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Netherlands Labour Authority  
*Ministry of Social Affairs and Employment*

# Investigation guideline

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# Reader's guide

An industrial accident has taken place within your organisation. The Netherlands Labour Authority has asked you to investigate this accident and report on it. This document contains information as to how and why you yourself investigate an industrial accident.

In the section entitled *General: Investigation and reporting* we explain what you should investigate and we describe and list the requirements the report must meet.

We discuss this in more detail in the section entitled *The Investigation*. We explain step-by-step how you can investigate an accident.

We explain for each step what sources you need, which questions you may ask and how you should lay down the information in order to identify the accident correctly.

# 1

## General: Investigation and reporting

You may use this guideline when carrying out your investigation if you do not use a standardised research and analysis method. The questions mentioned and the examples used constitute a guideline. In the event other questions are relevant to your accident situation, you should answer these questions as well.

Accidents (unintended events) are deviations from an intended work process. It is therefore important to establish during the investigation whether:

- the risks inherent in those specific activities were analysed sufficiently;
- a safe way of working had been developed;
- the necessary preconditions had been created for application of that safe way of working;
- adequate instructions had been issued;
- adequate and appropriate supervision was conducted.

But it is certainly also important to establish why there were deviations from the “intended work process” and the “work process that was implemented”, and in particular what caused those deviations.

Accidents and unintended events have many causes. What may appear to be an accident, being in the wrong place at the wrong time, may following analysis prove to be a convergence of circumstances in which things went wrong in several areas.

These causes can be divided into:

- Direct causes: these indicate what and where things went wrong.
- Root (underlying) causes: these indicate how and why things went wrong.

You have to find, develop and implement improvement measures for each direct and root cause.

### Who carries out the investigation?

The investigation has a greater impact if both management and the employees fully participate in it. Depending on the size of the company, it is important to involve (representatives of) the employees involved, supervisors, Quality, Health, Safety and Environment (QHSE) experts, business management, in the investigation.

This joint approach ensures that the available experience and practical knowledge is applied for the investigation. What is more, this approach creates support for the measures to be taken. Start the investigation as soon as possible. The persons involved have the best recollection of the situation and everyone still has the highest motivation.

# 2 The investigation

The investigation consists of the following four steps on the basis of which you may draw up the report:

1. Collecting information
2. Analysing information
3. Identifying appropriate measures
4. Formulating, implementing, evaluating, improving and implementing the improvement plan again, etc. We explain below what you should do for each step.

## 2.1 Collecting information

You collect information to find out what happened exactly. This is not limited to merely the industrial accident. You also investigate what went wrong during the planning, preparation and within the organisation and management of working safely and what should be arranged better.

Ensure that you not only describe the circumstances of the accident, but that you also provide the source of this information. Add all information to the report: witness interviews, photo/image materials, documents such as a Hazard Identification and Risk Assessment (RI&E) including a Plan of Approach, work instructions, procedures etc.

For this purpose, you may use the list of documents you have sent to us for example.

### 2.1.1 Investigate the scene of the accident

The first step is recording the situation at the scene of the industrial accident. For this purpose, you must first protect this scene against (unintended) changes. You must first collect the “evidence before changes may be made. Find out what happened and how the surroundings and the actions taken had an impact on the accident. Start doing so as quickly as possible.

You can gather a great deal of information during this initial phase. Not all information is available or matters are unclear in some cases. Always keep an open mind and take all possible scenarios into consideration.

It is important that you lay down the information as soon as possible. This will prevent you from laying down the wrong information. In addition, the situation at the scene of the accident will remain as it was as much as possible.

Lay down all information obtained (facts and circumstances). This includes among other things observations, experiences gained, the results of measurements performed, control documents, work permits and the environmental circumstances during the accident (sound, light, etc.). Take photographs and lay down existing image material, such as from camera systems (CCTV etc.).

