European Bank
for Reconstruction and Development

BN11
Accident and incident procedures

EBRD briefing note

November 2026

This briefing note outlines good international practices as regards organising a workplace induction on accident and incident procedures and does not constitute legal advice or replace professional advice from national labour inspectorates or other competent authorities. We strongly encourage our clients to seek information from these entities to ensure that the contents of this briefing note do not conflict with or contradict any legal requirements. The EBRD is not responsible for the content of any external references.

Introduction

Accidents and incidents at work are rarely the result of a single act or one person's error. They are almost always the final step in a chain of failures in how work is planned, resourced, supervised and controlled. Investigating them properly is one of the most effective ways an organisation can learn through review, prevent recurrence and demonstrate genuine care for its workforce. Investigation is not about apportioning blame; it is about understanding what happened, why it happened and what must change.

The EBRD's Environmental and Social Requirement 4 (ESR 4): Health, safety and security expects clients to identify, investigate, document and report occupational and community health, safety and security incidents, to analyse their causes and to implement corrective actions to prevent recurrence. Significant incidents, including fatalities and serious injuries, must be notified to the EBRD promptly in accordance with the legal agreements, followed by a root-cause analysis and, where necessary, a corrective action plan to address shortcomings.

Why investigate?

Effective investigation delivers benefits well beyond compliance.

- It prevents recurrence by identifying and correcting the true causes, not just the symptoms.
- It identifies weaknesses in risk assessments, procedures, training, supervision and equipment.
- It demonstrates to workers, regulators, lenders and communities that the organisation values health and safety standards and looks for continuous improvement.
- It reduces the direct and indirect costs of accidents, including lost time, damage, delay and reputational harm.
- It supports legal compliance with national reporting and investigation requirements.

Definitions

Accident: an unplanned event that results in injury to or ill health in people, or damage to equipment, property or the environment.

Incident: a broader term covering all unplanned events, whether or not harm resulted.

Near miss: an event that did not cause harm but had the potential to do so. Near misses are free lessons, an opportunity to consider how the same causes, given slightly different circumstances, could produce serious injuries.

Dangerous occurrence: a specified high-potential event, such as a structural collapse, crane failure or unintended explosion, which is often legally reportable, even when no one is hurt.

Occupational ill health: harm to health caused or made worse by work, such as noise-induced hearing loss, musculoskeletal disorders or occupational disease. These should be investigated in the same way as injuries.

What should be investigated?

All incidents should be reported and recorded, and the depth of investigation should be proportionate to the actual and potential severity. A minor cut may need only a brief supervisor review; a fatality, major injury, dangerous occurrence or high-potential near miss will require a full team investigation led by a competent person, with senior management oversight. Potential severity matters as much as the actual outcome: a scaffold tube falling into an empty walkway deserves the same attention as one that strikes a worker.

The investigation process

Step 1 – Respond and make the area safe: the first priority is always people: provide first aid and medical treatment and remove any continuing danger. Secure the scene to preserve evidence and only disturb it as far

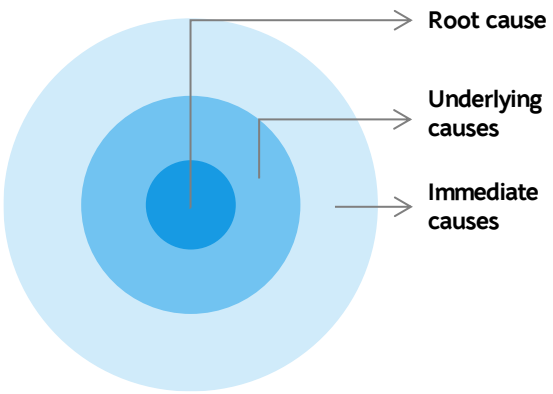
as necessary to help the injured or make the area safe. Notify management, the EBRD (for significant incidents on EBRD-financed projects) and the relevant national authorities, where legally required.

Step 2 – Gather evidence: collect information while it is fresh. Photograph and sketch the scene, retain damaged equipment and secure relevant documents: risk assessments, method statements, permits to work, training records, maintenance logs, inspection reports and shift rosters. Note environmental conditions such as weather, lighting and housekeeping.

Step 3 – Interview witnesses: interview witnesses individually, as soon as practicable, in a neutral setting and in a language they understand. Use open questions (who, what, where, when, how) and avoid leading or blaming. Reassure workers that the purpose is learning, not discipline; a just culture is essential if people are to report openly.

