HEALTH & SAFETY GUIDANCE

INCIDENT INVESTIGATION

GUIDANCE TITLE	Incident investigation		
PUBLICATION	February 2025	CURRENT VERSION	1 (Feb 25)
APPROVED BY	Director of Workplace Safety, Health & Wellbeing	NEXT REVIEW DUE	February 2028

PURPOSE	Provide individuals who are tasked with investigating health & safety incidents with a standard best practice approach, to ensure that all investigations are conducted consistently and effectively.

1. Introduction to health & safety investigation

1.1 Legal duty of employers

Under the Management of Health & Safety Regulations 1999, the University has a duty to monitor and review its health & safety arrangements to make sure they remain effective. This includes having a formal process for investigating incidents so that shortfalls in workplace health & safety management can be identified, and corrective actions can be made.

1.2 Purpose of investigating

The investigation process should work through establishing 4 key objectives:

FACTS
What are the key factual details of the incident?

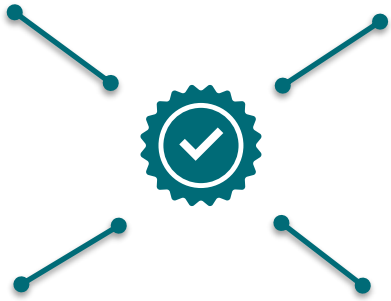
CAUSES
What went wrong and why?

SHORTFALLS
Were there inadequacies in the current health & safety arrangements that contributed to the incident?

CORRECTIVE ACTIONS
Do improvements need to be made to current health & safety arrangements so that the incident can be prevented in future?

1.3 Core principles of investigation

For an investigation to be effective, it should be conducted in line with the following core principles:



OBJECTIVITY
An evidence-based approach should be used to make fair and well-reasoned judgements.

IMPARTIALITY
Investigation has a systems-focused agenda. It does not seek to target individuals for blame or punishment.

PROPORTIONALITY
The robustness of the investigation should be in proportion with the nature & severity of the adverse event, factoring in the shortfalls that are apparent.

SUSTAINABILITY
Investigation should focus on tackling underlying failings at the organisational & management level. This way improvements will have the biggest impact with lasting effects.

2. Causes

It is essential to investigate how an adverse event was able to happen, so that we can learn lessons and make targeted corrective actions. There are 3 types of causes:

1. IMMEDIATE CAUSE
The most obvious and direct reason for the adverse event.
See examples below.

Example 1

A cut injury to the finger which was caused by contact with an unguarded circular saw

Example 2

A spillage of a hazardous chemical which was caused a glass beaker being knocked from the laboratory bench onto the floor

Example 3

A car lost control on a corner and collided with a building, which was caused by driving way above the speed limit on campus

2. UNDERLYING CAUSES

Shortfalls in organisational arrangements which lead to the immediate cause.
The main factors are listed below.

Risk Assessment

The task was carried out without the proper safeguards in place, as a risk assessment had not been done / was done poorly

Training & Competency

The person involved was not aware of the safeguards needed to carry out the task safely, as they had not been given adequate information, instruction & training

Work Equipment

The work equipment used to carry out the task was poorly maintained, which led to a defect that caused the incident

3. ROOT CAUSES

Systemic issues with health & safety infrastructure that allow underlying causes to develop & persist.
The main factors are listed below.

Processes

Formal processes that are needed to coordinate health & safety are absent or inadequate, such as:

- Risk assessment
- Training & competency
- Equipment maintenance
- Monitoring

Compliance

Failure to follow processes & procedures either due to lack of awareness & understanding, or lack of effort.

Leadership & Culture

Health & safety management is not given proper recognition as a critical business need. There is a lack of engagement and poor communications to support workplace health & safety.

3. Conducting the investigation

3.1 Planning the investigation

The following elements need to be considered when preparing to investigate:

Personal Safety

Never enter the scene of an adverse event until the area has been made safe.

Personal Protective Equipment (PPE)

Before entering a workplace, consider the PPE needed to comply with local rules.