**Tip:** Take photographs of how the accident occurred and include them in the appendix to the report:

1. Overview photos of the scene of the accident preferably from various angles.
2. Detailed photos of particulars. Indicate in this connection where the particulars can be found in the overview photos.
3. Possibly photos from the position of witnesses.
4. Photos of particulars. Once again indicate where these particulars are located in the overview photos.

### 2.1.2 Storing evidence

Circumstances change after the accident in most cases. This includes matters such as the weather or the need to resume work again as soon as possible. That is why you have to gather the evidence as soon as possible after the accident and store it in a safe place. Collect the evidence in a structured manner so you know what was where at the time of the accident.

### 2.1.3 Conducting interviews

Within the context of most accident investigations you acquire most of the evidence by interviewing people such as about the sequence of the events leading up to the accident. You can read in appendix B to this document which guidelines you can follow when conducting investigation interviews.

#### Witness interviews

Talk to the persons involved. This concerns all people who were close to the accident when it happened. Be sure to speak with all persons who witnessed the accident or who know something about the circumstances that resulting in the accident. By 'witnesses' we mean in this connection:

- the victim or the victims;
- the eyewitnesses;
- the persons who heard something at the time of the accident;
- the persons who know something about the events during the preparation (planning and the issue of instructions) of the work carried out;
- and the persons who know something about the normal work situation ((drawing up) safety measures) and possible deviations therefrom.

Attempt to speak to the witnesses in this order as much as possible. Moreover, ask each interviewee during each round of interviews who else was present at the location of the accident.

When collecting information, you should obtain answers to questions a up to and including k listed below.

- a. Where and when did the accident occur?
- b. Who was/were victim(s) and who else was/were involved in the accident?
- c. Who was/were witness(es) and what did he/she observe?
- d. How did the accident occur?

Describe the convergence of circumstances that resulted in the accident. Also describe the direct actions that were performed after the accident. It is often a matter of successive unforeseeable circumstances that create circumstances in which the accident can take place. You should create a timeline of these. For this purpose speak to the victim, witnesses, managers/supervisors and employees, and describe who did what and why.

You should also mark the position of the persons involved right before and during the accident and possibly do so on the floor plan / layout of the workplace.

Possibly create a sketch of the scene and/or use photos to support the description of the circumstance of the accident.

Lay down which tools, materials, machines etc., were involved in the accident. Note the brand, type/model, numbers, year of production, modifications to machines/tools, CE marking, etc. Lay down where the operation, stop buttons, safety devices etc. were located (you may also do this in the sketch of the scene). Enclose a manual, inspection report concerning the machine and instructions with the report.

- e. What activities were being carried out?  
Record not only which work the persons involved in the accident were carrying out, but if possible also what was being done in the area surrounding the accident. This could make it clear which circumstances contributed to the fact that the accident could take place.  
Be detailed: what were they doing, how many people were involved, what machines were being used, where were these persons located when compared to each other, are there further details as to the conduct of these persons, etc.
- f. How was the work organised in relation to the occurrence of the accident?

Investigate how the work was organised and lay this down. This includes for example the following questions:

- The preparation of the work, planning, instructions (drawings, maps), work meetings, etc. What was the plan?
  - Which work procedures were formulated prior to the accident?
  - How did the persons involved know what to do and how to do this?
  - Were a sufficient number and the correct materials, tools, stocks, etc. present?
  - What was the team composition? Had they worked together before?
  - To what extent is there a company culture that promotes working in a safe and healthy manner?
  - Were there misunderstandings and/or disagreements between the persons involved?
  - Was there sufficient time to carry out the tasks safely (rush/work pressure)?
  - Positioning: who was standing where when the accident occurred?
  - How were the activities to be performed supervised?
  - Did the employees have sufficient knowledge and experience? Were they sufficiently informed, educated or trained?
  - Was the workplace orderly and neat?
  - Were the tools/machines in order? Was there a maintenance planning?
  - How was the workplace laid out? This includes matters such as slippery floors, sharp materials, thresholds, harmful substances in the air, loud noises, bright light (making it impossible to observe warning signals) etc.
  - What does the Occupational Health and Safety Catalogue of your sector say about this situation?
- g. Were there deviations or something unusual?

