



# Motor Incident Investigations

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## Why investigate?

- To comply with regulations
  - To improve safety performance
  - To meet insurance requirements
  - To enhance company reputation
  - To enhance risk management
  - To reduce costs
- To enhance safety culture
  - To demonstrate due diligence
  - To ensure the safety of our colleagues
  - To identify the root causes
  - To learn from mistakes
  - Better decision making
- Continuous improvement
  - Improved engagement / retention
  - Improved absenteeism rates
  - Improved employee morale
  - Improved communication
  - **To prevent recurrence!**

# Investigation Process

Step 1

Gather  
Information / Data



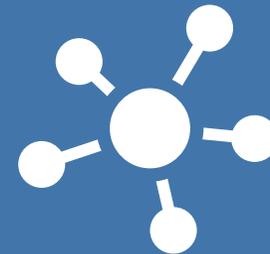
Step 2

Analyse  
Information / Data



Step 3

Determine  
the Cause



Step 4

Develop  
Recommendations



# Investigation Team

Investigation team:

*Supervisor*  
*Line Manager*  
*Alternative Manager*  
*Senior Manager*  
*HSE Professional*  
*(or a combination of)*

Investigation category:

*Potential worst consequence of event*

*x*

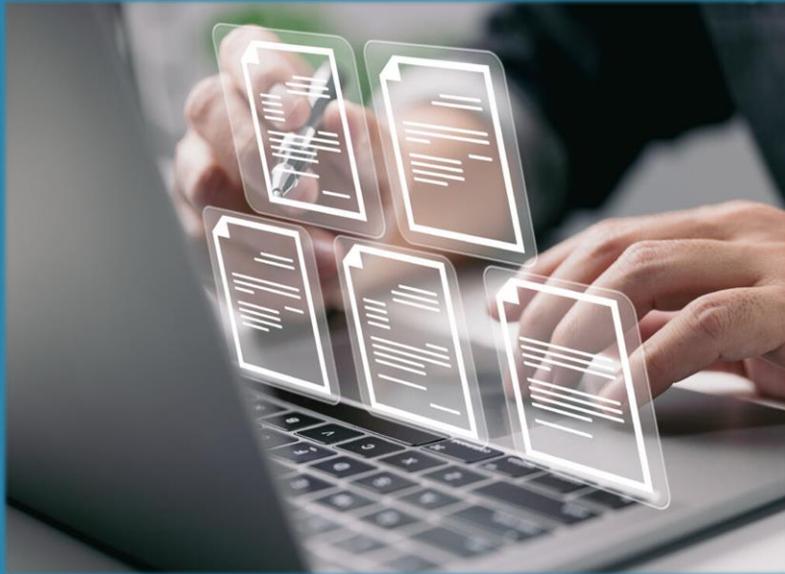
*Likelihood of recurrence*

Likelihood of recurrence	Potential worst consequence of adverse event			
	Minor	Serious	Major	Fatal
Certain	Yellow	Orange	Red	Red
Likely	Yellow	Orange with X	Red	Red
Possible	Yellow	Orange	Red	Red
Unlikely	Blue	Yellow	Orange	Red
Rare	Blue	Yellow	Orange	Red

Risk	Blue	Minimal	Yellow	Low	Orange	Medium	Red	High
Investigation level	Blue	Minimal level	Yellow	Low level	Orange with X	Medium level	Red	High level

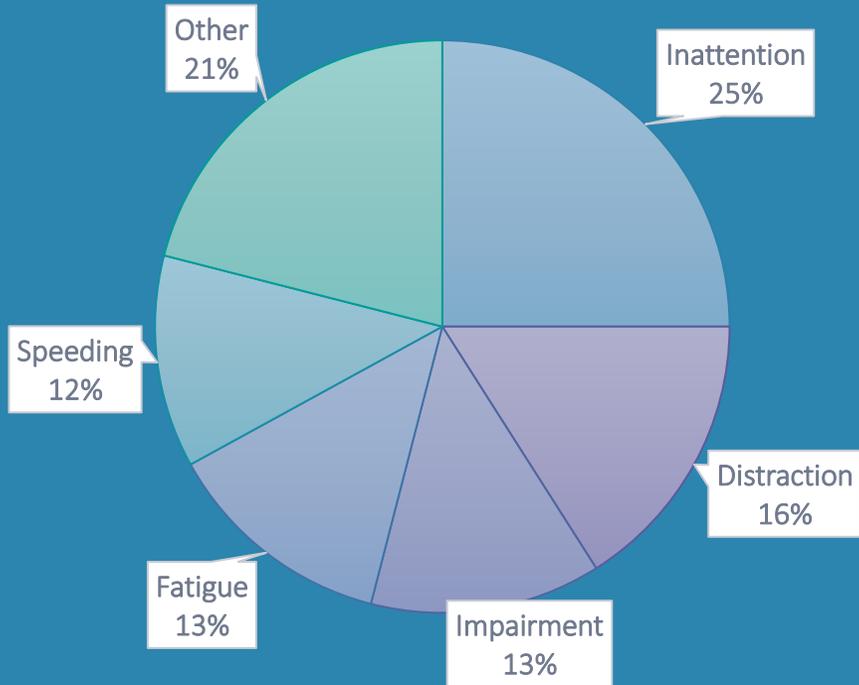
Reference: HSG245 - Investigating accidents and incidents

