

# Health and safety: accident investigation reports

## Latest Update

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## Author(s)

Laura Clare - Squire Patton Boggs

Rob Elvin - Squire Patton Boggs

An Accident Investigation Report is usually completed by an employer following an accident or a near miss. It should provide a detailed review of the incident and ensure that facts are recorded as accurately as possible, in order to protect the interests of all parties involved. It has become common for the Health and Safety Executive ("HSE") and Local Authorities ("LA") to request a copy of the Accident Investigation Report as part of their investigation and therefore the contents should be carefully considered. Businesses should consider whether an Accident Investigation Report should be created under Legal Professional Privilege, although the creation of a privileged report is not straightforward.

## Overview of Topic

1. **Requirements for written health and safety arrangements:** There is no specific requirement in law that an Accident Investigation Report must be completed. [Section 2\(3\)](#) of the [Health and Safety at Work etc. Act 1974](#) (HSWA) states that:  
"it shall be the duty of every employer to prepare and as often as may be appropriate revise a written statement of his general policy with respect to the health and safety at work of his employees and the organisation and arrangements for the time being in force for carrying out that policy, and to bring the statement and any revision of it to the notice of all of his employees."
2. There are also requirements on employers to plan, organise, control, monitor and review their health and safety arrangements ([reg.5](#) of the [Management of Health and Safety at Work Regulations 1999/3242](#) (MHSWR)), and to keep an accident record book under [reg.12](#) of the [Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013/1471](#) (RIDDOR). However, there is no express legal requirement on businesses to carry out an investigation or to prepare an Accident Investigation Report.

3. Most businesses will have a health and safety policy in order to comply with the requirements above, and this may contain an accident and near miss reporting and investigation procedure. Through this, a business and its employees will be guided in how to deal with near misses or accidents, and in deciding what type of investigation, if any, should be undertaken. It is common for businesses to record minor incidents and near misses very simply, making a note of only the place, location and any remedial steps taken. If an incident occurs by which an employee or contractor becomes seriously injured, however, then a more thorough accident investigation may be required. The decision factors for when an incident is deemed serious enough to warrant an accident investigation, may be included in a business' health and safety policy or a specific accident investigation protocol.
4. **Accident Investigation Reports and regulators:** The business' investigation may be linked to, or coincide with, an investigation by a regulator. For health and safety incidents the investigator is likely to be the HSE, a LA or the Police (if there has been a fatal accident). The decision to prepare an Accident Investigation Report might be motivated by the involvement, or potential involvement, of a regulator. If a regulator is involved in the incident in the early stages, then the Accident Investigation Report might be influenced by any particular queries raised by the investigating inspector or officer and this will aid the business in answering questions.
5. If a regulator is not involved during the early stages of an incident, the business might consider that a regulator could become involved at a later stage. Under RIDDOR, businesses are required to report certain accidents and dangerous occurrences in the workplace, which are covered by the regulations. The RIDDOR report will be received by the HSE and this may trigger an investigation. Not all accidents which are reported are then investigated, as regulators only have a limited amount of resource, and so regulators will prioritise which incidents are investigated. The HSE will determine this in accordance with certain [incident selection criteria](#) and the [Enforcement Policy Statement](#) (EPS).
6. However, the HSE *will* investigate (at first with the police), in all instances where there has been a workplace fatality, and a business may also expect a regulatory investigation where the incident involves a serious risk of harm (including incidents involving work at height and/or workplace transport). Setting up an accident investigation protocol may assist businesses in deciding whether an Accident Investigation Report would be necessary.
7. The regulator will commonly ask for a copy of the Accident Investigation Report, as a starting point for the business' findings of what occurred, and whether there are any failures or breaches of the law or the business' own procedures.
8. **Accident Investigation Report and Legal Privilege:** Where it is considered likely that a Regulator may become involved, a business should consider seeking legal advice. Legal advice might be useful in the context of both submitting a RIDDOR report, and in deciding whether an Accident Investigation Report should be carried out, and if so, how? Both could contain self-incriminating evidence. An Accident Investigation Report prepared in the [contemplation of legal proceedings](#) under the advisement of a business' legal team should be covered by legal privilege.
9. In order for a report to attract legal privilege however, there is a strict test to prove that it was created for the "dominant purpose" of litigation. In [Waugh v British Railways Board \[1980\] A.C. 521](#) the House of Lords adopted the dominant purpose test when

considering whether an accident investigation report was legally privileged. It was decided that a claimant must show that the relevant document is made with the dominant purpose of being used in, or in connection with, litigation. Use in such litigation need not be the sole purpose for which it is made, and can be used for other purposes other than litigation; however, where a document has other purposes, its use in or connection with, the litigation must be dominant.

