TOOL – Interview Starter Questions

Some reasons why interviewees fail to give good information

Interviewee behaviours	Possible reason
They cannot recall the exact details and are feeling under pressure to give an answer	This is not uncommon if they were in 'autopilot' when it happened, and they were not consciously aware. Use ECI techniques to help retrieve the detail they can remember. Resist the temptation to think they are 'hiding' something as this may bias your questions.
Feeling under pressure to give the 'right' answer	Setting the right tone at the outset of the interview will mean they understand that there is not a 'right' answer.
Giving very short answers with no details	Think about your questions and if you are asking closed questions. If so, try more open questions. Think about whether you built rapport with the witness at the start. A lack of rapport can lead to a lack of cooperation or less than optimal recall from a witness.
Worry about being blamed, threats to their employment or prosecution	Setting the right tone at the outset of the interview will clearly and overtly establish what the aim of the interview is. If it is clear that the interview is about finding out what happened, then this will reduce the fear of blame.
Worry about 'telling on' others	Being open at the start of the interview about the anonymity of reports or how information will be used in the final report may help to manage this.
Not giving much information away	Think about your questions and if you are asking closed questions. If so, try more open questions. Think about whether you built rapport with the witness at the start. A lack of rapport can lead to a lack of cooperation or less than optimal recall from a witness.
Fear of senior managers	Many witnesses will have no experience of interviews and are likely to be fearful or sceptical. To get good interview data, it is important to acknowledge this in the opening, to build rapport with the witness and to select the 'right' senior manager to be the lead for the interviews.
They may be traumatised or shocked	Witnesses who are displaying these signs need to be interviewed with care. The use of ECI techniques or interviewing them in a different location / format could be considered.
They may face several interviews, some of which may have been challenging	As memory is fragile, interviewing by multiple parties, with the use of different methodologies and for different aims or purposes, can affect an individual's recall of events and could create false memories. The use of ECI techniques could help to identify and iron out any anomalies.

These following questions are taken from the Health and Safety Executive guidance document and as such are focused on slips, trips and falls etc. However, they provide a good indicator for some investigative questioning lines that can be adopted. They are best used as wide open funnelling questions that are then probed down in more detail.

TOOL – Interview Starter Questions

Where, when and who?

1. **Where and when did the adverse event happen?**

2. **Who was injured/suffered ill health or was otherwise involved with the adverse event?**

Gathering detailed information: How and what?

Discovering what happened can involve quite a bit of detective work. Be precise and establish the facts as best you can. There may be a lack of information and many uncertainties, but you must keep an open mind and consider everything that might have contributed to the adverse event. Hard work now will pay off later in the investigation.

Many important things may emerge at this stage of the process, but not all of them will be directly related to the adverse event. Some of the information gathered may appear to have no direct bearing on the event under investigation. However, this information may provide you with a greater insight into the hazards and risks in your workplace. This may enable you to make your workplace safer in ways you may not have previously considered.

3. **How did the adverse event happen? Note any equipment involved.**

Describe the chain of events leading up to, and immediately after, the adverse event. Very often, a number of chance occurrences and coincidences combine to create the circumstances in which an adverse event can happen. All these factors should be recorded here in chronological order, if possible. Work out the chain of events by talking to the injured person, eyewitnesses, line managers, health and safety representatives and fellow workers to find out what happened and who did what. In particular, note the position of those injured, both immediately before and after the adverse event. Be objective and, as far as possible, avoid apportioning guilt, assigning responsibility or making snap judgements on the probable causes.

Plant and equipment that had a direct bearing on the adverse event must be identified clearly. This information can usually be obtained from a nameplate attached to the equipment. Note all the details available, the manufacturer, model type, model number, machine number and year of manufacture and any modifications made to the equipment. Note the position of the machinery controls immediately after the adverse event. This information may help you to spot trends and identify risk control measures. You should consider approaching the supplier if the same machine has been implicated in a number of adverse events. Be precise. Shop floor process and layout changes are a regular occurrence. Unless you precisely identify plant and equipment, you will not detect, e.g. that a machine or particular piece of equipment has been moved around and caused injuries on separate occasions, in different locations.

4. **What activities were being carried out at the time?**

The work that was being done just before the adverse event happened can often cast light on the conditions and circumstances that caused something to go wrong. Provide a good description, including all the relevant details, e.g. the surroundings, the equipment/materials being used, the number of employees engaged in the various activities, the way they were positioned and any details about the way they were behaving etc.