# Step 1 - Gather Information



<b>Minimal / Low</b> <i>Consider:</i>	<b>Low / Medium</b> <i>Minimal / Low 'and' consider:</i>	<b>Medium / High</b> <i>Low / Medium 'and' consider:</i>
<p><b>Statement:</b></p> <ul style="list-style-type: none"> <li>Driver's account of event</li> <li>Passengers / witnesses</li> </ul> <p><b>Individual &amp; Routine:</b></p> <ul style="list-style-type: none"> <li>Driving time / rest periods</li> <li>Work activity (driving &amp; other tasks)</li> <li>Incident history</li> </ul> <p><b>Vehicle Activity:</b></p> <ul style="list-style-type: none"> <li>Telematics data (loc / time / speed)</li> <li>Dashcams (any associated activity)</li> </ul> <p><b>Risk Assessment:</b></p> <ul style="list-style-type: none"> <li>Suitable and sufficient</li> <li>Understood &amp; communicated</li> <li>Review date</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>Driver competence / training</li> <li>Drink / Drugs / Fatigue</li> <li>Eyesight standards</li> <li>Illegal behaviours (i.e. phone use)</li> <li>Unsafe behaviours (i.e. driving tired)</li> </ul>	<p><b>RIDDOR:</b></p> <ul style="list-style-type: none"> <li>Is the incident RIDDOR reportable?</li> <li>Public road - is not RIDDOR</li> <li>Private property - may be RIDDOR</li> </ul> <p><b>Employee Support:</b></p> <ul style="list-style-type: none"> <li>GP / Hospital / Occupational Health</li> <li>Employee assistance programme</li> </ul> <p><b>Vehicle Activity:</b></p> <ul style="list-style-type: none"> <li>Journey history / speeds / times</li> <li>Risk events (harsh braking)</li> </ul> <p><b>Vehicle Husbandry:</b></p> <ul style="list-style-type: none"> <li>Daily / weekly vehicle checks</li> <li>Maintenance / servicing / MOT etc.</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>Health conditions (known / unknown)</li> <li>Sleep apnoea / diabetes etc.</li> </ul>	<p><b>Legal Support:</b></p> <ul style="list-style-type: none"> <li>Consider for the business / employee</li> </ul> <p><b>Transport Operation:</b></p> <ul style="list-style-type: none"> <li>Fleet / Driver related procedures</li> <li>Fleet / Driver related handbooks</li> </ul> <p><b>Individual:</b></p> <ul style="list-style-type: none"> <li>Evidence licence checks / history</li> <li>Health declaration (inc eyesight)</li> <li>Penalty point history</li> </ul> <p><b>Vehicle:</b></p> <ul style="list-style-type: none"> <li>Service, Maintenance, MOT</li> <li>Daily / weekly vehicle checks</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>Media / Social Media coverage</li> </ul>

# Step 3 - Determine the Cause



## Immediate Cause

The most visible reason for any incident, they are the events or actions that resulted in the incident.



## Underlying Cause

They are the conditions or events that create the opportunity for the immediate cause to occur.



## Root Cause

They are core issues that create an environment where safety incidents are more likely to occur.

To make a genuine difference we need to understand and address the 'root cause'.

# Root Cause Analysis

- The 5 Whys:
  - Simplicity
  - Identification of causes
  - Optimal corrective action plan
  - Repeatedly ask Why?



