, and that any final questions from the interviewee are invited.

Witness contact details should be obtained, telephone number, and email address should further contact be required and it should be ensured that each page is signed and dated by the person giving the statement.

The next stage of any process should be explained and the possible need for future interviews and the interviewee should always be thanked for engaging and cooperating with the process.

Evaluate

Post-interview, the statement and evidence obtained must be evaluated. Have the aims and objective of the interview and statement been achieved? Ask yourself these questions:

- Are there any unanswered questions arising from the interview?
- Have the cause(s) of the accident/incident been identified?
- Has the witness said something that is suspected of being inaccurate or untrue?

It is often challenging to tell if someone exaggerates, is uneconomical with the truth, or outright lies from an interview. Their evidence should not be argued or disputed based purely upon suspicion but a re-interview arranged at a later time/date with specific questions based upon known facts where they contradict previous statements.

An example of a witness statement template can be found within the [Risk Essentials – Witness Statement Template](#).

CCTV, physical evidence, photographs and video footage



Following an accident or incident, a critical step within the “Golden Hour” period is the harnessing of as much evidence as possible. Evidence can take the form of many different aspects including photographs and video footage of the scene. Following making the scene safe and attending to any immediate injuries, instigating the Golden Hour process is imperative; see further information regarding the Golden Hour [here](#).

Risk Essentials – CCTV, Physical Evidence, Photographs and Video Footage

Photographs, videos, and CCTV footage can be included in the accident or incident investigation report to provide an additional layer of explanation and evidence that can support the management process of public liability and employer liability claims if necessary. In addition, and most importantly, photographs, video footage and CCTV footage can help the accident or incident investigation process so that immediate, underlying and root causes can be identified so that appropriate remedial actions can be put in place to prevent accident or incident reoccurrence.

This Risk Essentials document sets out to provide best practices when taking photographs and video footage following an accident or incident, along with capturing and storing CCTV footage to support the accident or incident investigation process.

Physical evidence

Once an incident has occurred, it is important to preserve evidence to assist with any further action or legal proceedings. This includes visual evidence through photographs, sketches and videos. However, retention of physical evidence is as important and can intrinsically support identification of causation of negative events.

Physical evidence is evidence that is in the form of a tangible object, such as pieces of machinery, substances used or equipment (including safety equipment), that was directly involved in a negative event.

Physical evidence is objective and can corroborate and support statements that have been provided by associated parties. And when retained, documented and where necessary, undergone inspection or analysis, may be the only way to identify true causation.

It is also important to note that a register of physical evidence should be established and maintained. There may be instances where evidence is required to undergo testing or analysis, and it is important to document what, who, when and where items are supporting a chain of evidence. This includes items that may be seized by a regulatory body.

Photographs and video footage

With the majority of people now carrying smartphones and using tablet devices within the workplace, most employees now have the capacity to take and send images instantly. It is often stated that pictures and videos paint a thousand words, and this is certainly the case when using photographs and videos in an accident or incident investigation. Photographs and videos can eliminate disputes, record damage or accident or incident details, and support the overall accident or incident investigation. Below are some key points when taking photographs or video footage within the accident or incident investigation process.

- Ascertain through witnesses or the injured party (if appropriate) exactly where the adverse event took place. This will enable the person taking the photographs or video footage to capture all the information required.
- If the injured party is still at the scene, ensure that sensitivity is shown when taking photographs or video footage. The injured person's dignity must remain intact.
- Ensure that the first photographs and any video footage taken are of a general view taken at a reasonable distance. You should also include reverse angles to provide additional context to the photograph or video footage and taken at different angles or distances. See below for an example of general views and reverse angles.

General view



Reverse angle



Images c/o Stuart Marshall, QBE Insurance

Risk Essentials – CCTV, Physical Evidence, Photographs and Video Footage

- When taking photographs and video footage, try to take wide-angle, high level and overhead views if possible. Again, this will provide anyone reading the accident or incident investigation report with an additional perspective of the scene.
- Close-up photographs and video footage should also be taken; when doing this, you should provide a narrative to provide context. In certain circumstances, it may be beneficial to provide scale within the photograph; see the example below.

Scale

Which one is bigger and by how much?



How big are they?

Introducing scale can be as simple as placing a 50-pence coin in the photo, as everyone is familiar with the size of a coin. You could introduce other everyday items, such as a can of soft drinks or a pen. See below for an example of introducing scale.



Images c/o Graham Corner

- When conducting complex investigations, using a sketch, plan or map to annotate where photographs or CCTV were taken from and the direction the camera was pointing is useful.
- Always ensure that photographs and video footage include date and time stamps for authenticity. If a smartphone is used, download the photographs and video footage, back them up as soon as possible and keep them with a statement that states they have not been altered or edited.
- When taking photographs or video footage always focus on the exact position of vehicles, equipment, machinery guarding, etc.
- Ensure that road, surface markings and signage are always included when taking photographs and video footage.
- Photograph the view an operator or driver would have had on the walking or driving approach to the accident scene; 100m, 50m, 20m, 10m, etc.
- If lighting is a challenge, take photographs from different angles.
- Video footage can highlight a route taken or demonstrate an action and can put speed into context.

CCTV footage

CCTV can be vital in an accident or incident investigation, eliminating any ambiguity leading up to the event in question.

When working through the golden hour process, it is important to consider the following items in relation to identifying, reviewing, capturing and retaining CCTV evidence.

- Check where the accident or incident occurred to identify if CCTV footage is available.
- Review the CCTV footage and ascertain if the accident or incident was captured.
- When reviewing the CCTV footage identify any potential witnesses.
- Once the CCTV footage has been identified, ensure it is retained; this can be done through file transfer or saved directly into an electronic folder.
- Ensure a sufficient footage period is captured pre- and post-accident (e.g. 60 minutes before and after). This could show other contributing factors leading to the adverse event.
- Ensure GDPR protocols are followed and complied with. Further information regarding GDPR can be found at the following link: www.gov.uk/data-protection.
- Make a statement that accompanies the CCTV footage, stating where the footage was taken from, when it was retrieved, where it has been stored, and state that it has not been tampered with.

Summary

Capturing photographs, video footage, and CCTV footage is vital when conducting an accident or incident investigation; the information captured can support root cause analysis methodologies, which will ultimately drive corrective actions to prevent reoccurrence. The information captured as discussed above can be critical evidence in the management process of Public and Employers' Liability claims. The techniques and processes highlighted within this Risk Essential will enable organisations to consistently capture the above evidence and help enhance their operational risk profile.

Standard claims disclosure documents and evidence



Successful claims defensibility hangs on the existence of good-quality documented evidence demonstrating that the insured took all reasonable steps to discharge their duty of care towards both their employees and others who may be affected by their undertakings.

Claims defensibility relies on the availability of good-quality evidence. The types of documents expected to be available to provide support of an Employers' Liability (EL) or Public Liability (PL) claim and promptly, are detailed on the next page.

Legal requirements

Many of the most frequently requested documents to be disclosed will relate to the Health and Safety at Work Act and regulations governing Management of Health & Safety at Work, Workplace, PUWER, COSHH, Manual Handling Operations, Work at Height, Confined Space and Personal Protective Equipment although evidence can be requested under any applicable legislation relating to the claim.

QBE or your broker can advise on relevant requests for disclosure of EL and PL claims.

When a decision has been agreed to defend a claim or allege contributory negligence, the supporting evidence must be available at the earliest opportunity and comply with the Claims Procedure Rules. Failure to disclose requested evidence will likely result in the issue of a pre-action disclosure (PAD) requiring its release and incurring legal costs.

Further documentation can be requested at any time during the lifetime of a claim and organisations should ensure they have a document storage and archive system that facilitates prompt retrieval and disclosure.

Guidance and useful information

The standard disclosure list detailed under the Civil Procedure Rules is extensive and can be found using the following link: www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_pic

Good practice

An abbreviated list of the most frequently requested disclosure documents is shown below. This is by no means exhaustive, and there are many documents and pieces of evidence the claimant solicitors can request or seek disclosure from the courts if necessary.

- Completed Accident or Incident Report Form, Accident Investigation Report, First Aid report and RIDDOR form F2508 or F2508A.
- Risk assessments – generic and task-specific (pre and post event).
- Documented safe systems of work/ operating procedures .
- Training records – for the injured party and others involved in the incident.
- Contemporaneous witness statements (including negative statements).
- Photographs, CCTV, phone video footage.
- Measurements/weights/dimensions.

- Maintenance records/defect sheets/inspection records of machinery, vehicles, and tools involved.
- Occupational Health Records (subject to signed consent from the individual concerned) .
- Personnel records.
- Internal investigation report (without prejudice documents can be requested or a court order sought for disclosure).
- Health & Safety Committee meetings minutes and actions, consultation documents.
- PPE policy, requirements, minimum standards of protection, procurement of PPE and distribution to employees, compliance monitoring of wearing PPE.
- Permit-to-Work documentation.

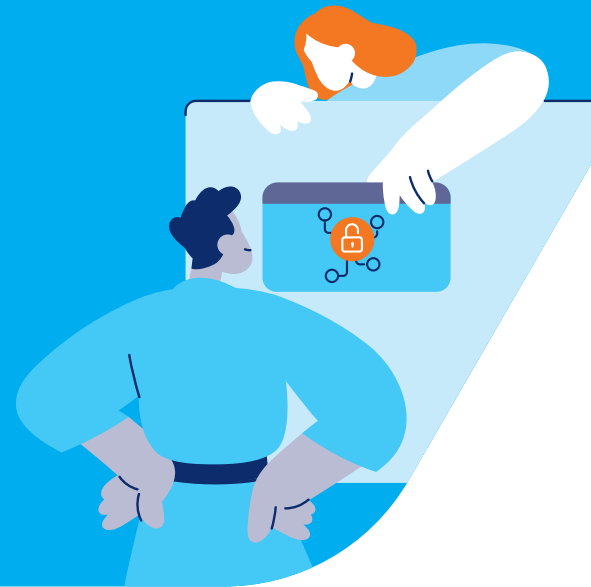
Public Liability claims

Claims involving members of the public or visitors to your premises present their own challenges in that these individuals may be unaware of the correct procedure for reporting accidents, which can often mean that the first notification you may receive will be a formal claim.