5. Was there anything unusual or different about the working conditions?

Adverse events often happen when something is different. When faced with a new situation, employees may find it difficult to adapt, particularly if the sources of danger are unknown to them, or if they have not been adequately prepared to deal with the new situation. If working conditions or processes were significantly different to normal, why was this?

Describe what was new or different in the situation. Was there a safe working method in place for this situation, were operatives aware of it, and was it being followed? If not, why not? Learning how people deal with unfamiliar situations will enable similar situations to be better handled in the future.
Was the way the changes, temporary or otherwise, were introduced a factor?

Were the workers and supervisors aware that things were different? Were workers and supervisors sufficiently trained/experienced to recognise and adapt to changing circumstances?

6. Were there adequate safe working procedures and were they followed?

Adverse events often happen when there are no safe working procedures or where procedures are inadequate or are not followed. Comments such as '...we've been doing it that way for years and nothing has ever gone wrong before...' or '...he has been working on that machine for years and knows what to do...' often lead to the injured person getting the blame, irrespective of what part procedures, training and supervision – or the lack of them – had to play in the adverse event. What was it about normal practice that proved inadequate? Was a safe working method in place and being followed? If not, why not? Was there adequate supervision and were the supervisors themselves sufficiently trained and experienced? Again, it is important to pose these questions without attempting to apportion blame, assign responsibility or stipulate cause.

7. What injuries or ill health effects, if any, were caused?

It is important to note which parts of the body have been injured and the nature of the injury - i.e. bruising, crushing, a burn, a cut, a broken bone etc. Be as precise as you are able. If the site of the injury is the right upper arm, midway between the elbow and the shoulder joint, say so. Precise descriptions will enable you to spot trends and take prompt remedial action. For example it could be that what appears to be a safe piece of equipment, due to the standard of its guarding, is actually causing a number of inadvertent cut injuries due to the sharp edges on the guards themselves. Facts such as whether the injured person was given first aid or taken to hospital (by ambulance, a colleague etc) should also be recorded here.

8. If there was an injury, how did it occur and what caused it?

Where an accident is relatively straightforward, it may seem artificial to differentiate between the accident itself (question 3) and the mode of injury, but when the accident is more complicated the differences between the two aspects become clearer and therefore precise descriptions are vital.

The mode of injury concerns two different aspects:

- the harmful object (known as the 'agent') that inflicted the injury; and
- the way in which the injury was actually sustained.

The object that inflicted the injury may be a hand-held tool like a knife, or a chemical, a machine, or a vehicle etc. The way in which it happened might, e.g., be that the employee cut themselves or spilt chemicals on their skin.

9. Was the risk known? If so, why wasn't it controlled? If not, why not?

You need to find out whether the source of the danger and its potential consequences were known, and whether this information was communicated to those who needed to know. You should note what is said and who said it, so that potential gaps in the communication flow may be identified and remedied. The aim is to find out why the sources of danger may have been ignored, not fully appreciated or not understood. Remember you are investigating the processes and systems, not the person. The existence of a written risk assessment for the process or task that led to the adverse event will help to reveal what was known of the associated risks. A judgement can be made as to whether the risk assessment was 'suitable and sufficient', as required by law and whether the risk control measures identified as being necessary were ever adequately put in place.

10. Did the organisation and arrangement of the work influence the adverse event?

The organisational arrangement sets the framework within which the work is done. Here are some examples; there are many more:

- standards of supervision and on-site monitoring of working practices may be less than adequate.
- lack of skills or knowledge may mean that nobody intervenes in the event of procedural errors.
- inappropriate working procedures may mean certain steps in the procedures are omitted, because they are too difficult and time-consuming.
- lack of planning may mean that some tasks are not done, are done too late or are done in the wrong order.
- employees' actions and priorities may be a consequence of the way in which they are paid or otherwise rewarded.
- high production targets and piecework may result in safety measures being degraded and employees working at too fast a pace.

