# Accident investigation

Hello everyone,

In this week's message I would like to talk about accident investigation.

The obvious reason we investigate is to find out how an event happened, but there's more to it than that. We investigate to find out what **allowed** something to happen. We can only do this by establishing the root causes – and that means analysing our processes, the work environment, supervision and all of the human factors involved. It's not about apportioning blame or liability, it's about continuous learning and taking preventative measures to stop something from happening again. If we don't learn and use that learning to drive change, we won't succeed.

**Rob Cairns,**
**Regional Managing Director**

Safety investigations form an important part of Network Rail's Health and Safety Management System. They fit in to our objective to get everyone home safe every day through the effective control of risk. Our Fair Culture principles enable us to understand the types of human error and promote a fair and proportionate response – so by encouraging employees to participate in investigations openly and honestly, the quality of our learning improves and the actions and recommendations arising from them are effective.

Our investigators are trained in all aspects of leading an investigation, from preliminary level one investigations to formal level three investigations. Once approved by the appropriate 'designated competent person' (usually the head of the function involved), level two and three investigation reports are presented to regional recommendations panels to provide independent review, oversight and manage the actions arising from them.

All of this helps a positive safety culture to develop. This means a culture where colleagues can report *anything* that has the potential to cause harm. It also means that when incidents do happen, people can have utmost confidence that they will be investigated thoroughly and fairly, and that we will learn from them.

So, if you're busy with the day job but you're asked to help with an investigation in whatever capacity that might be, think of the Ladbroke Grove accident in October 1999 and the 31 people who lost their lives, along with 417 others who were injured. As well as the creation of RAIB and the RSSB, the Cullen Inquiry that followed required all industry partners to investigate events on the railway (Rail Industry Standard 3119) and to improve safety management to ensure that the industry "learns the lessons from previous accidents, near misses and the behaviour leading to unsafe acts in order to avoid another tragedy." This is why investigation and the mechanisms that sit behind them are so important to achieving our priorities as a region.

Stay safe,

Rob

This update is provided by the Wales and Western Communications team. For any queries, please contact walesandwesterncomms@networkrail.co.uk