Step 4 – Analyse the causes: work back from the event through three layers of causation. Immediate causes are the unsafe acts and conditions at the point of the event (for example, a missing guard or an unsecured load). Underlying causes are the workplace failures that allowed the event to occur (inadequate supervision, poor maintenance, unsuitable equipment, time pressure, fatigue). Root causes are the management system failures from which the others flow (no risk assessment process, poorly understood or practised procedures, inadequate training arrangements, unclear responsibilities, weak contractor management). Techniques such as the "five whys", timelines and cause-and-effect (fishbone) diagrams help to structure the analysis.

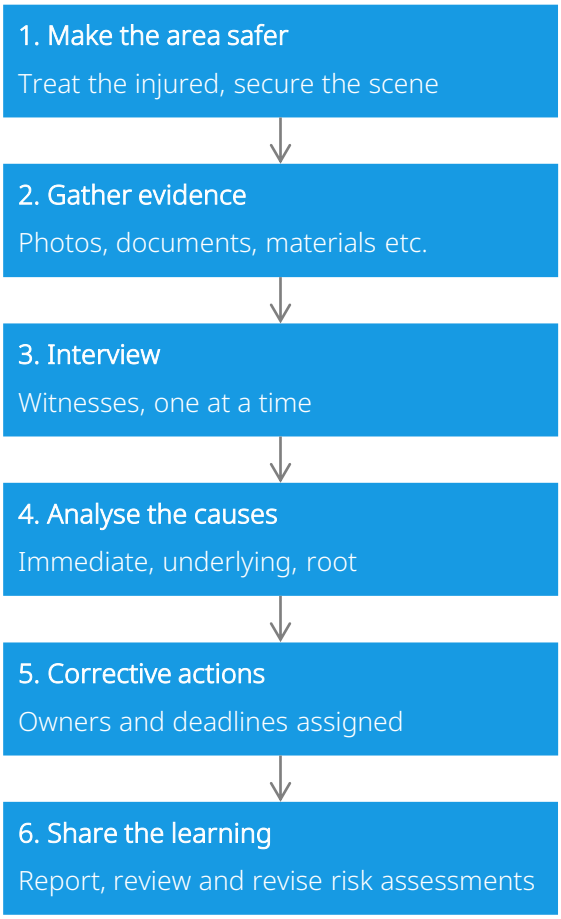
Figure 1. The causation relationship



Step 5 – Agree corrective and preventive actions: actions should address every level of causation and follow the hierarchy of controls, preferring elimination and engineering measures over reliance on compliant behaviours. Each action needs a named owner, a deadline and a means of verifying completion and effectiveness.

Step 6 – Record, report and share the learning: produce a clear written report, update the accident register, revise the relevant risk assessments and procedures, and brief the workforce on the findings. On EBRD-financed projects, significant incidents and the resulting corrective action plans should be reported to the Bank, and lessons learned should be shared across sites and contractors.

Figure 2. The six stages of an incident investigation



Fatalities, serious injuries and dangerous occurrences on EBRD-financed projects must be notified to the EBRD without delay, in compliance with the project legal agreements, followed by a root-cause investigation and a time-bound corrective action plan.

Recording and notification

Every workplace should maintain an accident and incident register capturing, as a minimum: the date, time and location of the event or near miss; the people involved; the nature of any injury, ill health or damage; a short description of the event or near miss; the immediate action taken; and the status of the investigation and corrective actions. Records support trend analysis: recurring near misses, locations or activities point to weaknesses that can be corrected before someone is seriously hurt.

Companies must also comply with their national requirements for notifying police, labour inspectorates or other competent authorities of specified injuries, occupational diseases and dangerous occurrences, within the timescales set in national law.

Investigation team and competence

Serious investigations should be led by a person with investigation training and independence from the work being investigated, supported by a supervisor familiar with the task, a worker or worker representative, and specialists (engineers, occupational hygienists), where needed. Worker involvement improves both the quality of findings and the workforce's trust in the outcome.

Summary

An effective accident and incident investigation arrangement should confirm whether:

- all accidents, incidents, near misses and cases of ill health are reported and recorded
- there is a written investigation procedure with clear responsibilities (see Annex A)
- the depth of the investigation is proportionate to actual and potential severity
- the scene has been made safe and evidence preserved
- witnesses are interviewed fairly, promptly and without apportioning blame
- the analysis identifies immediate, underlying and root causes
- corrective actions have owners, deadlines and verification
- national authorities and the EBRD are notified, where required
- findings are shared and risk assessments updated
- trends are reviewed by senior management.