11. Was maintenance and cleaning sufficient? If not, explain why not.

Lack of maintenance and poor housekeeping are common causes of adverse events. Was the state of repair and condition of the workplace, plant and equipment such that they contributed to or caused the adverse event? Were the brakes on the forklift truck in good working order? Were spills dealt with immediately? Was the site so cluttered and untidy that it created a slipping or tripping hazard? Was there a programme of preventative maintenance? What are the instructions concerning good housekeeping in the workplace? You should observe the location of the adverse event as soon as possible and judge whether the general condition or state of repair of the premises, plant or equipment was adequate. Those working in the area, together with witnesses, and any injured parties, should also be asked for their opinion. Working in the area, they will have a good idea of what is acceptable and whether conditions had deteriorated over time. Consider the role the following factors may play:

- a badly maintained machine or tool may mean an employee is exposed to excessive vibration or noise and has to use increased force, or tamper with the machine to get the work done.
- a noisy environment may prevent employees hearing instructions correctly as well as being a possible cause of noise-induced hearing loss.
- uneven floors may make movement around the workplace, especially vehicle movements, hazardous.
- badly maintained lighting may make carrying out the task more difficult.
- poorly stored materials on the floor in and around the work area will increase the risk of tripping.
- ice, dirt and other contaminants on stairs or walkways make it easier to slip and fall.
- tools not in immediate use should be stored appropriately and not left lying around the work area.

12. Were the people involved competent and suitable?

Training should provide workers with the necessary knowledge, skills and hands-on work experience to carry out their work efficiently and safely. The fact that someone has been doing the same job for a long time does not necessarily mean that they have the necessary skills or experience to do it safely. This is particularly the case when the normal routine is changed, when any lack of understanding can become apparent. There is no substitute for adequate health and safety training. Some of the problems that might arise follow:

- a lack of instruction and training may mean that tasks are not done properly.
- misunderstandings, which arise more easily when employees lack understanding of the usual routines and procedures in the organisation; n a lack of respect for the risks involved, due to ignorance of the potential consequences.
- problems due to the immaturity, inexperience and lack of awareness of existing or potential risks among young people (under18). You must assess the risks to young people before they start work.
- poor handling of dangerous materials or tools, due to employees not being properly informed about how things should be done correctly.

People should also be matched to their work in terms of health, strength, mental ability and physical stature.

13. Did the workplace layout influence the adverse event?

The physical layout and surroundings of the workplace can affect health and safety. Injuries may be caused by sharp table edges. Hazardous or highly inflammable fumes may be produced in areas where operatives work or where there are naked lights. Or the workplace may be organised in such a way that there is not enough circulation space. Or it may be impossible to see or hear warning signals, e.g. during forklift truck movements.

Employees should be able to see the whole of their work area and see what their immediate colleagues are doing. The workplace should be organised in such a way that safe practices are encouraged. In other words, workplace arrangements should discourage employees from running risks, e.g. providing a clear walkway around machinery will discourage people from crawling under or climbing over it.

14. Did the nature or shape of the materials influence the adverse event?

As well as being intrinsically hazardous, materials can pose a hazard simply by their design, weight, quality or packaging, e.g. heavy and awkward materials, materials with sharp edges, splinters, poisonous chemicals etc.

The choice of materials also influences work processes, e.g. a particularly hazardous material may be required. Poor quality may also result in materials or equipment failing during normal processing, causing malfunctions and accidents.

15. Did difficulties using the plant and equipment influence the adverse event?

Plant and equipment includes all the machinery, plant and tools used to organise and carry out the work. All of these items should be designed to suit the people using them. This is referred to as ergonomic design, where the focus is on the individual as well as the work task the item is specifically designed to carry out. If the equipment meets the needs of the individual user, it is more likely to be used as it is intended - i.e. safely. Consider user instructions here. A machine that requires its operator to follow a complicated user manual is a source of risk in itself.

16. Was the safety equipment sufficient?

You should satisfy yourself that any safety equipment and safety procedures are both sufficient and current for all conditions in which work takes place, including the provision and use of any extra equipment needed for employees' safety. For example:

- extra technical safety equipment at machines.
- power supply isolation equipment and procedures.
- personal protective equipment (PPE).
- building safety systems, e.g. an extract ventilation system.

Make a note of whether the safety equipment was used, whether it was used correctly, whether or not it was in good condition and was working properly etc.

17. Did other conditions influence the adverse event?

'Other conditions' is intended to cover everything else that has not been reported yet, but which might have influenced the adverse event. For example:

- disagreements or misunderstandings between people; n the weather.
- unauthorised interference in a process or job task.
- defective supplies or equipment.
- deliberate acts, such as trespass or sabotage.