Lay down what was new or out of the ordinary. Was a safe way of working agreed for this situation? Was everyone aware of this? Did implementation take place in accordance with the safe way of working? If not, why not?

Unintended events often take place when the work takes place other than as usual. People have to adapt to a new situation, especially if there are unknown risks. If the situation was out of the ordinary, why was this the case?

Did the way in which the changes were introduced play a role in the accident? Was everyone aware of the changes? Was everyone sufficient experienced/trained to handle the changed situation?

- h. What instructions were issued to work safely and did everyone follow these instructions?

What was wrong with the normal way of working as a result of which this accident could occur? Was there a safe way of working and was it applied? Why was this way of working insufficient? Or why was this way of working not applied? How was supervision organised? Was this organisation sufficient? Why / why not?

Accidents sometimes take place if there are no or insufficient safety procedures and/or if no or insufficient instructions are provided. “We have been doing it this way for years and it always went fine” or “he has been working with this machine for years, he is every experienced and he knows what to do” are comments that are heard frequently. These comments may result in the victim being blamed for the accident without taking a closer look at the role of procedures, training and supervision in the occurrence of the accident.

- i. How could the injuries arise? What type injury does it concern?

This concerns the following two matters:

- The object, substance, etc. that caused the injury.
- The manner in which the injury was caused

Consider among other things the materials: weight, shape, sharp edges, splinters, hazardous substances, etc. You should also assess whether the material was already damaged during/as a result of previous use.

The relationship between the accident and the manner in which the injury was caused is particularly interesting in case of complicated accidents.

- j. Was the risk known and included in the RI&E? If so, why was it possible that the accident occurred (despite the fact that the risk was included in the RI&E)? What is important is to establish whether the source of the danger and the possible seriousness of the consequences were known, whether this information had been communicated and, more importantly, whether it was known to the persons who should have been aware of this information. Pay close attention to who said what in order to determine whether the communication worked. Find out why the risk was ignored, why it was not understood or why people were not aware of it at all. Keep in mind that what is important is the process and not blaming persons.
- k. Do comparable risks exist elsewhere within the company? Are these risks controlled with adequate measures?

Look for comparable situations elsewhere within the company and how people work there. Should the way of working be applied there as well?

## 2.2 Analysing information

The information gathered should allow you to understand how and/or why the accident could take place. It should therefore show the direct and root causes of the accident. The analysis should also show what you should arrange differently at every level within the organisation in order to prevent similar accidents from occurring.

You may apply different investigation and analysis models, such as S137, STAMP, SOAT, Tripod and Prisma, to find all the facts. Working Conditions Information Sheet AI-43 (accident investigation), AI-45 (risk control) and AI-61 (Hazard Identification and Risk Assessment) explain various investigation methods. You are free to choose one of those methods. Choose the method you think best suits the accident situation.

See for more information:

[www.sdu.nl/bedrijfsvoering/arbo/arbo-informatiebladen?q=arbo%20informatiebladen](http://www.sdu.nl/bedrijfsvoering/arbo/arbo-informatiebladen?q=arbo%20informatiebladen)

You may also use the method set out below for the purpose of the analysis.



### 2.2.1 Example of an analysis method

There are many methods to analyse the information that has been collected. It is up to you to choose the most suitable method. The method referred to here is merely a simple analysis method for non-complex cases, and in some cases it may not be sufficient to analyse the accident within your organisation.

An accident is often preceded by a process to which various factors contribute. You identify this process by analysing the information that has been collected.

One of those factors is human action (see Appendix A). But human action is based on other influencing factors. It often concerns the question how working safely is organised in an organisation and how safety measures were formulated and implemented. This means that an accident does not happen to a person/employee, but to the entire organisation. This means that you must also find a solution within your organisation.