Therefore, visitors to your premises must be made aware of the need to report any accident and that your employees are well-trained in the actions they must take in recording and securing evidence.

There may be occasions where there is no report of any accident or incident, and in these situations, it will be vital to evidence the measures taken to ensure that visitors to the premises, both invited and uninvited, are protected, which will require that documentation is kept secured for a sufficient period of time (seven years).

Supervision and recording safety inspections



Supervisors are integral part of the accident investigation process. The supervisor will usually be responsible for managing the “Golden Hour” phase following an accident or incident therefore it is critical they are familiar with an organisation's accident investigation procedures and processes. The supervisor will be most likely be responsible for the completion and collation of safety critical documentation that will inform the accident or incident investigation and its outputs. In addition, the supervisor will also be familiar with working practices and behaviours which is essential intelligence when generating appropriate remedial actions and lessons learned to prevent accident or incident reoccurrence.

Supervision

Supervision is a crucial factor which should form an essential part of a health and safety management system as it will reduce the likelihood of human failure. The supervisor has been defined as “the shop floor face of the organisation, the filter or lens through which management messages and attitudes are transmitted to the workforce and views and feedback from the shop floor are passed back up to line management” Lardner & Miles 1998 (1). Studies have shown that organisations with a larger number of available supervisors per employee have fewer accidents.

Effective supervision promotes compliance with procedures, training, positive culture, and safety-critical communication and prevents problems caused by workload and fatigue, thereby reducing the risk of accidents. Supervisors have a key role in decision-making, planning, and leadership, promoting worker involvement in safety initiatives and monitoring performance and compliance. Health and safety performance monitoring is essential if standards are to be improved. These processes need to be documented as they may be used as evidence, which is critical in reference to claims management and defensibility.

Organisations must measure how well they implement their health and safety management system. Simply accepting low accident rates may hide the fact that risks are not being controlled. Effective monitoring will look at reactive issues, such as accident statistics and safety deficiencies, and active issues, such as compliance with health and safety standards. Active monitoring can also include periodic examination of documents, environmental monitoring and inspection of premises and plant. Reactive monitoring will allow remedial action to be taken to stop incidents from recurring, trends can be identified and discussed, and action can be taken to reduce insurance claims.

Below is a list of key items employers should consider in relation to supervision within their operations:

- Ensure supervisors have the resources, time and opportunity to interact with their teams.
- Clearly define supervisory roles and monitor, audit and review all aspects of the supervisor’s performance.
- Select the right people and give them training to be supervisors. They need planning, communication and delegation skills, an understanding of local hazards and control measures, credibility, and experience.
- Supervisors need achievable targets and support in conflict resolution.
- Senior management reviews accident and claims data, benchmark performance, and commits to prioritised ‘risk-based’ improvement targets, with personal ownership throughout the business.
- Monitoring activities include verification that Supervisors are effectively discharging their duties in full.
- Clear supervisory arrangements are needed for managing contractors and third parties on site.

The supervisor plays a key role within the accident investigation process due to their knowledge of operational matters. In addition, the documentation the supervisor generates will inform the outputs of the accident or incident investigation process. When completing accident investigations, it essential to actively involve supervisors so that robust remedial actions and lessons learnt can be generated to prevent accident or incident reoccurrence. Lastly, it is important to explore and understand what actions and level of supervision was in place prior, during and post event within the accident or incident investigation.

Safety inspections

A system of inspection is an important aspect of an active monitoring programme. Inspections can include safety tours, incident inspections, safety sampling of particularly dangerous activities, behavioural observations and safety surveys. Inspections also form part of a compliance regime for preventative plant and equipment maintenance. Inspection timescales will vary depending on the level of risk. Workplace inspections of low-risk workplaces could be carried out monthly, high-risk environments more frequently, and plant checks daily. When conducting accident or incident investigations, inspection records should be analysed and included within the accident investigation report as they may consist of crucial intelligence to inform the accident investigation process. The below provides a list of good practices in relation to safety inspections:

- Monitoring health and safety performance should be a clearly defined line management responsibility.
- Monitoring can be supplemented by senior manager safety tours, surveys of employee opinions on health and safety and, if they are available in the workplace, inspections by safety representatives.
- Managers should monitor compliance with the standards for which they are responsible.
- Inspection programmes should be planned, properly targeted and undertaken by competent people.
- Summarise lists of remedial actions with names and deadlines to track progress and prioritise actions.
- Analyse inspection forms, identify common problems needing action and assess inspection frequencies. Allocate actions to individuals with target dates for completion, which should be regularly monitored to ensure that items are completed in a timely fashion.
- Record inspections, share the follow-up actions with the workforce and involve safety representatives. Detail all areas and items inspected, date and time, and who undertook it.
- The weather conditions if these are relevant to the inspection.
- Record positives i.e., no defects found.

Audit

Systematic review of procedures and policies to ensure they are fit for purpose and contain clear instruction, for how certain elements are to be effectively and consistently controlled. Inspections are a compliance exercise whilst audits are process driven.

Legal requirements

Employers are required to monitor health and safety performance by measuring how they implement their health and safety policy and assessing how they control risks. This is made clear in the Approved Code of Practice (ACOP) accompanying the Management of Health and Safety at Work Regulations. Regulation 10 of the Control of Substances Hazardous to Health Regulations 2002 requires monitoring employees' exposure to hazardous substances. A range of legislation requires the inspection of plant and equipment such as pressure vessels, lifts, cranes, chains, ropes, lifting tackle, power presses, scaffolds, and local exhaust ventilation equipment.

The Occupiers' Liability Act 1957 and 1984 lays out the duty of care owed to visitors, both lawful and those on land/premises without permission, i.e. trespassers, meaning that maintaining premises, land, footpaths, and boundary fences is important in both preventing incidents from occurring and defending potential claims. This is particularly important when considering the protection of young children.

Guidance and useful information

- (1) Lardner, R. & Miles, B. (1998). Supervision, self-management and safety. *The Chemical Engineer*, Jan 1998, 650, 28–31.
- Different types of supervision and the impact on safety in the chemical and allied industries, HSE Research Report 292, 2004 ISBN 0 7176 2929 5: www.hse.gov.uk/research/rrpdf/rr292.pdf
- Managing for Health & Safety: www.hse.gov.uk/pubns/books/hsg65.htm
- Effective Supervision Framework links:
 - Effective Supervision Risk Insight – QBE European Operations
 - Effective Supervision Framework – Roles and responsibilities – QBE European Operations
 - Effective Supervision Framework – Selection – QBE European Operations
 - Effective Supervision Framework – Training, competence, verification & appointment – QBE European Operations
 - Effective Supervision Framework – Supervisor observational assessment – QBE European Operations

Human factors in accident investigation



Incidents and accidents are opportunities to understand why they occur and what lessons an organisation can learn to hopefully prevent further or similar incidents, near-misses and accidents in the future.

The cause of many incidents and accidents is often put down to human error. This is a far too quickly arrived-at conclusion and is usually too readily accepted by many organisations. There are undeniably frequent human factors involved in the immediate cause, and focusing on these human factors will enable the investigation team to understand the underlying and root causes better and develop an action plan that hopefully prevents further occurrences.

Risk Essentials – Human Factors in Accident Investigation

The HSE define human factors as “environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety”. Further information can be found within HSG 48:

www.hse.gov.uk/pubns/books/hsg48.htm

The three primary elements associated with the human factor are the job, the individual, and the organisation. Each element is summarised below.

- **The job** includes procedures and processes, the task, workloads, task environment, and design of risk control features. When designing a task, ergonomic principles should be considered, including employee strengths and limitations. This approach should consider the mental and physical strengths of employees.
- **The individual** includes competency, skills, risk perception, attitudes, mental health, and wellbeing. These characteristics influence employee behaviour in many different ways. A person’s personality is said to be fixed, although attitude, risk perception, etc, can be influenced positively and negatively.
- **The organisation** includes organisational safety culture, work schedules, resources, communication, leadership, supervision, etc. These elements are often not considered during the planning and design of the task, and they can heavily influence behaviours at the individual and group levels.

In summary, human factors relate to what employees are being tasked with, the people conducting the task, and the physical environment in which the task is completed.

Human factors should be a key consideration when developing a health and safety management system. In addition, it should be a key factor within the accident investigation process. It is imperative to assess human factors holistically rather than in isolation.

Accident investigation

Organisations will have their own process for investigating and analysing adverse events, but they usually involve the following steps:

- gathering and organising information on what happened, when, where, to whom, etc. and the collection of supporting evidence, both physical and documentary, and;
- analysing the information to understand why and how the event occurred and making recommendations to prevent re-occurrence.

The role of the investigation team and the outcome of the report is to make recommendations for change if required, and broader stakeholder engagement is necessary to turn these into practical actions to prevent reoccurrence.

Information should be captured from various sources within the accident investigation process. This information could include witness statements, photographs, CCTV, and documentation. A more comprehensive list of information can be found at the following link. This evidence will allow investigators to understand the human factors that relate to the accident or incident.

[Pre-Action Protocol for Personal Injury Claims – Civil Procedure Rules \(justice.gov.uk\)](http://www.justice.gov.uk/pre-action-protocol)

It is vital that this information is captured and retained as it will be critical evidence within the claims management process.