## Problem Statement

Driver rear ends third-party vehicle causing significant damage to both vehicles

Why

• Driver did not brake in time

Immediate

Why

• Driver was distracted

Underlying

Why

• Driver was taking a handsfree call

Underlying

Why

• LM requesting location update

Underlying

Why

• LM under pressure to meet KPIs

Root

## Corrective Action

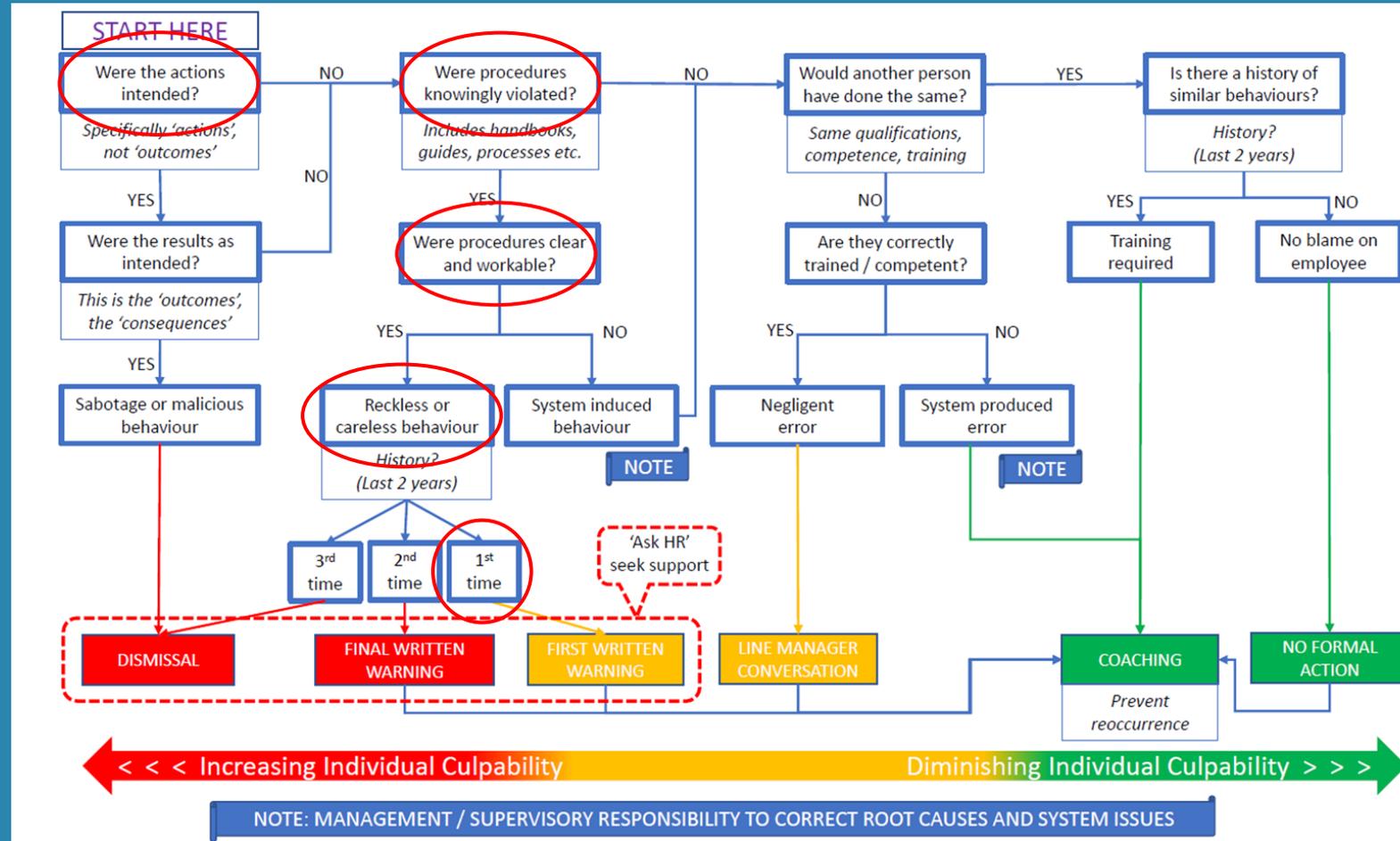
Review KPIs - are they achievable?  
Use of telematics - to establish vehicle location  
Review phone policy - phone use / no phone use?  
Communicate expectations and / or any changes



# Just Culture - Driver



- Were the actions intended?  
No
- Were procedures knowingly violated?  
Yes
- Were procedures clear and workable?  
Yes
- Reckless or careless behaviour  
1<sup>st</sup> time
- Intervention  
First Written Warning