We use the following terms as part of the analysis method:

- Event: An act, omission or other event.
- Accident event: The occurrence of the accident, such as a ladder falling over, a hand in the machine, slipping on the floor etc.
- Incident: An event that was both significant to the accident and incorrect.
- Contributing factor: A factor that could have contributed to the occurrence of the event, such as insufficient lighting, the wrong tools, incorrect planning, lacking working arrangements, communication etc.

The first step in the analysis of the information collected is ordering the information.

#### 1. Create a timeline

- a. What events/acts/omissions preceded the accident?
- b. Start with the accident and work as far back in time as possible.
- c. Place every event related to the accident by order of time; you should also note the time at which this event took place.

#### 2. What events on the timeline contributed to the accident and were incorrect (events)?

Establish the following for each event on the timeline:

- a. Was the event relevant to the occurrence of the accident?
- b. Should this accident not have taken place (or should it in case of an omission) if the work had been carried out safely?
- c. Mark all events on the timeline.

#### 3. Analyse why each event could occur (5x Why method)

Discover the contributing factors.

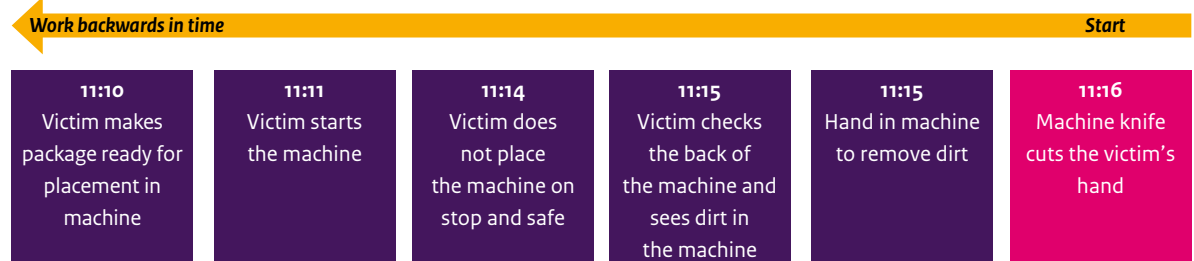
- a. Repeatedly ask the question for each event (at least 5x Why, see example) in order to find the structural shortcomings.
- b. Use the example timeline provided below.

#### 4. Discover the structural shortcomings

- a. Use the example timeline provided below.
- b. Note the structural shortcomings.

## 2.2.2 Examples for creating a timeline

### Step 1:



### ■ Accident event

This example includes a limited number of steps that preceded the accident. A sound analysis generally requires reasoning back several more steps. The further you look back over time, the more effectively the underlying causes can be identified. In some cases, going back in time to the purchase of the materials may be necessary.

### Step 2

Determine whether the act (in the block) was incorrect or unintended.

### Step 3

Ask the question for each incorrect/unintended act why it was performed the way it was. When answering that why-question, you once again ask the question why that was the case.

The why-question can sometimes result in multiple answers. You should divide those answers and continue asking the why-question. Continue to ask why-questions until the answers are no longer relevant. The answers are usually no longer after you have asked the why-question five times.

### Step 4

The timeline and the '5x why' method reveal structural and occasional shortcomings that formed the reason for the occurrence of the accident. A list of shortcomings that may be identified by the why-questions is provided below. This list is merely intended as an example. Other shortcomings may be relevant in your situation.

- The lack of safety screens on the machine;
- Work/safety instructions insufficiently in order;
- Handled differently than set out in the instructions;
- RI&E and Plan of approach not specifically applicable to the accident situation;
- Incorrect working method developed;
- Knowledge level and safety compliance insufficient;
- No targeted supervision;
- Communication between managers and between manager(s) and employee resulted in misunderstandings;
- Unclear division of duties;
- Incorrect procurement / no suitable work equipment;
- Insufficient maintenance/wear and tear;
- And other shortcomings not mentioned above.

All of these shortcomings have a direct impact on the layout of the workplace or environment, the use and suitability of work equipment such as machines, the structure of the work process and procedures, and human action. These shortcomings are referred to as the direct and root causes of the accident.