Human factors and human failure

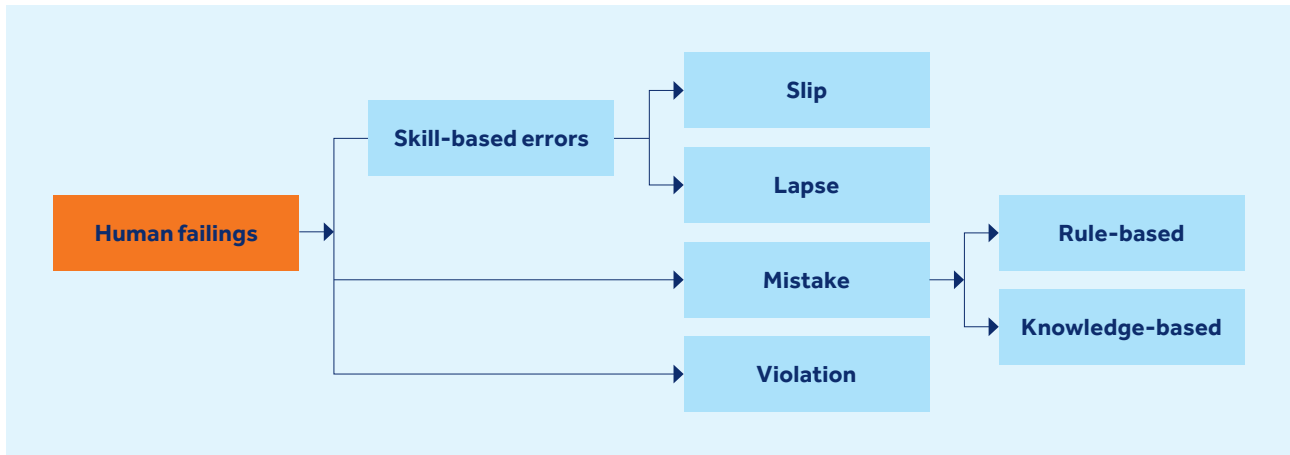
Human factors must be reviewed with an open mind to understand and learn as much as possible from investigations. Organisations will adopt different tools and techniques to assist, but ultimately, the investigation team needs to understand and accept human factors.

To improve the quality of how human factors are explored in investigations, the following factors should be considered:

- The differing types of human failures.
- Understanding the capabilities and limitations of the people involved.
- Factors that influence human failures (peer pressure, timescales, etc).
- What is human error, and how and why does it apply?

The HSE has published HSG 245 and HSG 48, which provide valuable models for identifying human failings (see Figure 1 on the next page). This model can be utilised once the root cause analysis has been completed. Although this model will not identify all human factors, it helps identify and manage human failure.

Figure 1



See the below links to the HSG 245 and HSG 48 guidance documents, which provide further information on utilising the model presented in Figure 1.

www.hse.gov.uk/pubns/hsg245.pdf

www.hse.gov.uk/pubns/books/hsg48.htm

Accident investigation outcomes

Investigations should look to encompass more than the people in the event and should consider whether behaviours or decisions at the point of work were influenced by management, leadership, peer pressure, organisational deficiencies or any multiple of these. These are usually termed latent failings.

If people do not have all the required information (for example, risk assessments, safe operating procedures, training, supervision, etc), then this may lead to human failures. Violations are often assumed to be wilful and malicious, whereas they are usually a function of poorly written procedures, inadequate training, poor supervision, etc.

Addressing human factors in investigations aims to identify these broader factors affecting human performance issues. For example, if a procedure was not followed, the investigation should explore why. Identifying the deficiency in the system that led to such a situation and understanding if the same deficiency could affect other procedures will lead to broader learning.

Summary

Requirements and recommendations arising from the incident, near-miss or accident investigation should be associated with the underlying causes, of which human factors are one component, rather than purely focussing on managing the behaviours or decisions of individual people. Issues such as a lack of competence or inadequate procedures are not root causes; the investigation should continue to identify further information. For example, suppose it is determined that a critical factor was a 'lack of competence'. In that case, the investigation should understand why this was the case and what organisational processes failed thereby creating that situation. There may have been failures in the selection processes, the training needs assessment, or the training delivery. The more thorough the level of analysis, the more prudent the requirements and recommendations will become.

Further information on root cause analysis can be found within the [Risk Essentials – Accident Root Cause Analysis](#).

Accident root cause analysis

Guidance



1. Introduction

- 1.1 As part of the risk management strategy established by the company, we are keen to develop a root cause analysis process for use by the appointed investigator incident and serious near-miss investigation process.
- 1.2 The ultimate aim is to identify the root causes of incidents, accidents and near-misses and to identify trends from these root causes in order to effectively drive the risk management programme and to reduce the occurrence and significance of future incidents and losses.

2. Root cause analysis

- 2.1 Root causes are the underlying and fundamental issues which have led to an incident happening and must be addressed in order to improve risk management and the prevention of losses. The aim is not one of applying blame but to learn how to prevent similar incidents happening again.
- 2.2 Root causes are defined as the prime reason or reasons why an incident occurred and are often related to deficiencies in management systems. It is essentially the earliest point at which action could have been taken which would have prevented the incident from occurring. Root Cause Analysis is the structured investigation which aims to identify the true cause of the incident and the actions necessary to eliminate and prevent it recurring.

3. The investigator

- 3.1 The aim of this initiative is to provide a simplified Root Cause Analysis process for use by the appointed investigator as part of any accident, incident and serious near-miss investigation. If appropriate, supervisors can seek the assistance of colleagues, specialist health, safety and environmental advisors or operational team members, in order to complete the Root Cause Analysis investigation.

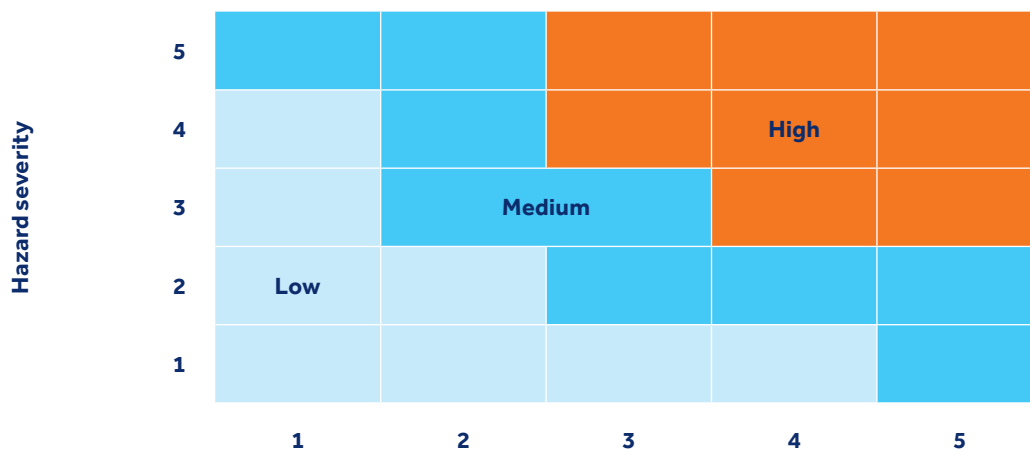
4. When to apply root cause analysis

4.1 The decision as to when to apply root cause analysis should be based upon the potential severity of a near-miss or the actual severity of an incident and the likelihood of them recurring. These factors could be considered by utilising a simple 5×5 matrix in order to calculate the Risk Rating as follows:

Hazard Severity Rating (HSR)	Value
Death(s) / permanent incapacity / widespread Loss	5
Major injury (reportable to HSE) / severe incapacity / serious loss	4
Injury/illness requiring 3 or more days absence (reportable to HSE) / moderate loss	3
Minor injury/illness – lost time	2
Trivial injury (immediate first aid only) / illness / loss	1

Likelihood Probability Rating (LPR)	Value
Almost certain / regular or frequent occurrence	5
Likely to occur often	4
Even chance / likely to occur sometime	3
Unlikely but may occur exceptionally	2
Improbable / extremely unlikely to occur	1

The Risk Rating is the Hazard Severity Rating (HSR) multiplied by the Likelihood/Probability Rating (LPR) and provides an indication of the overall **RISK** and therefore the need to apply Root Cause Analysis to the incident or potential incident.