Equipment

Consider equipment to take with you for capturing photographs or videos, taking measurements or other readings.

Contacts

Who are the relevant people to facilitate the investigation:

- Injured / affected person
- Eye witnesses
- First responders
- Workplace managers

Documents

What documents do you need to access for review:

- Risk assessments
- Training records
- Equipment servicing reports

3.2 Gathering & analysing evidence

An objective investigation is dependent on tangible evidence, so that we can establish how and why an adverse event occurred. It is crucial that evidence is gathered and put on record, as justification for the outcome of an investigation.

Several key types of evidence should be considered when carrying out an investigation:

Evidence type	Value
Photographs & videos	Images preserve the state of the scene and give valuable insight in what contributed to the incident e.g. equipment failure. Video records, where accessible, are incredibly useful in giving the audience a direct observation of the incident.
Accounts from people who observed the incident or were involved (witness statements)	Firsthand perspective on how the situation materialised, and confirmation of the steps that were taken in response to the incident. Witnesses can add useful details which could identify causes e.g. human factors, procedural lapses or workplace environment issues.
Documentation (e.g. risk assessments; training records; standard operating protocols; maintenance reports; local record logs	Verify that the work activity was being carried out under the proper planning, organisation & control.
Expert analysis	Assessment & judgement from relevant professionals on how or why something went wrong e.g. specialist equipment.
Data & measurements	Any relevant sources of data may be useful to establishing the timings and circumstances of an incident e.g. digital access logs; digital equipment monitoring.

Collectively, the evidence should be enough to reasonably establish a factual chain of events, how & why the adverse event occurred and identify gaps in health & safety arrangements that contributed to it.

NOTE: evidence that has been gathered as part of an investigation must be stored in a departmental electronic shared folder that is accessible to operations staff. Investigation records should not be stored in the personal drive of the investigator as there is a risk that the data can be lost if they cease employment.

3.3 Deciding on corrective actions

Once the causes of an adverse event have been identified, then a decision needs to be made on corrective actions to take in an effort to prevent recurrence. Some common examples are listed below:

Corrective action type	Applications
Communication & awareness	In many cases, the incident may have simply resulted from human error and was not attributed to any significant gaps in the safety arrangements. In this case it is appropriate to send out communications to all relevant workers, making them aware of the incident and reminding them of the correct protocols to follow. This can be through digital channels (e.g. a safety alert) or could be shared in a team meeting.
Training & supervision	Often, incidents happen because individuals have not had the proper training to be fully competent to carry out the task. They should be earmarked for training in the risks and safeguards needed to carry out the task. They should also be given the proper level of supervision to ensure that they are competent to carry out the task autonomously, in line with the safety standards. Similarly, it is best practice to provide retraining / refresher training to an individual involved in the incident. It would also be useful to extend the retraining / refresher training session to other colleagues who carry out the same task.
Equipment maintenance	If the incident involved defective facilities or work equipment, then remedial action needs to be taken (repair or replace) to make safe for use.
Safety monitoring	Factors may have contributed to the incident, such as: • Deterioration of workplace environment & safety standards • Deterioration of work equipment & work practices • Poor compliance with H&S processes Ultimately these can develop due to inadequate monitoring. Enhanced safety monitoring can be introduced so that remedial action can be taken at the soonest opportunity.
Review & revision of workplace safety measures	An incident can trigger rethinking of how safety can be better planned, organised and controlled, for example: • Introduction of useful signage or visual instructions • Re-organisation of the workplace or practical systems that can be introduced to improve safety or compliance • Considering safety of equipment – whether more modern equipment can be used with better safety features, or adjustments need to be made to existing equipment.
Review & revision of standard operating protocols	User documents (codes of practice; instruction manuals; standard operating procedures) may need to be updated with key details to factor in lessons learned and better practices.

NOTE: It is a legal requirement to review the adequacy of a risk assessment in response to an incident that has occurred and consider improvements.