The direct causes are the circumstances immediately preceding and/or during the accident. This concerns the direct acts and the situation at the moment of the accident.

In order to deal with these shortcomings structurally at the source, it is important to know where and why these shortcomings could arise. You use this to search for the underlying causes. In order to identify causes, you have to assess at least the following themes critically.

- *The business organisation*

You should ask the main questions “do we have that?”, “how do we do that?” and “how do we make sure we do it right?” concerning the subjects of knowledge, information, cooperation, communication and supervision. You then ask the questions “why do we do it like that?” and “could that be improved?” for each answer.

- *Planning and implementation: how we prepare*

You should ask the main questions “how do we prepare?”, “which aspects have priority?”, “how do we implement that?”, and “how do we make sure (manage) we do it right?” concerning the subjects of occupational hazards, layout of the workplace and the work process. You then ask the questions “why do we do it like that?” and “could that be improved?” for each answer.

Going through the relevant questions above leads you to the possible base causes.

You have now created insight into all causes. You should remove those causes in order to prevent similar accidents from occurring in the future. The next steps are conceiving suitable measures and including them in an improvement plan.

## 2.3 Identifying appropriate measures

After you have performed the analysis, you search for suitable measures for each cause (direct and structural/underlying). Describe why these measures are suitable, which causes they match, etc.

For example, carry out for all measures a strength-weakness analysis in order to obtain an idea of which measures will be most successful.

Steps 1 up to and including 3 are effectively a situational Hazard Identification and Risk Assessment (RI&E). You should therefore include these steps in your written RI&E.

Involve management, (a representation of) the employees and experts in the area of safety when conceiving suitable measures. The measures can be divided into two categories:

- Solutions to direct causes. These solutions follow the occupational hygiene strategy.
- Solutions to underlying causes. This concerns solutions in the area of the organisation, technology and human beings.

## 2.4 Formulating, implementing, evaluating, improving and implementing the improvement plan again, etc.

You include the measures you identify in step 3 in an Improvement Plan. Make sure that you formulate this plan in specific terms. This means that the actions to be taken must be specific, measurable, acceptable, realistic and time-bound (SMART).

You should also look beyond merely the solutions to the accident. Consider your RI&E for example. Are there more comparable situations and points for attention? Include these if there are.

Include these actions in your organisation’s Improvement Plan. Ensure that the RI&E is also assessed in case of changes, especially if they are required by law.

Make sure that you evaluate the changes to your organisation after the accident. You made changes to your occupational health and safety management system in response to the accident. Check regularly whether the measures are actually effective: do they contribute to safer and healthier work within your company? Specifically include the evaluation in the Plan of Approach as one of the measures and provide it with a date and action. Incorporate in your businesses processes a repeat system concerning “identification of current processes, application of possibilities for improvement, evaluating improvements, adjustment”. This also referred to in technical terms as the PDA cycle (Plan-Do- Check-Act).

### **Reporting**

You are allowed to use your own format for reporting to the Netherlands Labour Authority. You should add the investigation documents (witness interviews, photo/image materials, the analysis, relevant documents etc.) to your report in order to substantiate how you arrived at the circumstances, analysis and the measures to be implemented.

# Appendix A: Human action

## Assumptions

### **Human action as a factor**

Human action is identified as a contributing factor somewhere in the process for nearly every accident. It is easy to place the blame here, but that is not the aim. All persons in the entire process preceding the accident act on the basis of environmental factors. Consequently, it concerns not only the conduct of the victim, but the conduct of all persons throughout the chain. How then should human action be handled during the investigation and analysis? Human action is often a consequence of other environmental factors.