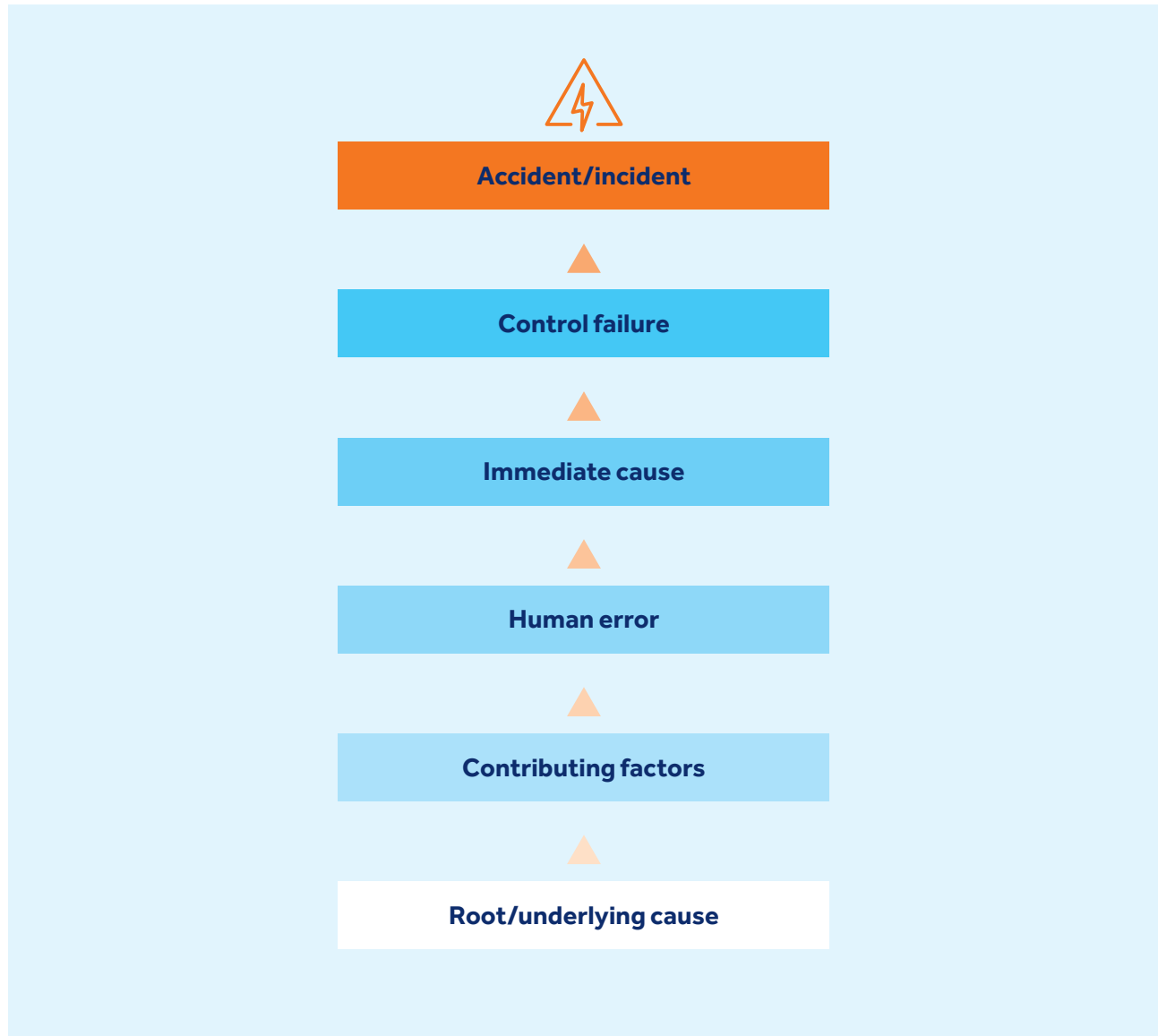


4.2 Root Cause Analysis could then be applied to any incident falling within the medium- and high-risk categories.

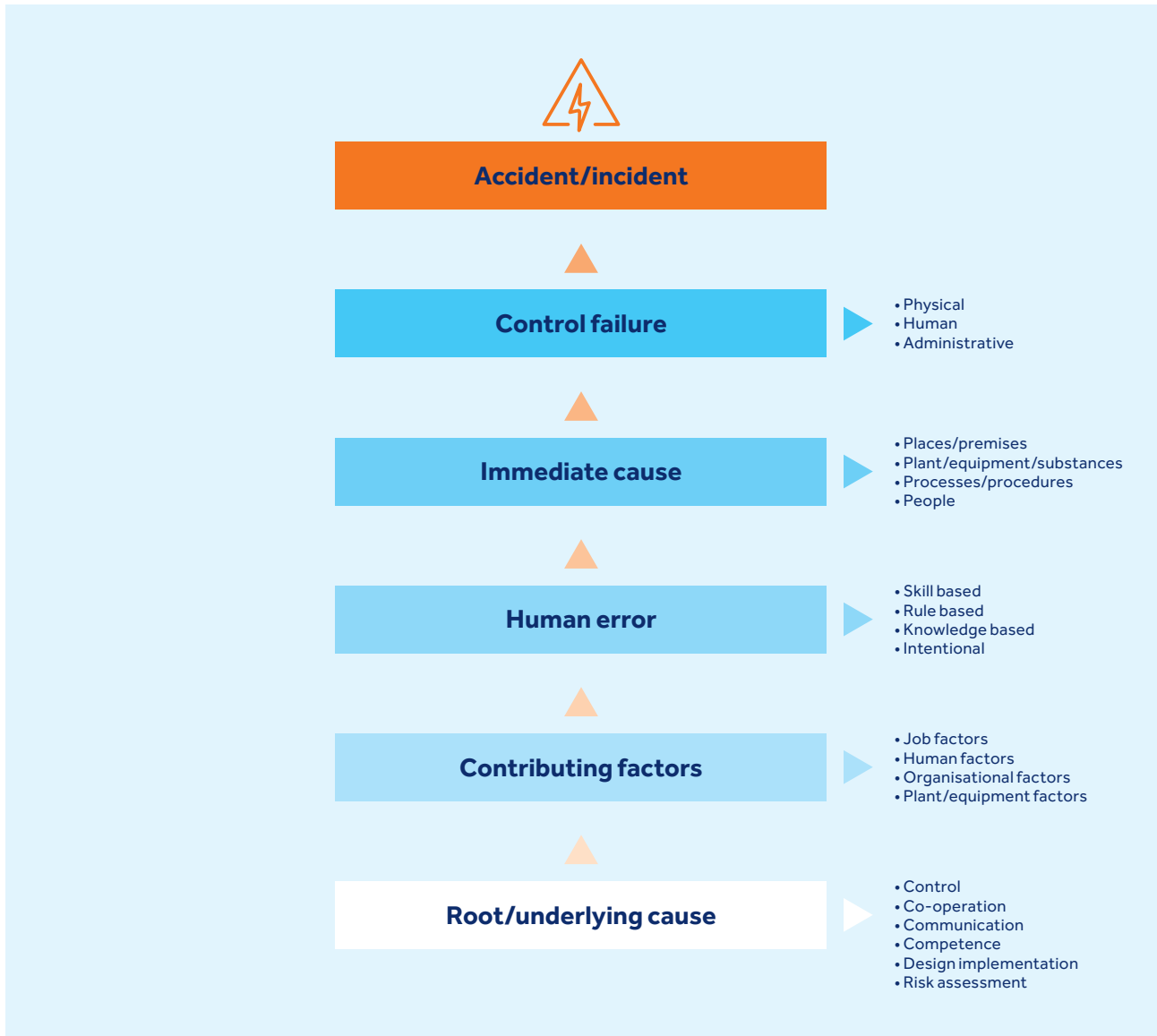
5. Understanding how incidents occur

- 5.1 Incidents have many causes which can effectively be seen as a chain of failures and errors that lead almost inevitably to an incident. These are represented on the following flow charts:

Root cause analysis process

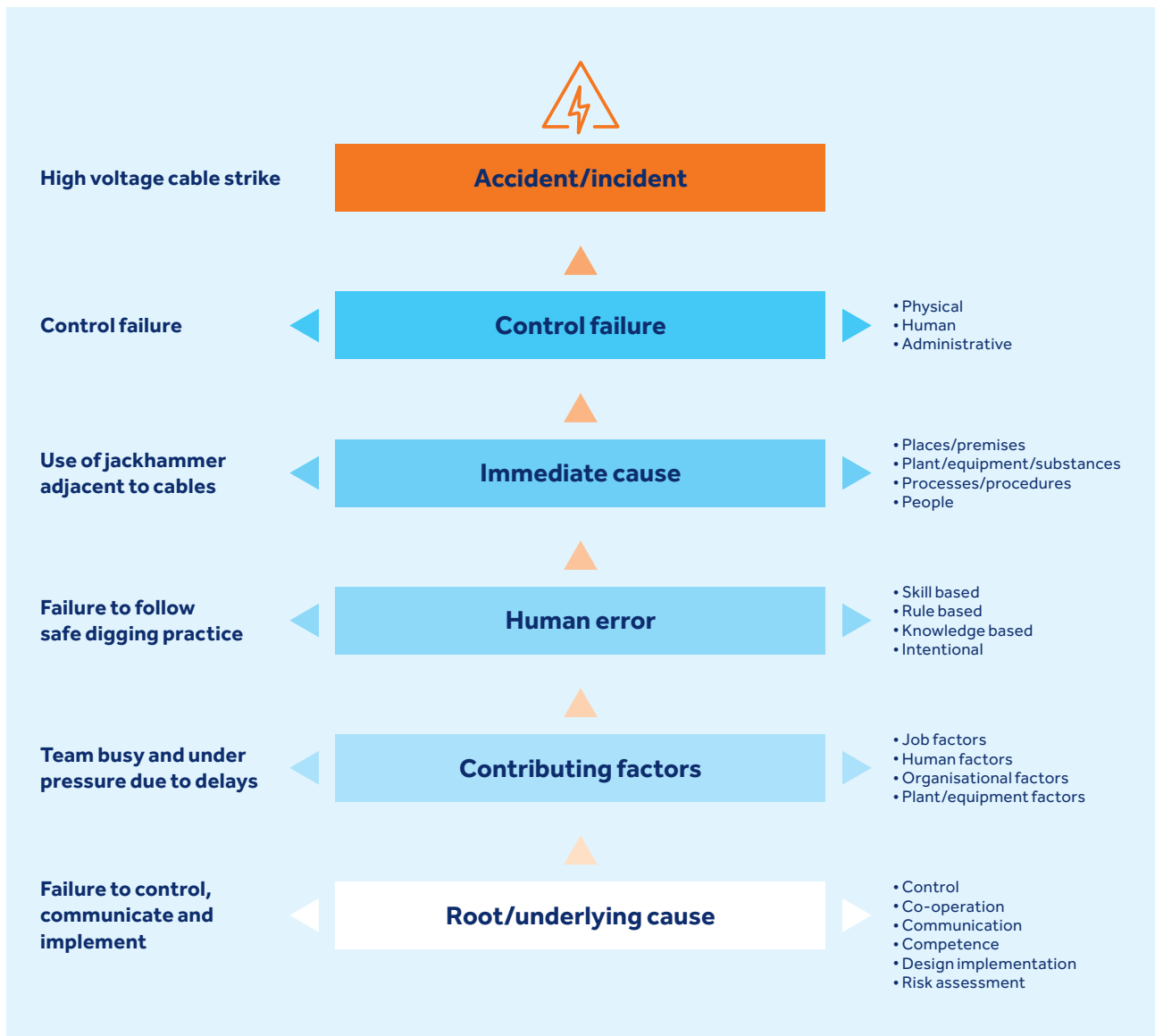


Root cause analysis process explained



Risk Essentials – Accident Root Cause Analysis

Root cause analysis process example



6. Controls

- 6.1 These are put into place to prevent incidents occurring and therefore the potential for harm. These can be categorised as follows:
- 6.1.1 **Physical** – these are physical barriers which prevent the harm occurring e.g. guard rails, insulation, safe guards etc.
 - 6.1.2 **Natural** – these are time or distance removed from the occurrence, e.g. utility plans, trials holes.
 - 6.1.3 **Human actions** – e.g. training and instruction, competence, supervision.
 - 6.1.4 **Administrative** – policies and procedures, supervision and training, risk assessment.

