

SITE SURVEY REPORT

Accident Investigation Form

Prepared for	Swiftline Parcels Ltd
Date	6 Oct 2026
Site	Swiftline Parcels, Daventry depot
Prepared by	R. Bains

FORM

Accident Investigation Form

1. Investigation details

Project	Swiftline Parcels, Daventry depot: accident investigation (completed example)
Workplace address	Unit 7, Brookfield Distribution Park, Daventry NN11 8QZ
Client or employer	Swiftline Parcels Ltd
Location (GPS)	52.2683, -1.1512
Date the investigation started	6 Oct 2026
Lead investigator	R. Bains, operations manager
Original incident report reference	IR-2026-118
Date of the accident or near miss	5 Oct 2026
Time	07:40
What is being investigated?	Accident: someone injured
Exact location	Aisle C, bay 14, beside the roll cages staged for the morning sort
Country	UK (England, Scotland, Wales)
What happened, in brief	A warehouse operative stepped out from between staged roll cages into aisle C as a colleague pulled a loaded hand pallet truck backwards along the aisle. The truck ran over the operative's right foot.
Person injured or involved	J.R., warehouse operative, Swiftline Parcels Ltd
Injury or ill health, as recorded	Fractured little toe, right foot, diagnosed at hospital the same morning
Days unable to do their normal work so far	10
Worst realistic outcome	Serious
Could it happen again?	Likely
Level of investigation	Medium

This is the follow-up investigation of an accident, near miss or dangerous occurrence that has already been reported. Keep the original incident report: this record adds the evidence, the causes and the actions.

Investigation team 1: R. Bains

Name	R. Bains
Role	Supervisor or line manager

Investigation team 2: S. Okoro

Name	S. Okoro
Role	Health and safety adviser

Investigation team 3: M. Hale

Name	M. Hale
Role	Employee or safety representative

2. Scene examination

Was the scene made safe and left as it was until it was examined?	No
What was moved or changed before the examination, and why?	The roll cages were moved out of aisle C at 08:15 to keep the sort running. Their positions were marked on the floor with tape and photographed first by the shift supervisor.
Scene location (GPS)	52.2684, -1.1510
Conditions at the time	Congested area or vehicle traffic, Busy period or time pressure
What the scene shows	Aisle C is the route from goods in to the sort belt. Six roll cages were staged along the racking side, leaving a narrow lane. The operative was picking between the cages; the pallet truck operator could not see past the load when pulling it backwards.

Scene photos

**Measurements 1: Clear width between the staged cages (tape marks) and the racking**

What was measured	Clear width between the staged cages (tape marks) and the racking
Measurement	1150
Unit	mm
How measured	Tape or laser

Measurements 2: Width of the loaded pallet on the truck

What was measured	Width of the loaded pallet on the truck
Measurement	1000
Unit	mm
How measured	Tape or laser

Measurements 3: Height of the carton stack on the pallet

What was measured	Height of the carton stack on the pallet
Measurement	1.4
Unit	m
How measured	Measured from a photo (estimate)
Was any equipment, vehicle or tool involved?	Yes
Equipment	Hand pallet truck, depot fleet number PT-04

Taken out of use and labelled until it has been checked?

Yes

Condition found when checked

Quarantined and checked by the fleet engineer on 6 October. Wheels, handle and brake-free steering in good order; no defect that contributed.

Equipment photos



3. Evidence and witness interviews

Evidence gathered 1: CCTV footage

Type	CCTV footage
Description	Camera 6, aisle C, 07:30 to 07:50 on 5 October
Who holds it	R. Bains
Where it is kept	Saved to the depot H&S folder

Evidence gathered 2: Equipment or part

Type	Equipment or part
Description	Hand pallet truck PT-04
Who holds it	Fleet engineer
Where it is kept	Quarantine bay until 6 October, now back in use

Evidence gathered 3: Document or record

Type	Document or record
Description	Peak season floor layout v2 (cages staged in aisle C)

Who holds it	S. Okoro
Where it is kept	Depot H&S folder

Evidence gathered 4: Training record

Type	Training record
Description	Pallet truck training records for the sort team
Who holds it	HR
Where it is kept	Training system
Items of evidence	4
Were there witnesses, or people who know the conditions?	Yes

Witness interviews 1: J. Rowe

Name	J. Rowe
Who are they?	Injured person
Interviewed on	8 Oct 2026
Interviewed by	R. Bains and M. Hale
Where they were and what they could see	Between the third and fourth cages, facing the racking
Their account	I was scanning parcels in the cages and stepped back into the aisle to reach the next cage. I did not hear the truck coming over the belt noise. I was wearing my safety trainers.

Signature of the person interviewed

*J. Rowe***Witness interviews 2: L. Price**

Name	L. Price
Who are they?	Employee
Interviewed on	6 Oct 2026
Interviewed by	R. Bains and S. Okoro
Where they were and what they could see	Pulling the pallet truck backwards from the goods-in end

Their account

The way round by the dock was blocked with cages so I took the pallet down aisle C. I pulled it because the load was too high to see over. I felt it stop and heard J. shout.

Signature of the person interviewed

L. Price

Witness interviews 3: D. Szabo

Name	D. Szabo
Who are they?	Supervisor or manager
Interviewed on	6 Oct 2026
Interviewed by	S. Okoro
Where they were and what they could see	At the sort belt, about 15 m away, facing aisle C
Their account	Saw the pallet coming down the aisle with people working in the cages. Did not see the moment of contact. Gave first aid and called the duty manager.

Signature of the person interviewed

D. Szabo

Interviews 3

4. Sequence of events and causes

Sequence of events 1: 07:15

Time	07:15
What happened	Morning sort starts. Six roll cages staged in aisle C under the peak layout.