Human errors are not committed in isolation. They are a consequence of other factors. You should therefore always answer the why-question in this connection. Why was someone not paying attention? Why did someone act in this way? Why did someone make the mistake? Why was that specific tool made available/purchased? You should therefore consider the context in connection with the occurrence of human errors. That context is largely determined by the culture of the organisation. The culture consists of all of the shared standards, values and conduct of employees of the company. To what extent is there a culture that promotes working in a safe and healthy manner? Think of questions such as: does the manager display exemplary behaviour? Does he/she wear the right personal protective equipment for example? Are employees asked for their ideas to make the work safer? Do employees feel safe to report errors? Does the organisation learn from accidents and incidents? As a good employer, you examine the company culture and you determine points for improvement for the purpose of working in a healthy and safe manner.

The division into three categories of human error provided below can help you direct this.

**Category 1: implementation errors:** someone wishes to carry out a suitable/correct task, but makes an error when doing so. This is referred to as an implementation error. These errors can be divided into slips and lapses.

- *Slips* are errors in which someone is not paying attention, such as when someone carries out his/her task on automatic pilot, without thinking about it.
- *Lapses* (of memory) concern errors in which someone does not remember how he/she should carry out an action correctly.

**Category 2: mistakes:** acts are the result of an incorrect assessment of the situation or insufficient knowledge. A wrong decision was made. This category can in turn be divided into:

- *Regulatory errors:* the acts and procedures are known, but the wrong acts are performed or the wrong procedures are applied.
- *Knowledge errors:* someone is confronted with an unknown/new situation, starts using different priorities, knowledge and/or experience, and thus arrives at the wrong conclusion.

**Category 3: breaches:** intentional failure to comply with instructions/agreements and/or taking short cuts to save time or effort and therefore be able to work more efficiently/simpler. In such cases, someone may be of the opinion that the instructions/agreements are too strict and/or that compliance with the instructions/agreements is not monitored anyway.

You should therefore not judge the human error that contributed to the accident as an unrelated human factor, but as a consequence of a system error and/or organisation failure.

Assuming that the error "is attributable to the victim himself/herself due to his/her own actions" is an incorrect assumption.

# Appendix B: Conducting interviews

## Guidelines for conducting investigation interviews

The interviews are intended to obtain a correct and complete image of all the facts that could be relevant to learn from an accident. That is why we provide the following guidelines:

- Create an interview plan and a list of witnesses you will be interviewing. Prepare the questions as much as possible.
- Make sure that you are familiar with the scene of the accident and, if possible, conduct the interview after you have visited the scene of the accident and have laid down the necessary information on-site.
- Make sure that you understand the technology of the machines, the equipment and product process involved in the production process. This knowledge will allow you ask the right questions, understand the answer and ask follow-up questions.

The interviewee / witness may be a person who witnessed the accident or heard something immediately before or after the accident. However, the interviewee / witness may also be a foreman who checks whether work is being carried out safely, or someone from planning who knows something about safety measures.

Ideally, the various interviewees do not have contact with each other until all interviews have been completed. Not everyone saw everything and not everyone is a very good observer. This means that every witness knows only part of the overall story. In the event the witnesses come together and naturally talk to each other about the accident, they will incorporate that conversation in order to obtain a conclusive picture of the accident for themselves. This has an influence on their own observations. This does not make your task as investigator easier; it may be difficult for you to separate the 'true' facts from the 'added' facts. After all, memory and details fade as time passes. Own interpretations arise and/or a witness is influenced unintentionally by other witnesses. You should therefore schedule the interviews you will be conducted as soon as possible and take your time to conduct the interviews. A quiet room is sometimes good, but it can also be handy to visit the scene of the accident in order to obtain a correct explanation of the activities or to carry out a reconstruction (safely).

Separating the main witnesses and asking them to write down their story prevents them from influencing each other. Make sure you have sufficient time for the interview. Give yourself time to listen calmly to what the interviewee has to tell you.

### **How should interviews be conducted?**

Explain to the interviewee why you are interviewing him/her and explain the purpose of the investigation, namely preventing accidents and not finding someone to blame.

You start the interview by recording the name, position (title and brief description) and the experience with the task, related to the accident.