7. Human errors

- 7.1 Human errors occur when actions and decisions of individuals result in failures which can immediately or directly lead to an incident. Root Cause Analysis requires a greater understanding of human error failures.
- 7.1.1 **Skill-based errors**

These involve the unintended deviation of actions from what may have been a perfectly good system of work. They normally occur when employees' thought processes are not focused on the task in hand, e.g. whilst marking up identified buried services, operative is interrupted by a colleague and forgets to mark one particular identified buried service.
 - 7.1.2 **Rule-based errors**

Rule-based errors occur when individuals encounter relatively familiar problems but apply the wrong established solution either through wrong application of a good system or the application of a bad system e.g. an operative who is marking up buried services mistakenly marks buried electrical cables with the wrong-coloured marking paint usually used for marking water services.
 - 7.1.3 **Knowledge-based errors**

These are mistakes where the individual encounters a new situation for which their training does not provide a solution. Consequently, they apply solutions based upon their experience and where there is lack of experience, this may lead to an error, e.g. inexperienced operative using a CAT to identify buried services misinterprets the reading and does not identify buried services for marking.
 - 7.1.4 **Intentional actions**

Some human errors are not mistakes but result from conscious decisions to deviate from an accepted or company practice. These are sub-categorised as routine, reasoned or reckless.

 - 7.1.4.1 **Routine**

Routine errors involve regularly performed short cuts which are accepted locally and sometimes by management maybe as a result of the system or task being poorly designed, e.g. using a powered road breaker within 250mm of a known buried service to save time with hand digging.
 - 7.1.4.2 **Reasoned errors**

These are occasional deliberate deviations from the procedure for well-intentioned reasons. These often help to avoid or mitigate a more serious potential incident, e.g. using an excavator to expose a damaged water pipe to speed up the identification of the damaged area.
 - 7.1.4.3 **Reckless errors**

These are deliberate deviations from accepted practice and the reason is often questionable. These often involve an active lack of care and can include acts of sabotage, e.g. excavator operative deliberately damaging a buried service to stop work for the day.

8. Contributory factors

- 8.1 When a failure occurs the human error does not occur in isolation; there will be a number of contributory factors which led to the incident. Contributory factors can be categorised as follows:
- 8.1.1 **Job factors** – These could determine how much attention is needed for the task in hand with both too little and too much leading to higher error rates, divided attention or distractions, inadequate procedures and inadequate time available.
 - 8.1.2 **Human factors** – These relate to the physical ability (size and strength) competence (knowledge, skill and experience), fatigue, stress, moral, wellbeing, alcohol or drugs.
 - 8.1.3 **Organisational factors** – These relate to work pressures, long hours, availability of sufficient resources, quality of supervision, management beliefs in health and safety, namely their safety culture.
 - 8.1.4 **Plant and equipment factors** – These relate to how easy the controls are to understand, whether it has been properly designed and whether the workplace has been laid out to be user friendly.

9. Root/underlying causes

- 9.1 The root/underlying causes can then be effectively categorised into seven categories as follows:
- 9.1.1 **Control**
 - 9.1.1.1 Were the workplace and work activities adequately supervised and monitored in order to ensure that risk control measures were effective and implemented as intended?
 - 9.1.1.2 Did the supervisors have adequate resources to carry out their duties?
 - 9.1.1.3 Were people held accountable for their performance in carrying out their duties regarding health and safety?
 - 9.1.1.4 Were there adequate arrangements for overseeing and controlling contractors?
 - 9.1.2 **Co-operation**
 - 9.1.2.1 Were employees and representatives involved in determining workplace arrangements, preparing risk assessments and safe working practices?
 - 9.1.2.2 Did individuals involved in the incident share information?
 - 9.1.2.3 Were the arrangements for cooperation with and coordination of contractors effective?
 - 9.1.3 **Communication**
 - 9.1.3.1 Were responsibilities and duties clearly set out?
 - 9.1.3.2 Were they clearly understood by those involved?
 - 9.1.3.3 Did everyone involved know who they report to and who reports to them?
 - 9.1.3.4 Was there sufficient up-to-date information to enable good decisions to be made?
 - 9.1.3.5 Were there adequate arrangements for passing on information at shift changes?

Risk Essentials – Accident Root Cause Analysis

- 9.1.3.6 Were written instructions, safe working procedures, Method Statements and information sheets practical and clear?
- 9.1.3.7 Were there instructions and procedures available to all who needed them?
- 9.1.3.8 Was the communication between workers and supervisors effective?
- 9.1.3.9 Was the communication between different sections effective?
- 9.1.3.10 Were there effective communications with contractors?

9.1.4 **Competence: Training and suitability**

- 9.1.4.1 Were the people involved assessed as suitable for the work in terms of health and physical ability?
- 9.1.4.2 Were the health and safety training needs of people identified on recruitment, with change of job, with changing work practice, and was there periodic training and refresher training?
- 9.1.4.3 Were the training requirements for particular jobs identified?
- 9.1.4.4 Was the training effectively delivered with adequate resources, was it assessed, were training records kept?
- 9.1.4.5 Was the competence of contractors, employees and agency workers checked?

9.1.5 **Design**

- 9.1.5.1 Were the workplace and equipment layouts designed with consideration to health and safety?
- 9.1.5.2 Were the controls, displays etc of plant and equipment designed to reduce the risk of or prevent human error?
- 9.1.5.3 Were work activities suitably planned to avoid risk – were CDM duties fulfilled?

9.1.6 **Implementation**

- 9.1.6.1 Were there arrangements for ensuring that suitable and sufficient plant, equipment and materials available?
- 9.1.6.2 Were there arrangements for ensuring that sufficient and suitable labour was available?
- 9.1.6.3 Was there adequate cover for leave or sickness absence?
- 9.1.6.4 Were suitable contractors appointed?
- 9.1.6.5 Were there adequate arrangements for cleaning?
- 9.1.6.6 Were there adequate arrangements for reporting defects in plant and equipment?
- 9.1.6.7 Were there adequate arrangements for carrying out maintenance work?
- 9.1.6.8 Were there adequate arrangements for reporting health and safety concerns?
- 9.1.6.9 Were there adequate arrangements for reporting near-misses and undesired circumstances?
- 9.1.6.10 Were there adequate arrangements for carrying out health surveillance?
- 9.1.6.11 Were there adequate arrangements for carrying out monitoring?
- 9.1.6.12 Did production targets take account of health and safety?
- 9.1.6.13 Were there adequate arrangements for appointing and controlling contractors?

Risk Essentials – Accident Root Cause Analysis

9.1.7 Risk assessments

- 9.1.7.1 Were there risk assessments for the work in question?
- 9.1.7.2 Were they suitable and sufficient:
 - Did they correctly identify the risks?
 - Were they up-to-date and reviewed as necessary?
 - Were correct technical standards used?
 - Were adequate risk control measures identified?
 - Were safe working procedures/method statements developed?
 - Were there clear conclusions and recommendations?
 - Were employees involved in preparing them?
- 9.1.7.3 Did the risk assessments result in a risk control Action Plan with clear objectives?
- 9.1.7.4 Were responsibilities for implementing the risk control Action Plan set out?
- 9.1.7.5 Had the risk control Action Plan been implemented?
- 9.1.7.6 If there had been similar adverse events in the past, had they been investigated?
- 9.1.7.7 Were investigation findings fed back into the risk assessments?
- 9.1.7.8 Did the risk assessments include the risks from work carried by contractors?

10. Investigation process

Information gathering

10.1 Documents

As part of the investigation process a number of documents will need to be collated, including the following:

- 10.1.1 Safety Policy and Procedures, Method Statements, Risk Assessments, Training Records, Equipment Maintenance and Calibration Records, Site Inspections, Toolbox Talks records and Employee Briefing and Consultation records.

10.2 People

Identifying key witnesses and individuals involved in the incident is critical and names should be recorded as soon as practicable. Company procedures for taking witness statements and interviewing operatives should be followed.

10.3 The site

Timely visiting of the site is critical and the following protocol should be followed:

- 10.1.1 Sites should be visited as soon as practicable after the incident.
- 10.3.2 Investigators should be accompanied by someone familiar with the sites.
- 10.3.3 Where possible and relevant, the sites should be left undisturbed.
- 10.3.4 A sketch should be considered to show layout.
- 10.3.5 Photographs are essential.
- 10.3.6 Relevant equipment should be “quarantined”.
- 10.3.7 Where relevant, the sites should be operating at similar levels and at a similar time of day to when the incident occurred.
- 10.3.8 Essential equipment for investigation should include camera, note pad and pen, tape measure, personal protective equipment.