References

EBRD (2024), Environmental and Social Policy, London. Available at: https://www.ebrd.com/home/news-and-events/publications/institutional-documents/environmental-and-social-policy-2024.htmlhttps://www.ebrd.com/home/news-and-events/publications/institutional-documents/environmental-and-social-policy-2024.html.

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International Labour Organization (1981), Occupational Safety and Health Convention, 1981 (No. 155), Geneva. Available at: https://www.ilo.org/media/107601/download.

See also:

- BN10: Management of contractors and subcontractors
- BN12: Workplace risk assessment
- BN14: Protecting the public

Annex A: example accident investigation procedure

This example accident investigation procedure should be adapted to the organisation's structure, national legal requirements and the project's Environmental and Social Action Plan. Defined roles are illustrative.

1. Purpose and scope

This procedure describes how the organisation reports, records, investigates and learns from all work-related accidents, incidents, near misses, dangerous occurrences and cases of occupational ill health. It applies to all employees, contractors, subcontractors and visitors at all workplaces under the organisation's control.

2. Responsibilities

- All workers: report every accident, incident and near miss to their supervisor immediately; cooperate with investigations.
- Supervisor/line manager: make the area safe; arrange first aid; report upwards immediately; preserve the scene; complete the initial incident report within 24 hours; lead investigations of minor events.
- Health and safety adviser: classify the event; advise on notification duties; lead or support investigations; maintain the accident register; analyse trends and report to management.
- Site/project manager: appoint the investigation team; notify national authorities and the EBRD, where required; approve and resource corrective actions; verify close-out.
- Senior management: review significant investigations and trend reports; ensure a just, no-blame reporting culture; confirm lessons learned are shared across the organisation.

3. Classification and response levels

- Level 1 – Minor: first-aid injury, minor damage or low-potential near miss. Investigation by the supervisor using the report form, reviewed by the health and safety adviser.
- Level 2 – Serious: lost-time injury, occupational ill health, moderate damage or high-potential near miss. Team investigation led by the health and safety adviser with the supervisor and a worker representative.
- Level 3 – Major: fatality, life-changing or multiple injuries, dangerous occurrence or community member harmed. Full root-cause investigation led by a competent independent person, with senior management oversight, immediate notification to the national authorities and the EBRD, and scene preservation pending any regulatory investigation.

4. Procedure

1. Make the area safe and treat the injured. Responsible: supervisor/first-aiders. Timescale: immediately.
2. Report the event and secure the scene. Responsible: supervisor. Timescale: immediately.
3. Notify authorities/the EBRD, where required. Responsible: site/project manager. Timescale: per legal timescales; EBRD – without delay for Level 3 events.
4. Complete the initial incident report. Responsible: supervisor. Timescale: within 24 hours.
5. Gather evidence and interview witnesses. Responsible: investigation team. Timescale: within 48 hours, where practicable.
6. Analyse immediate, underlying and root causes. Responsible: investigation team. Timescale: during the investigation period.
7. Agree corrective actions with owners and deadlines. Responsible: team/site/project manager. Timescale: on completion of analysis.
8. Issue the investigation report; update the register and risk assessments; brief the workforce. Responsible: health and safety adviser. Timescale: within 10 working days for Level 2 events and 20 working days for Level 3 events.
9. Verify actions are complete and effective; close out. Responsible: site/project manager. Timescale: per action deadlines.

5. Investigation report form (template)

Part A – Event details

- Report reference: _____
- Classification (Level 1/2/3): _____
- Date and time of event: _____
- Date reported: _____
- Exact location: _____
- Person(s) involved (name, role, employer): _____
- Type of event (injury/ill health/near miss/dangerous occurrence/damage): _____
- Injury and body part (include which side of body)/nature of harm: _____

Part B – What happened

- Description of the event and activity at the time: _____
- Immediate action taken: _____
- Witnesses interviewed: _____
- Evidence collected (photos, documents, equipment): _____

Part C – Why it happened

- Immediate causes (unsafe acts/conditions): _____
- Underlying causes (task, equipment, environment, people factors): _____
- Root causes (management system failures): _____

Part D – Actions and close-out

- Corrective/preventive actions: _____
- Owner: _____
- Deadline: _____
- Date verified complete: _____
- Additional corrective/preventive actions: _____
- Owner: _____
- Deadline: _____
- Date verified complete: _____
- Risk assessment(s) updated? (ref.): _____
- Workforce briefed on (date): _____
- Authorities/EBRD notified? (date, ref.): _____
- Investigator (name, position, signature, date): _____
- Approved by (name, position, signature, date): _____
- Report retention period: _____

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