You should then divide the interview into three sections:

- a. Have the interviewee describe exactly what happened: the unrestricted story without asking questions directly.
- b. Continue to ask questions about subjects put forward by the interviewee himself/herself (step a).
- c. You should then ask questions about subjects that were not yet addressed and that are relevant to the own investigation.

Try to ask open questions: questions that cannot be answered with only a “yes” or “no” answer. Use a simple formula so you do not forget anything. Ask the seven questions: ‘who’, ‘what’, ‘where’, ‘which’, ‘how’ and ‘why’.

#### **Examples:**

Who was injured. Who installed the equipment? Who was responsible? Who was involved? The accident itself determines to a large extent exactly which questions you should ask.

What happened? What were the persons doing? What equipment and devices were being used? The answer to this type of question should lead to actions, events and objects surrounding the accident.

Where did it happen? Where was the victim located? Where were the witnesses located? What was the exact location of the objects that were involved in the accident? The ‘where’ questions help you lay down the location and establish which circumstances preceded the accident.

When? The answers to the ‘when’ question should provide you with more information than merely the time of the accident. ‘When’ questions help you create a connection between activities or events.

Which? The questions provide you with information about the connection between the accident and for example the way of working/procedures, instructions, training etc.

How? ‘How’ questions concern not only the actions of the machines and parts thereof, but also the acts of victim(s) and witnesses.

Why? The why question leads you to the opinion of the witness. You should really ask this question last, because you in fact ask the witness to draw conclusions. You ask for an opinion and no longer for the facts. You are actually asking how he/she thinks the accident could have been prevented and what should happen now.

In order to provide structure to the interview, you can discuss the following subjects with the interviewees:

- *Where (location) and when the accidents occurred*
- *How the accident occurred*
- *Other witnesses (present)*
- *Duration of the activities*
- *How long has the interviewee been working at the company, on the basis of what form of employment, with what experience*
- *Who determined what activities had to be carried out, who issued the instructions to do so*
- *Training, courses etc. attended*
- *Show the photos and (own) interpretation to the interviewee*
- *What was the situation; How was it standing, where was it standing, possibly have the interviewee make a drawing*
- *Instruction manual present, read, the contents of the instruction*
- *Relationship with the accident*
- *General and specific instruction meetings (written)*
- *Or toolboxes for example, how often and where are these provided, when was the last one, and who provided it*
- *Specifically about the work equipment*
- *Choice of this scope, What was this way of working based on? Why this way of working and not another one?*
- *Supervision inspection: how, how often (in writing); who, how often, from what is this evident*

- *What safety measures were implemented*
- *Deviations from the safety measures*
- *What safety measures were necessary to carry out the work safely*
- *Challenged previously concerning conduct, safety etc.*
- *How can such an accident be prevented from occurring in the future*
- *Etc.*

If you have questions about the answer and/or interpretation provided, ask the witness how he/she obtained the information indicated.

Indicate at the end of the interview that the interviewee should definitely contact you if he/she remembers new relevant information.

Lay down in a written statement what the interviewee told during the interview. Have the interviewee read this statement. Correct any errors it may contain.



## Example of an interview report

### INTERVIEW VICTIM or WITNESS

On XX-XX-XXXX at XX.XX hours, we, NAME (POSITION) and NAME (POSITION), were located at NAME LOCATION at STREET, HOUSE NUMBER in PLACE.

We spoke there with:

**Name** : ...  
**First name** : ...  
**Date of birth** : ..-..-....  
**Place of birth** : ...  
**Nationality** : ...  
**Address** : ...  
**Place of residence** : ...  
**Position** : ... at company ...

We spoke with NAME about the industrial accident that occurred on ...day ... (date +year) at a work location at STREET HOUSE NUMBER in PLACE, in which he/she was involved as a witness/victim.

Q: question (open question asked of the interviewee)

A: answer (response provided by the interviewee)

Q: What can tell about ....

A: ...

Q: ...

A: ...

Q: ...

A: ...

Q: ...

A: ...

The witness or victim,

SIGNATURE

NAME