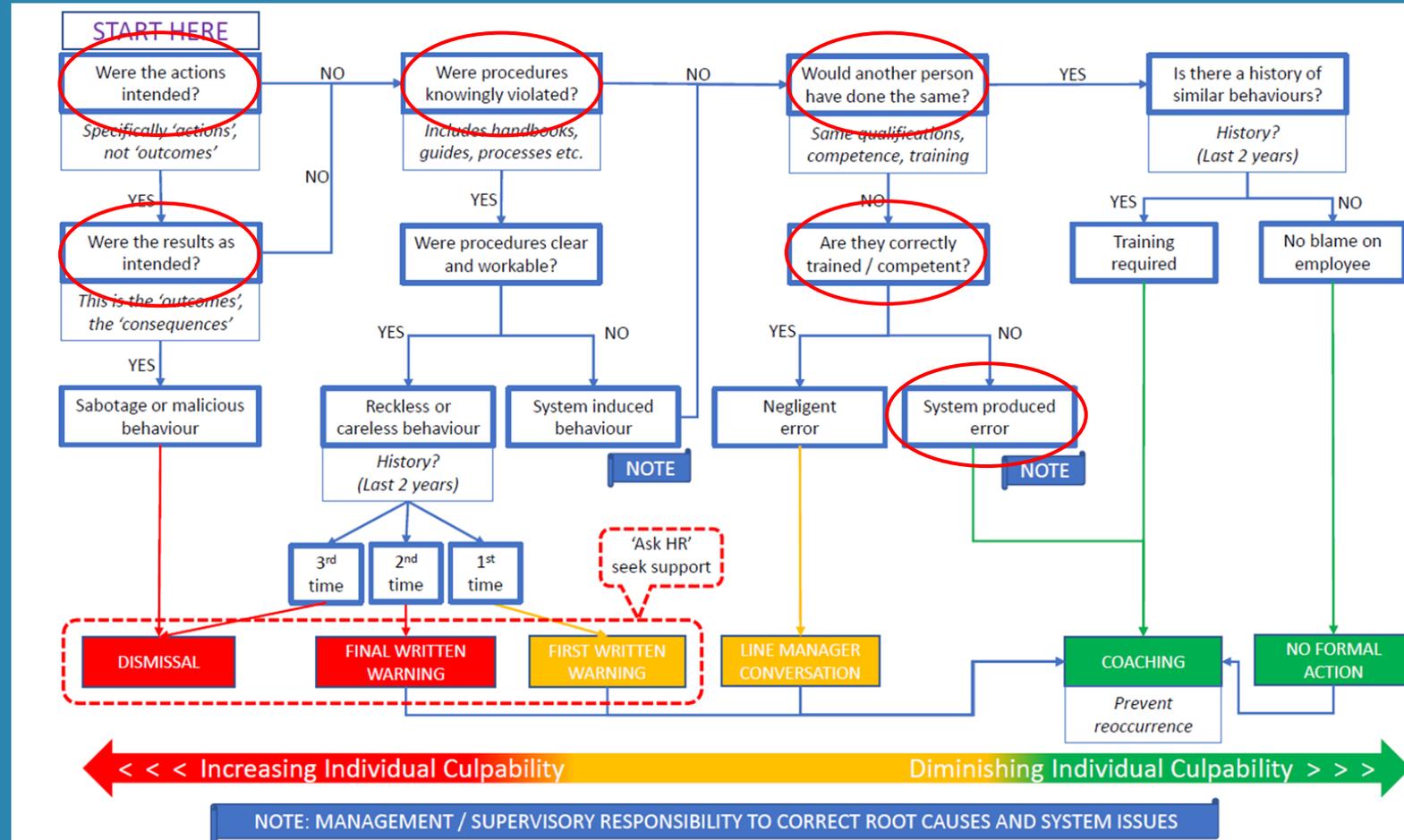
← ← ← Increasing Individual Culpability      Diminishing Individual Culpability → → →

NOTE: MANAGEMENT / SUPERVISORY RESPONSIBILITY TO CORRECT ROOT CAUSES AND SYSTEM ISSUES

# Just Culture - Line Manager (new in role)



- Were the actions intended?  
Yes (the phone call)
- Were the results as intended?  
No (the collision)
- Were procedures knowingly violated?  
No (new employee)
- Would another person have done the same?  
No (peers are trained)
- Are they correctly trained and competent?  
No (new in role)
- System produced error  
↓
- Coaching (Training)



# Communicate Lessons Learnt

- What happened?
  - High-level overview only
- Investigation findings
  - What did the investigation reveal
- What message do you want to share
  - What are the lessons learnt
- Is there a 'Call to action'
  - Is there a specific ask?
  - Any additional actions?



# Summary



- Gather Information:

- Be thorough
- Be proportionate

- Root Cause Analysis - 5 Why's:

- ..... Immediate cause
- ..... Underlying cause
- ..... & Root cause

- Just Culture:

- Encourages transparency
- Identification of failures
- Effective / Proportionate intervention
- Consistent approach