Risk Essentials – Accident Root Cause Analysis

Analysing the information

- 10.4 Key part of the analysis is to identify the relevant contributory factors underlying the incident, analysis should be objective and unbiased, identifies the sequence of events and conditions that led up to the incident, identifies the immediate causes, identifies the underlying causes and identifies the root causes.
- 10.5 The first step in understanding what happened and why is to organise the information that has been gathered. This can be done by use of the Root Cause Analysis and Recommendation form appended to this section. By analysing information, the immediate cause of the accident should be categorised and for each of the immediate causes, the simple technique for asking “why” over and over until the answer is no longer meaningful is a valid technique for identifying the root cause. This can be done through use of the flow chart systems.
- 10.6 This should lead to valid conclusions regarding the underlying and root causes of the accident and incident.

Action Plan and implementation

- 10.7 Use of the Root Cause Analysis Record sheet should identify a series of underlying and root causes and this should then be forwarded to the Safety Department for collation and review of implementation of the required recommended actions.

Root cause analysis and recommendations

Division

Date

Name of investigator

Date of incident

Location of incident

Incident details

Immediate cause

Root cause

Recommendation

Further information on root cause analysis models can be found within the following link:
www.hsestudyguide.com/7-different-root-cause-analysis-techniques/

Rehabilitation and occupational health



Accidents can and often do happen. With this in mind, good-quality rehabilitation and occupational health provision should be part of every company's risk management strategy. Managing the long-term consequences of an injury can often prove difficult, particularly where this involves significant personal injury and absence from work due to physical or psychological injury.

QBE understands the difficulties and challenges this can pose, but through our market-leading pre-claim rehabilitation product, QBE Return+, we're able to assist our customers by providing early access to private treatments and support that helps you manage your employees' health and well-being after a workplace accident.

Following an incident in the workplace, QBE focuses on getting employees safely recovered and back to work, accelerating recovery times and reducing absence times in the return-to-work process.

At QBE, we believe in taking a proactive approach to rehabilitation. The faster we get involved, the more we can do to limit the cost of workplace accidents and safely return employees back to work. QBE's focus is capturing accidents and injuries early, enabling us to provide the right rehabilitation and claims support at the right time. This means effective protection for our customers, injured employees, and the overall claims position.

Engaging occupational health support at the earliest opportunity will also help to ensure that disruption to the business is minimised and that the potential for a future claim and the costs associated with that claim are controlled. When an employee receives the best possible rehabilitation support in the early stages, it can facilitate a successful and sustained return to work.

Occupational health

Good occupational health support can help return the injured person back to the workplace as quickly and sustainably as possible. Initially, this may involve light duties but, wherever possible, should result in returning to their full pre-accident status. If an injury is more serious and a formal claim has been presented, and a referral to QBE's pre-claim rehabilitation service hasn't already been made, QBE's Rehabilitation team can still assist by seeking agreement from the injured person's legal representatives to instruct one of QBE's rehabilitation providers to assess the individual's rehabilitation needs. The provider will triage the injury's severity and propose a treatment programme to ensure the employee is returned to as close to their pre-injury health status as possible. Where a full recovery cannot be achieved, best use should be made of the injured person's capabilities, effectively recognising that they can still contribute fully, albeit in a redefined role. QBE Rehabilitation can provide expert guidance to help ensure that the best outcome is achieved for all concerned, not least the injured person.

Commercial benefits of occupational health

The commercial benefits of improving workforce occupational health are well documented. The results of such studies have demonstrated that appropriately targeted occupational health provision can help organisations:

- Reduce the number of workdays lost to absenteeism;
- Reduce liability-related costs through the reduction in claim frequencies;
- Potentially reduce plant downtime and enhance the efficiency of operations;
- Enhance staff productivity, motivation and commitment;
- Improve staff retention and reduce staff turnover;
- Meet their legal responsibilities.

An environment for successful rehabilitation / occupational health

The injured person will need support and encouragement at the earliest opportunity through what may be a traumatic period for them. The employment contract should explain the need to maintain close contact, wherever possible, arranging for the employee to attend the workplace to discuss plans for rehabilitation, where appropriate. Other factors that should be considered include:

- Referring to QBE's pre-claim rehabilitation service QBE Return+;
- Adopting as flexible an approach as possible;
- Utilising occupational health services;
- The availability of alternative or light duties;
- Job rotation.

Benefits to the employer of a successful strategy

A positive approach towards rehabilitation and occupational health can produce significant benefits, including:

- Reduced claims frequency;
- Lower claims settlements;
- An improved risk profile of your business as an insurable "risk";
- Improved employee skills retention, producing savings against recruitment and training costs;
- Active demonstration of a positive policy which is likely to produce a more appreciative and motivated workforce;
- Compliance with the requirements of the Disability Discrimination Act;
- Enhanced brand reputation.



Rationalisation and site closures

Site rationalisation – when rationalising a site’s processes, looking at making employees redundant or planning a full site closure, the organisation’s changing liabilities should not be overlooked. There is a clear business case for designating financial and management resources to a strategy that considers the key issues, identifies current and future exposures, plans how they should be managed, then determines how information will be captured and archived in an effective and easily retrievable manner.

Risk Essentials – Rationalisation and Site Closures

During the run-down period, new risks will be presented as the site experiences non-standard activities such as the dismantling of plant and process equipment, building structures and infrastructure, and temporary plant and materials are introduced. The business also needs to protect itself against the increased propensity for individuals to pursue personal injury claims as their loyalty and connection to the business is severed. Without taking fundamental risk management steps, a business could find that it has gone through all the tough decisions necessary to preserve its short-term position, only to expose itself to liability issues which undermine its long-term viability.

Key elements of the rationalisation process are:

- Appoint an executive team to create, implement, manage, and monitor the site closure strategy.
 - Liaise closely with your insurance broker to ensure insurance cover reflects the changing site activities and risk profile.
 - Record operations and site conditions whilst fully operational with video footage and photographs.
 - Pay particular attention to any contentious activity prone to speculative claims, especially where an existing claims pattern is already established.
 - Fully assess and document any processes with the potential for future disease claims, e.g. noise, vibration, respiratory disorders, etc.
 - Consult with local and regulatory authorities.
 - If the site is leased, confirm all ongoing responsibilities once operations have ceased.
 - If the site is owned, consider how to protect the asset – revise fire and security arrangements.
 - If the site is to be sold, ensure relevant present/future liabilities are transferred to the buyer.
 - If employees are being transferred to new employers, check position under the Transfer of Undertakings Protection of Employment rights (TUPE).
 - Identify and assess non-routine or enhanced risk exposures flowing from closure activities.
 - Ensure risk assessments, safe system of work and training procedures are maintained.
 - Ensure robust monitoring, investigation and recording of incidents/accidents, however minor.
- For employees being transferred internally, arrange appropriate training for the new environment.
 - Consider cultural and human factors as claims drivers, especially where job losses are planned.
 - Ensure controlled communication with employees, customers, suppliers and the media.
 - Re-assess business continuity planning in light of new arrangements.
 - Appoint learned legacy contacts for liaising with insurers, local and regulatory authorities etc.
 - Ensure all relevant documentation created when the site was fully operational and during the rundown period is captured and stored so that it will be promptly retrievable.

Limitation Act

Section 11 of the Limitation Act 1980 states the limitation period for actions including damages for personal injury, is three years from the date at which the cause of action accrued – this normally being the date of the injury. For minors at the time of the accident, the period is three years from when they reach age 18.

QBE recommends that all records relating to accidents should be retained for at least seven years from the date of an accident or if the injured party is a minor, seven years after they reach age 18.

The limitation period may differ in disease claims and may be three years from the claimant's date of knowledge or from the date when it was reasonable to have acquired knowledge that their disease or illness may be connected to their work. The date of knowledge may therefore be some time after the date of any exposure.

Documentation relating to potential short tail disease claims such as Occupational Asthma, Hand Arm Vibration Syndrome and Dermatitis, should be retained for seven years after exposure to the work activity ceased. For long-tail disease claims such as Noise Induced Hearing Loss, Asbestos related disease, Silicosis, COAD, COPD records should be retained for 40 years, as it could be many years before employees begin to suffer symptoms.

Employee work history records should be reviewed to confirm that sufficient information is held to clearly identify what roles, jobs, departments and work areas the individuals were engaged in, and for what periods. Safety arrangements that were in force in a particular area, for example job rotation, should also be recorded with dates indicating the periods they were effective.

Fraud identification

Guidance



When things don't seem quite right

Accidents happen, but sometimes things are not as clear cut as they suggest. From 2010 to date, QBE have received 78,000 fraud referrals. 24,000 claims were successfully investigated for fraud, and over £600m of savings have been made for our customers.

Here are some things to consider when a claim is received that can help assist the fight against fraud.

- Has there been a “tip off” that the incident was staged or exaggerated?
- Is the claimant unwilling/unable to provide specifics of where and when the accident happened?
- Is the timing of the incident unusual?
- Check for available CCTV of the accident area, and ensure that pre-accident and post-accident footage is also stored as this can be also important to review behaviours and reactions. CCTV footage often has an overwriting timescale of 30 days, so it's important this is obtained as soon as possible.
- Were there any witnesses to the incident? Gather their names and contact numbers to allow statements to be taken by your insurer. Similarly, if there are employees who assert that no incident occurred at the alleged time, please also provide their details.
- Compile the claimant's attendance records, occupational health records, disciplinary records and any incident logs for your insurer to review to compare against the allegations and evidence provided by the claimant.
- Take a look at the claimant's pre- and post-accident behaviour; has there been any instances involving them that are out of character? Have they had any changes to their personal circumstances such as divorce, civil or criminal convictions, financial detriment etc. Does the claimant have any personal relationships with colleagues who may be able to provide insight?
- Is the claim for an occupational disease NIHL, asthma, ULD, deafness, etc despite an apparent absence of causative exposure?
- Should you decide to review the claimant's social media, as well as any screenshots you have obtained, please provide URL links to any accounts to allow your insurer to review also.