10. The facts of *Waugh* related to a claim brought by a widow under the [Fatal Accidents Act 1846](#) following the death of an employee of the British Railway Board. A report of this accident was created two days following the incident, incorporating many witness statements of other employees who had been at the scene. The British Railway Board refused to disclose the report, and an application for specific disclosure was made. The Board asserted that personal injury claims were "commonly anticipated" and would assist their solicitors in determining liability. It was decided that the report had to be disclosed, and that the accident report had not been the dominant purpose of the creation of the report, but that the safe operation of the railway had been the main purpose of the investigation.
11. However, an accident investigation report can be privileged as was the case in [McAvan v London Transport Executive \(1983\) 133 N.L.J. 1101](#), where the Court of Appeal held that the dominant purpose of the information gathering into a number of reports was to enable to defendant to be advised on its prospects in relation to any legal claim.
12. However, the difficulties in claiming litigation privilege over accident investigation reports should not be underestimated and [Rawlinson and Hunter Trustees SA & ors v Akers & anr \[2014\] EWCA Civ 136](#) highlighted that the courts are likely to take a strict approach in determining the purpose for which a report or document is prepared when assessing claims to litigation privilege. When asserting privilege, clear and precise evidence of the dominant purpose of the report must be provided and 'vague or equivocal' evidence is not likely to satisfy the courts.
13. It is important to note that simply heading an accident report "legally privileged" or "prepared in contemplation of litigation" will not be determinative of the "character of the report" (Lord Strathclyde in [Whitehill v Glasgow Corp 1915 S.C. 1015](#) at 1017, quoted by Lord Edmund-Davies in [Waugh](#) at 539), and will not be considered by the Court. The labelling of documents may however assist employees in an investigation to identify potentially privileged documents at an early stage, so that they can be set aside until further legal advice can be taken as to whether such documents should be disclosed.
14. Depending on what the circumstances of the incident are, the findings of the report and whether the business considers it is in a strong position, the business may still consider waiving privilege and disclosing the Accident Investigation Report to a regulator. This can be a good way for the business to demonstrate transparency and co-operation with a regulator, despite a document being legally privileged. It might go to persuade a regulator that enforcement action is unnecessary or not justified. Where an Accident Investigation Report might highlight a potential breach of the law, the business may be advised not to disclose the report to the investigator, but only where the report is legally privileged.
15. **The accident investigation team:** The accident investigator has an important role, as they should have knowledge of both the law regarding health and safety and the business and its policies. The accident investigator will be required to collect

information from a number of sources, and the key issue for an investigator is that they must be impartial and should report impartially. The person responsible for completing an Accident Investigation Report should not be "too close", nor have a vested interest in the outcome, and should not be a direct manager of those involved in the incident. The person responsible for completing the Accident Investigation Report therefore might not be the person who was first on the scene of an incident and so their ability to gather information will be crucial.

16. The accident investigator might need support from those with more in depth knowledge of the business' processes, particularly in a large scale workforce, where procedures are technical and varied. It is therefore a good idea to establish the parameters of the investigation before it commences, and to appoint those persons available to assist.
17. Where an Accident Investigation Report is carried out under legal privilege, the investigation team should be requested to keep all communications marked privileged and to ensure that communications are copied to the legal advisors to try and maintain legal privilege around the investigation and corresponding communications. This will not only include the accident investigation report, but any other related documents including witness statements.
18. **Investigation Process:** The Investigation itself is a complex process, and the HSE has issued guidance ([HSG245](#)) on what steps might be reasonably considered during an investigation.
19. The Accident Investigation Report may be completed in several phases which the HSE suggest are:
  - a. Step one: Gathering the information;
  - b. Step two: Analysing the information;
  - c. Step three: Identifying risk control measures;
  - d. Step four: The action plan and its implementation.
20. **Gathering Information:** The HSE recommends that investigations should be done in a timely manner and the sooner an investigation can take place after an incident the better. Information will need to be gathered from a number of sources, including witnesses and potentially an injured employee. Recollection of events will deteriorate not long after the event, therefore the accident investigation should be commenced as soon as reasonably possible after it is decided one is required.
21. The investigator should aim to investigate all reasonable lines of enquiry and should identify in a structured manner, what is known, what is not known and what records are available. Investigations should not take any comments at face value. If a witness states that they "just knew it should be done like that", the investigator should ask, how did they know, was it covered in training, was a risk assessment, or method statement available? Were there any specific reasons that a procedure was not followed in the particular circumstances?
22. Photographs of the scene should be taken and labelled, photographs of any equipment used should be taken, particularly where machinery is used and photographs should be taken of the equipment's final position. If an incident has occurred during the technical operation of a piece of equipment, an investigation and assessment of the procedure and operation of the equipment should be done so that the investigator can first

understand how the machine is operated. Notes should be taken of all the details available, including the manufacturer, model type, model number, machine number and year of manufacture and any modifications made to the equipment.

