



## **Risk control**

### **Slips, Trips and Falls Toolkit: Incident Investigation**



In partnership with



# Slips, Trips and Falls Toolkit: Incident Investigation

## Introduction

When someone falls, it is important to learn lessons so that steps can be taken to prevent similar events happening in the future. This brief guidance gives advice on how to investigate a fall incident so that both the root cause and preventative solutions can be identified.

## Investigation

A thorough incident investigation should be conducted as soon after the event as possible. It is important to ensure that others will not be exposed to any potential hazards, so the area must be made safe before the investigation begins. Any actions taken to make the area safe should be recorded as part of the investigation process.

To maximise the value of the investigation, local managers and relevant staff should be involved in the investigation process. All pertinent details should be recorded accurately. The investigation should be conducted in a systematic way, and it is often helpful to use a template of specific questions.

It is recommended that photographs of the scene are taken and relevant evidence, such as the condition of the victims' footwear and floor surface, recorded to provide a more detailed analysis of the event. Photographic evidence should be captured as soon after the event as possible.

When taking photos, consider the circumstances of the incident. For example, when investigating a fall down a staircase, ensure that the photos show the view looking down the staircase, the direction the person was travelling.

If possible, speak to the person involved in the incident and any witnesses to establish their account of the events. Ask them to be detailed in their account and question any aspects that are not explicit. Aim to establish the facts of what happened, what hazards were present, and why the hazards were there. It is important to separate facts from opinions.

## Causation

It is important for all those involved in the investigation to recognise the difference between a slip, a trip and a fall and to understand exactly what took place.

Slips, trips, and falls can be defined as follows:

- **Slip:** a lack of grip (friction) causes uncontrolled sliding of the foot
- **Trip:** the pedestrian catches their foot on an obstacle causing a loss of balance
- **Fall:** an unrecovered loss of balance which can occur because of a slip or trip, but also for other reasons such as

misplacing feet on stairs or suffering an adverse health event.

Falls happen very quickly, with people sometimes failing to recall the initiating factor. Be aware that people often use the terms slip, trip, and fall interchangeably as a description of losing their balance. If a person slips, they tend to fall backwards; if they trip, they tend to fall forwards.

It is important to establish what the person was doing at the time of the event and where exactly it took place. Was the activity well planned and was the environment suitable for the activity?

Identify hazards that may have led to the event, such as contaminated floor surfaces, obstacles, uneven surfaces, or poor visibility.

It is important to understand what factors lead up to the event so that the root cause (the failure from which all other failings flow) can be identified. For example, if the floor was contaminated, establish why was it contaminated.

## Contributing Factors

Was the person rushing or distracted at the time of the incident? Did their behaviour or work task expose them to greater risk. For example, pushing or pulling a heavy load, using a mobile phone while walking, or carrying bulky items in both hands.

All the above factors make an incident more likely but do not assume that human error was the sole cause as this can inhibit the identification of other factors that could lead to the prevention of a similar incident in the future.

Establish what has been done historically (if anything) to prevent this type of incident and investigate why these measures did not work on this occasion.

Were procedures followed? Have other similar incidents occurred? Previous near misses? Were all the causal factors identified in a risk assessment and were the control measures appropriate and fully implemented?

## Risk Assessment

Consider all the factors identified in the investigation and assess how likely they are to reoccur. Consider what took place and assess whether there are any additional control measures that would be reasonably practicable to implement to reduce the risk of similar events happening in the future. Review existing risk assessments and update as necessary.

## Monitor and Review

Regularly monitor and review incident and near miss reports to identify trends and highlight areas of concern. Consider using a management database to capture incident information as this may help to identify problematic processes, activities, behaviours, equipment, locations etc. Monitoring will also help to establish if any newly implemented controls are effective.

## Consultation and Advice

If an investigation fails to identify what went wrong or to identify suitable control measures to prevent similar events occurring again, it is often helpful to gain the views of others. Always consult the workforce and encourage them to voice their concerns and propose solutions. Ask other organisations within your sector what they do and try to adopt industry best practice. Discuss any unresolved issues with a fall prevention specialist and, if necessary, try to develop bespoke solutions.

Risk Management Partners and Gallagher Bassett would like to thank QBE European Operations for the material used to shape this toolkit segment.

### Further information

For access to further RMP Resources you may find helpful in reducing your organisation's cost of risk, please access the RMP Resources or RMP Articles pages on our website. To join the debate follow us on our LinkedIn page.

### Get in touch

For more information, please contact your broker, RMP risk control consultant or account director.

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