Accident investigation report checklist



	Question	Yes	No	Please state why 'no' below
01	Has your organisation's accident investigation policy and procedure been followed?	<input type="checkbox"/>	<input type="checkbox"/>	
02	If applicable, has the event been reported per RIDDOR requirements? Further guidance can be found here: www.hse.gov.uk/riddor/	<input type="checkbox"/>	<input type="checkbox"/>	
03	Has your Employers' Liability insurance or Public Liability carrier been informed in line with policy conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
04	Has a trained and competent person within your organisation reviewed the accident investigation report to ensure liability has not inadvertently been admitted?	<input type="checkbox"/>	<input type="checkbox"/>	
05	Are suitable and relevant photographs included in the accident investigation report?	<input type="checkbox"/>	<input type="checkbox"/>	
06	Have photographs been taken at various angles and distances so that the reader of the accident investigation report can fully appreciate the accident scene?	<input type="checkbox"/>	<input type="checkbox"/>	
07	Have items been used to demonstrate the scale of photographs taken? For example, a fifty pence coin can be used to illustrate how big something is.	<input type="checkbox"/>	<input type="checkbox"/>	
08	Have all witnesses (eyewitnesses, witnesses to events surrounding the accident, negative witnesses) been identified at the accident scene?	<input type="checkbox"/>	<input type="checkbox"/>	

Risk Essentials – Accident Investigation Report Checklist

	Question	Yes	No	Please state why 'no' below
09	Are witness statements included in the accident investigation report?	<input type="checkbox"/>	<input type="checkbox"/>	
10	Does the witness statement contain all the relevant witness details (name, surname, address, contact number)?	<input type="checkbox"/>	<input type="checkbox"/>	
11	Does the witness statement provide details of where the interview took place, such as face-to-face, MS Teams, etc?	<input type="checkbox"/>	<input type="checkbox"/>	
12	Are witness statements fully legible?	<input type="checkbox"/>	<input type="checkbox"/>	
13	Is each page of the witness statement numbered with the witness's initials?	<input type="checkbox"/>	<input type="checkbox"/>	
14	Are all paragraphs within the witness statement numbered?	<input type="checkbox"/>	<input type="checkbox"/>	
15	Are all spaces within the witness statement crossed out and initialled?	<input type="checkbox"/>	<input type="checkbox"/>	
16	Does the witness statement include a statement of truth?	<input type="checkbox"/>	<input type="checkbox"/>	
17	Has documentary evidence of the adverse event been identified and included in the accident investigation report? For example, risk assessments, maintenance records, safe systems of work, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
18	If applicable, has CCTV footage been secured to support the accident investigation?	<input type="checkbox"/>	<input type="checkbox"/>	
19	Has the adverse event been recorded within the accident book or its equivalent?	<input type="checkbox"/>	<input type="checkbox"/>	
20	Has a sketch plan of the layout of the work area been included in the accident investigation report?	<input type="checkbox"/>	<input type="checkbox"/>	
21	Does the sketch plan include the location of any CCTV?	<input type="checkbox"/>	<input type="checkbox"/>	
22	Have environmental conditions on the day of the accident been reported within the accident investigation report? For example, weather, visibility, temperature, etc.	<input type="checkbox"/>	<input type="checkbox"/>	

Risk Essentials – Accident Investigation Report Checklist

	Question	Yes	No	Please state why 'no' below
23	Has a scene log been included in the accident investigation report? This document should record any changes made to the accident scene.	<input type="checkbox"/>	<input type="checkbox"/>	
24	Have human factors been considered within your accident investigation? Further guidance can be found within the following link: www.hse.gov.uk/pubns/books/hsg245.htm	<input type="checkbox"/>	<input type="checkbox"/>	
25	Has a root cause analysis been conducted so that immediate causes, underlying causes, and root causes are correctly identified?	<input type="checkbox"/>	<input type="checkbox"/>	
26	Has a post-event action plan been implemented to track remedial actions until completion?	<input type="checkbox"/>	<input type="checkbox"/>	
27	Is all the pertinent information centrally stored and available in the event of HSE interaction or claim presented	<input type="checkbox"/>	<input type="checkbox"/>	

Name of person completing the checklist

Job role

Signature

Accident investigation report template



It is essential to understand that the processes associated with the accident/incident investigation (AI) report will contribute to the identification and implementation of remedial actions to prevent accident/incident reoccurrence; in addition, the AI report is a critical document in the event of a criminal prosecution or civil liability claim. An AI report is one key piece of evidence to manage a civil liability claim. The AI report is a disclosable document when a civil liability claim is litigated and should capture relevant facts and appropriate/missing documentation so the correct decision on liability can be made quickly and efficiently. It's vitally important that only facts are recorded within the accident investigation report. Recording hearsay, uncorroborated evidence and opinions can negatively impact the management of a civil liability claim and the outputs of the accident investigation process.

The purpose of this form is to record all accident or incident events. The term accident is used where injury or ill health occurs. The term incident includes near-misses and undesired circumstances where there is the potential for injury.

- **Part 1** should be filled out immediately by the manager or supervisor for the work activity involved.
- **Part 2** should be completed by the person responsible for health and safety.
- **Part 3** should be completed, where appropriate, by the investigation team.
- The investigating team and managers should complete **parts 4 & 5** with the authority to make decisions.
- **Part 6**, the appendices section of this report, should always be populated as the information within is vital to the civil liability claims management process.

Please note that the example on the following pages is fictitious and is used to demonstrate how the report template and associated models should be used.

Note: guidance text is highlighted with an orange outline within this document.

Part 1

Overview

Reference number

QBE 001

Reported by

Wesley Ruane

Employee position

FLT Driver

Name and role of injured person

Ali Fox – Apprentice Engineer

Date of adverse event

23 / 06 / 23

Time

10am

Type of event

Incident Ill health Minor injury Serious injury Specified injury

Site address

9 QBE Way
Liverpool
Merseyside
L11 8BR

Location of accident

Aisle 6, warehouse

Brief details of event circumstances (what, where, when, who and emergency measures taken)

Ali Fox entered the warehouse to collect inventory information to support an order she was making on the day of the accident. Whilst walking through the warehouse area, it is reported that she was struck by a forklift truck (FLT – Asset number 24563) driven by Wesley Ruane, resulting in her being knocked unconscious. Immediate first aid was given, and emergency services were called, who then attended the accident scene. The ambulance service then transferred Ali to the hospital. Operations have ceased within the warehouse, and the FLT has been quarantined until further investigation occurs.

Name of witness(es)

Bobbie Wills (Site Supervisor)
Wesley Ruane (FLT Driver)

Contact details

0788909XXXX
0705467XXXX

Reported to

Vikki Preston (H&S Manager)

Date

23 / 06 / 23

Time

11am

Time lost event day (first day of absence)

24.06.23

Injured person return-to-work date

The injured person has not yet returned to work.

Part 2

Initial assessment

(To be carried out by the local health-and-safety-nominated person)

The decision to investigate

The table below will assist you in determining the level of investigation which is appropriate for the adverse event. Remember you must consider the worst potential consequence of the adverse event (e.g. a scaffold collapse may not have caused injuries but had the potential to cause major or fatal injuries).

Likelihood of recurrence	Potential worst consequences of adverse event			
	Minor	Serious	Major	Fatal
Certain	Minimal	Low	Medium	High
Likely	Minimal	Low	Medium	High
Possible	Minimal	Low	Medium	High
Unlikely	Minimal	Low	Medium	High
Rare	Minimal	Low	Medium	High

Risk	Minimal	Low	Medium	High
Investigation level	Minimal level	Low level	Medium level	High level

Further information on this process can be found within HSG245. The link is provided below:
www.hse.gov.uk/pubns/hsg245.pdf

Part 2

Initial assessment

continued

Type of event

Incident Ill health Minor injury Serious injury Specified injury

Actual/potential for harm

Fatal Major Serious Minor Damage only

RIDDOR-reportable?

Yes No

RIDDOR reported to the HSE?

Yes No

If 'yes', please provide the date

15 / 03 / 23

Reported by

Chris Barker (Director)

Via

Phone Online

Call received by an HSE inspector?

Yes No

Has an entry been made into the accident book?

Yes No

If 'yes', please provide the date

15/03/24

Reference

QBE 003

Investigation level

High level Medium level Low level Minimal level

Initial accident assessment carried out by

Bobbie Willis

Date

23 / 06 / 23

Further investigation required?

Yes No

Priority

Immediate (example)

For investigation by

Vikki Preston (H&S Manager)

Jo Taylor (Site Manager)

Bobbie Willis (Site Supervisor)

Part 3

Investigation information gathering

Where did the adverse event happen?

Main warehouse, aisle 6, rack 1

Date of adverse event

23 / 06 / 23

Time

11am

Who was injured/suffered ill health or was otherwise involved with the adverse event?

Ali Fox – Apprentice Engineer – Injured Person (IP)
Wesley Ruane – FLT Driver – Witness

How did the adverse event happen? (Note any equipment, substances or articles involved.)

The FLT Driver was working within the warehouse area, conducting standard loading/unloading activities on the adjustable pallet racking system. After finishing a loading activity, the FLT driver stated that he proceeded to leave racking (row 4) to gain access to racking row 7 to pick up a load. While moving out of racking row 4, the driver states that he took a right turn, which resulted in the collision with the IP. The driver states that he shut down the FLT and immediately began to administer first aid to the IP.

What activities were being carried out at the time?