23. The HSE suggests that in the gathering information stage, there are three key questions which should be asked:
  - a. Where and when did the adverse event happen?
  - b. Who was injured/suffered ill health or was otherwise involved with the adverse event?
  - c. Was the risk known? If so, why wasn't it controlled? If not, why not?
24. **Analysing the information:** The HSE does not advocate any one method to analyse or investigate incidents, however the information gathering stage and analysis stage will often take place side by side. All businesses are different and it may be that one method might be more convenient than another, in some workplaces for example a team approach might be more beneficial in identifying all the root causes, or any gaps in the analysis.
25. The analysis of the information might simply be that the investigator keeps asking the question - why? Or it could be that a more complex approach is taken, such as [Events and Causal Factor Analysis](#), which is a more formulaic approach to analysis. An investigator could also use a simple checklist of questions about the possible immediate causes of the incident (the place, the plant, the people and the process) and identify which are relevant. The investigator would then record all the immediate causes identified and the necessary risk control measures.
26. Great care should be taken when addressing human factors in an investigation. If upon reviewing all of the information, it seems that human error, negligence or a lack of care might have contributed greatly to the incident, then correctly identifying this will be important. However, the way in which this is worded will need to be considered, as if the report is later disclosed to a regulator the business would want to avoid the impression that it blames the employee for the entire incident, unless of course that is fair. But more often than not, and unless it was not reasonably foreseeable that an employee would behave in a certain way (and similar to the principle in various liability that an employee is on a [frolic of their own](#)), the company must consider all potential causes.
27. **Step Three: Risk control measures:** Through the information and analysis stage, the accident investigation will have likely uncovered some further risk control measures. For the Accident Investigation Report purposes, it is important to identify whether the company believes that the risk control measures in place were already adequate and compliant with legislative requirements. It is possible from any incident, that learning will take place and improvements can always be made. It might be appropriate for a company to identify these new control measures as enhancements, rather than remedial steps, where appropriate. If the investigation has identified that there were gaps in the risk control measures, and that new measures have been put in place which fill these gaps, then this should be identified.
28. The HSE identifies that there are three types of risk control measures:
  - a. measures which eliminate the risk, e.g. using a water-based product rather than a hydrocarbon-based solvent;

- b. measures which combat the risk at source, e.g. the provision of guarding;
  - c. measures which minimise the risk by relying on human behaviour, e.g. safe working procedures, the use of personal protective equipment.
29. The HSE suggests that control measures that do not rely on human processes are preferred, such as guarding.
30. The report should also identify if similar risks exist anywhere else or have happened before, and whether the control measures will be implemented elsewhere in the business' processes.
31. **Step Four - Implementation action plan:** The Accident Investigation Report should identify any new risk control measures or remedial steps that need to be taken and accordingly should identify the timescales for the implementation of these steps. If there are any reasons why the steps cannot be taken immediately, then the Accident Investigation Report should set these reasons out clearly.
32. If a business finds itself being subsequently prosecuted for a health and safety offence, the business might need to explain why steps were not taken sooner. The duty on an employer is to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees ([s.2\(1\) Health and Safety at Work etc. Act 1974](#)). The duty is therefore qualified by what is "reasonably practicable", and if the company can demonstrate that it was not reasonably practicable for the company to take any steps which have been identified, then it might be able to prove that it exercised its qualified duty.
33. The business should also consider noting the financial costs of taking any steps in the Accident Investigation Report. For example, if a Company has inserted a new state of the art light guided emergency shutdown at a cost of £5,000 it should note this in the report.
34. The new [Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline](#), which came in to force on 1 February 2016, sets out a list of aggravating and mitigating features for sentencing purposes (which reflects the previous case law position under [R. v Friskies Petcare \(UK\) Ltd \[2000\] 2 Cr. App. R. \(S.\) 401](#)). One of these aggravating features is "cost-cutting at the expense of safety". After coming to a starting point on the level of fine to be imposed, dependent upon culpability and harm risked, the Court will use the aggravating and mitigating features of a case to establish where within a range of sentence the fine should sit. Therefore, if the business is able to evidence that it has spent money on ensuring remedial steps or enhancements are implemented, it should document this in the Accident Investigation Report. This will be of some assistance, should the matter ever reach a prosecution in refuting any accusations that it does cost cut at the expense of safety.

## Key Acts

[Health and Safety at Work etc. Act 1974](#)

## **Key Subordinate Legislation**

[Management of Health and Safety at Work Regulations 1999/3242](#)

[Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013/1471](#)

## **Key Quasi-legislation**

[Investigating accidents and incidents; A workbook for employers, unions, safety representatives and safety professionals - HSE, HSG245 \(2004\)](#)

## **Key European Union Legislation**

None.

## **Key Cases**

[R. v Friskies Petcare \(UK\) Ltd \[2000\] 2 Cr. App. R. \(S.\) 401](#)

[Rawlinson and Hunter Trustees SA & ors v Akers & anr \[2014\] EWCA Civ 136](#)

[Waugh v British Railways Board \[1980\] A.C. 521](#)

## **Key Texts**

None.

## **Analysis**

**KEY AREAS OF COMPLEXITY OR UNCERTAINTY**

## **LATEST DEVELOPMENTS**

1. New [Guidelines on Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences](#) from the Sentencing Council came into force on 1 February 2016.

## **POSSIBLE FUTURE DEVELOPMENTS**

1. In February 2016, the Sentencing Council launched a [Consultation on reduction in sentence for an early guilty plea](#). The consultation closed on 5 May 2016.
2. The Sentencing Council has [stated](#) that it is unlikely to publish the final guideline until Spring 2017.

## **HUMAN RIGHTS**

None.

## **EUROPEAN UNION ASPECTS**

None.

## **Further Reading**

None.