Sequence of events 2: 07:35

Time	07:35
What happened	L. Price collects a pallet of cartons from goods in; route by the dock blocked, takes aisle C.

Sequence of events 3: 07:40

Time	07:40
What happened	J. Rowe steps back out of the cages; the pallet truck runs over the right foot.

Sequence of events 4: 07:45

Time	07:45
What happened	First aid given by D. Szabo; ice and foot raised.

Sequence of events 5: 08:30

Time	08:30
What happened	Taken to hospital by a colleague. Fracture of the little toe diagnosed.
Where were the immediate causes?	The place: layout, floor, lighting, access, The process: task, method, pace
Immediate causes	Loaded pallet truck pulled backwards along a narrow, busy aisle with the operator unable to see past the load. Operative stepped into the aisle without seeing the truck.
Underlying causes	Peak layout staged roll cages in aisle C, narrowing it to about 1.15 m and putting pickers in the pallet route. The usual route by the dock was blocked. No marked pedestrian area or rule for pallet moves during the sort.
Root causes	The peak season layout was changed in September without reviewing the warehouse risk assessment. There is no step in the depot procedure to check layout changes for people and pallet routes.
How were the causes found?	Asking why, again and again (5 whys)

Why chain 1: Why was J. Rowe's foot run over?

Why?	Why was J. Rowe's foot run over?
Because	The truck was pulled backwards along a narrow aisle where people were picking.

Why chain 2: Why was it pulled backwards down aisle C?

Why?	Why was it pulled backwards down aisle C?
Because	The load was too high to see over and the dock route was blocked by roll cages.

Why chain 3: Why were roll cages in aisle C and by the dock?

Why? Why were roll cages in aisle C and by the dock?

Because The peak season layout staged them there.

Why chain 4: Why did the layout put cages in a pallet route?

Why? Why did the layout put cages in a pallet route?

Because Nobody checked the people and pallet routes when the layout changed.

Why chain 5: Why was it not checked?

Why? Why was it not checked?

Because Layout changes are not reviewed against the risk assessment before use.

Was there a risk assessment for this work? Yes

Risk assessment reference RA-WH-07 rev 3, warehouse traffic and pallet handling

Did it cover what happened? Yes, but the controls were not enough

Has the risk assessment been reviewed after this investigation? Yes

What changed in it Rev 4 adds: no staging in pallet aisles during the sort, a marked pedestrian zone in aisle C, a second person to guide any load that blocks the operator's view, and a check of every layout change.

5. Reporting

RIDDOR category Over-7-day injury to a worker

Has it been reported? Yes

Date reported 15 Oct 2026

Report reference RIDDOR-EXAMPLE-01

Days from the accident to the report 10

Has the original incident report been updated with what the investigation found? Yes

Who else has been told? The injured person, Safety representative, Insurer, Senior management

6. Actions, lessons and sign-off

Actions recorded 4

Result

Open: actions still to complete and verify

Corrective and preventive actions 1: Stop staging roll cages in aisle C during the sort and mark a pedestrian zone with floor tape and signs.

Action	Stop staging roll cages in aisle C during the sort and mark a pedestrian zone with floor tape and signs.
Type	Corrective: puts this right
Cause it deals with	Underlying
Priority	Immediate: before the work restarts
Who will do it	R. Bains
Due by	6 Oct 2026
Status	Done, checked
How it was checked	Walked the sort on 8 and 13 October: aisle C clear, cages in the new bay, zone marked and used.
Checked by	S. Okoro
Date verified	13 Oct 2026

Corrective and preventive actions 2: Review RA-WH-07 for the peak layout and brief all sort staff on the changes.

Action	Review RA-WH-07 for the peak layout and brief all sort staff on the changes.
Type	Preventive: stops it happening again
Cause it deals with	Underlying
Priority	Within a week
Who will do it	S. Okoro
Due by	12 Oct 2026
Status	Done, checked
How it was checked	Rev 4 issued 9 October. Briefing sign-in sheet shows all 24 sort staff on 10 and 12 October.
Checked by	M. Hale
Date verified	12 Oct 2026

Corrective and preventive actions 3: Refresher pallet truck training for the sort team, including moving loads that block the view.

Action	Refresher pallet truck training for the sort team, including moving loads that block the view.
Type	Preventive: stops it happening again
Cause it deals with	Immediate
Priority	Within a month
Who will do it	Training coordinator
Due by	23 Oct 2026
Status	In progress

Corrective and preventive actions 4: Add a layout change check to the depot procedure: any change to storage or staging is reviewed against the risk assessment before use.

Action	Add a layout change check to the depot procedure: any change to storage or staging is reviewed against the risk assessment before use.
Type	Preventive: stops it happening again
Cause it deals with	Root
Priority	Within a month
Who will do it	Depot general manager
Due by	20 Nov 2026
Status	Open
Actions still open	2
Decision	Investigation complete: actions in progress
Date to review the actions	23 Nov 2026
How the lessons were shared	Team briefing or toolbox talk, Safety committee, Other sites or depots
Lessons learned	Temporary layouts change traffic routes. Check people and pallet routes before staging anything in an aisle, and do not move a load you cannot see past without help.
Summary of the findings	Over-7-day injury to an operative's foot from a pallet truck in aisle C, reported under RIDDOR on 15 October. Caused by roll cages staged in a pallet route during the sort, under a layout change that was not risk assessed. Aisle cleared and marked, risk assessment revised; training and a layout change check are in progress.

Lead investigator name

R. Bains

Lead investigator signature

R. Bains

Manager responsible name

K. Whitlock, depot general manager

Manager responsible signature

K. Whitlock