Standard FLT loading and unloading activities were taking place within the warehouse at the time of the activity. The IP states that her supervisor (Stephen Brown) verbally instructed her to enter the warehouse area to collect an inventory document (Form 02QBE) to support an order she was making on the day of the accident. The IP’s supervisor confirmed this instruction.

Was there anything unusual or different about the working conditions?

No issues have been identified in relation to the working environment.

Were there adequate safe working procedures, and were they followed?
(Inclusive of monitoring arrangements and supervision.)

Yes. Safe working procedures were in place (SSOW 002) within the health and safety management system. These requirements are usually communicated through the origination’s induction process. The IP had not gone through the induction process and gained unauthorised access to the warehouse area. Physical controls to prevent unauthorised access were not in place.

What injuries or ill-health effects, if any, were caused?

The IP suffered a fracture to the clavicle and a fracture to the tibia.

If there was an injury, how did it occur, and what caused it?

The injury was caused by the collision between the IP and the FLT, which resulted in the IP being knocked off balance and falling to the ground.

Part 3

Investigation information gathering

continued

Was the risk known? If so, why wasn't it controlled? If not, why not?

The risk of unauthorised entry to the warehouse was a known risk, and the organisation's management system set out to minimise this risk through the induction process, in which rules regarding entry to work areas are communicated. On this occasion, the IP was a new starter to the business and missed her planned induction due to other work commitments. The IP's supervisor stated that he was unaware that the IP had not attended the induction, so he instructed her to enter the work area. The IP alleges that no one within the organisation instructed her that access to the warehouse is prohibited unless the induction process has been completed.

Did the organisation and arrangement of the work influence the adverse event?

(Noting any changes to process or environment.)

Controlled entry to the warehouse was not in place, allowing the IP to access an operational area without the correct training.

Was maintenance and cleaning sufficient? If not, explain why not.

Yes.

Were the people involved competent and suitable?

No, the IP had not received the appropriate induction training to enable her to enter the warehouse area.
The FLT driver was adequately trained to conduct the task he had been assigned.

Did the workplace layout influence the adverse event?

No. Authorised pedestrian routes were in place and adequately maintained.

Did the nature or shape of the materials influence the adverse event?

No.

Did difficulties using the plant and equipment influence the adverse event?

No.

Was the safety equipment suitable and sufficient? (For example, machinery guarding, PPE, etc.)

Yes.

Did other conditions influence the adverse event? (Environmental factors e.g., weather, lighting, work hours.)

No.

Part 4

Root cause analysis

This section of the accident investigation report template focuses on root cause analysis. The primary objective of root cause analysis is to identify immediate, underlying and root causes so that measures can be implemented to prevent recurrence. See below the definitions of the aforementioned elements:

- **Immediate causes** – the most obvious reason why an adverse event occurs.
- **Underlying causes** – the less obvious system or other failures.
- **Root causes** – initiating events from which all other failings or causes spring.

There are many root cause analysis models that can be utilised within the accident investigation process, such as fault tree analysis and failure mode and effect analysis. When conducting accident investigations, these models can effectively identify immediate, underlying, and root causes. Many more root cause analysis methodologies can be applied to accident investigations, but we cannot address each within this guidance document. See the links below for further information on the aforementioned models.

- www.safetyculture.com/topics/fault-tree-analysis/
- www.hsestudyguide.com/failure-mode-effect-analysis-fmea/#:~:text=It%20involves%20identifying%20failure%20modes,before%20they%20lead%20to%20accidents
- [Risk Essentials – Accident Root Cause Analysis](#)

In addition, a helpful method is the fishbone methodology, which is regularly utilised in multiple industries. A fishbone diagram root cause analysis visually represents an accident/incident and its possible causes, which can facilitate communication and collaboration with team members and stakeholders to identify immediate, underlying, and root causes. Further information on the fishbone diagram root cause analysis model can be found in the following link:

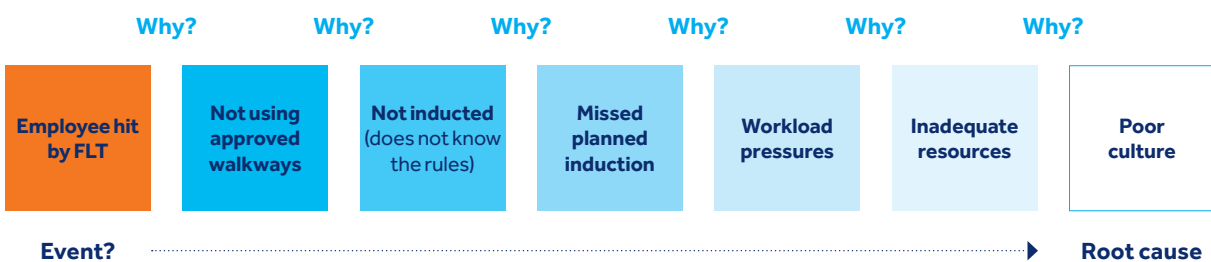
- www.designorate.com/problem-solving-cause-and-effect-diagram/

For the purposes of this guidance document, we will apply the 5 Whys root cause analysis models to the scenario provided. See the definitions below for this model.

- 5 Whys (or 6 Whys) is an iterative interrogative technique used to explore cause-and-effect relationships.

5 Whys root cause analysis for this document’s scenario

Note: Readers may produce a different 5 Whys sequence than that presented in this paper; this is an example only. This point also reinforces that root cause analysis should be conducted as a team so that various perceptions are captured when working through the model. Although this model is named “5 Whys” there does not have to be five causation factors; this can be more or less depending on the circumstances.



Part 5

Findings and remedial actions

Once the root cause analysis has been completed, remedial actions will have been identified to prevent reoccurrence; see below example:

Findings

Engineering controls, risk assessment, and SSOW's should have resulted in restricted access to the warehouse to authorised personnel only through a security key fob entry system. This control would eliminate an untrained, unauthorised employee accessing restricted areas. Administrative controls, such as induction training on rules and instruction, come next within the risk assessment hierarchy of controls and rely on human behaviour, so reliance on these controls in isolation should not have been accepted by the organisation.

Remedial actions

- 01 Check training records and management system requirements
- 02 Design and implement an access/egress system in the warehouse
- 03 Implementation of an organisational safety culture programme
- 04 Etc
- 05 Etc
- 06 Etc

Note: Further controls can be identified from this scenario, but they have not been included within this document as this is for guidance purposes only.

Do similar risks exist elsewhere? If so, what and where?

Yes, multiple warehouse operations are included within the site footprint. Therefore, remedial actions must be implemented holistically to ensure adequate risk control.

Have similar adverse events happened before? If so, give detail.

No.

Part 5

The risk control action plan

Who will take responsibility for remedial actions? (Include timescales)

Control measure	Expected completion date	Person responsible
01 Check training records and management system requirements		
02 Design and implement an access/egress system in the warehouse		
03 Implementation of an organisational safety culture programme		

Which risk assessments and safe working and management procedures need to be reviewed and updated?

Name of risk assessment and safe working procedure	Expected completion date	Person responsible
01 Traffic management		
02 Induction		

Have the adverse event details and the investigation findings been recorded and analysed?
Are there any trends or common causes that suggest further investigation? What did the adverse event cost?

Details have been recorded – no trends or common causes. Estimated cost of accident unknown at this time.

Signed on behalf of the investigation team

Vicky Preston

Name and position

Vikki Preston (H&S Manager)

Members of the investigation team

Vikki Preston
Jo Taylor
Bobbie Wills

Position

H&S Manager
Site Manager
Site Supervisor

The findings of this investigation need to be communicated to the following managers, union and employee safety representatives.

Person	Position	Date
Chris Barker	Director	02 / 07 / 2023
Lesley Fox	Operations Manager	02 / 07 / 2023
Stephen Taylor	Regional manager	02 / 07 / 2023

Part 6

Appendices

Note: This is not a comprehensive list of information that must be collected as part of an accident investigation. Below is an example of potential evidence that may need to be collected.

- Appendix A – Witness statements
- Appendix B – Photographs
- Appendix C – Sketches and plans
- Appendix D – Risk assessments
- Appendix E – Safe operating procedures
- Appendix F – Maintenance records
- Appendix G – Induction records
- Appendix H – Associated safe working procedures
- Appendix I – Training records
- Appendix J – Monitoring records
- Appendix K – Associated briefings
- Appendix L – Toolbox talks



Witness statement template

Internal reference number

Date

Time

Full name (including if known by another name)

Occupation (interviewee's role)

Address

Contact number

Interview location (for example, face-to-face, Microsoft Teams, etc.)

Witness statement

- In the witness's own words.
- Be fully legible.
- Each page should be numbered and bear the witness's initials.
- Paragraphs should be numbered.
- Any empty space should be crossed out, initialled, and dated by the witness.
- Start the statement with the following: I, (insert name) of the above address, am employed by (insert employer's name and address) as a (insert position) make this statement of my own free will. On the (insert accident date) I was

Statement of truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes or causes to be made a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signature of the witness

Date

Note: The PEACE model is a helpful framework to help support the witness statement-taking process; further information can be found within the following link: www.college.police.uk/app/investigation/investigative-interviewing/investigative-interviewing#peace-framework

For more information please contact

David Dexter

Risk Solutions Practice Leader

– Casualty & Construction

David.Dexter@qbe.com

Or visit qbeurope.com/risk-solutions/

QBE European Operations

30 Fenchurch Street

London EC3M 3BD

+44 (0) 20 7105 4000

QBEurope.com

QBE European Operations is a trading name of QBE UK Limited, QBE Underwriting Limited and QBE Europe SA/NV. QBE UK Limited and QBE Underwriting Limited are both authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority. QBE Europe SA/NV is authorised by the National Bank of Belgium under licence number 3093.