

Guidance for the Reporting of Accidents and Incidents

Manchester Metropolitan University

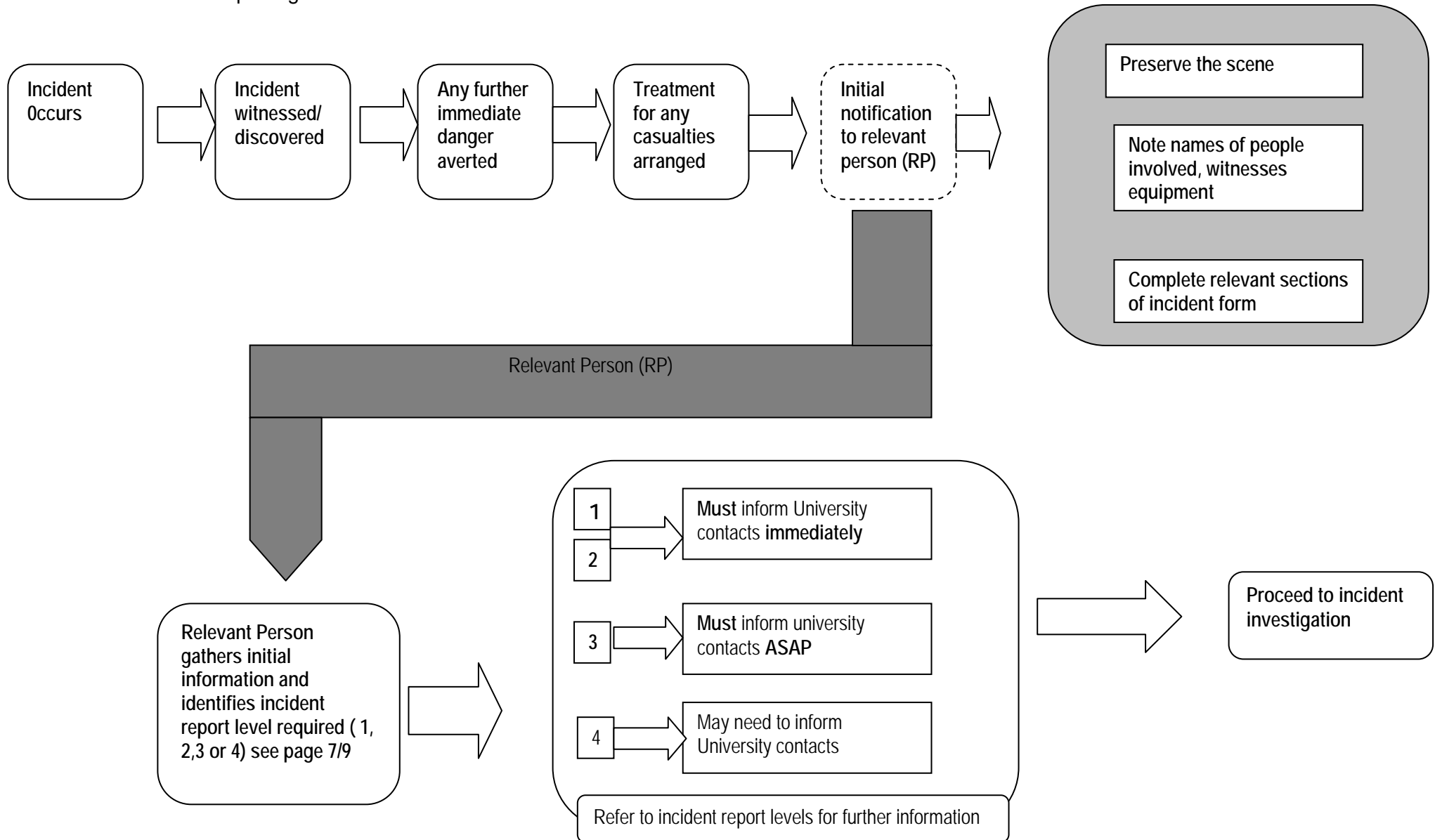
Guidance for the Reporting and Investigation of Accidents and
Incidents

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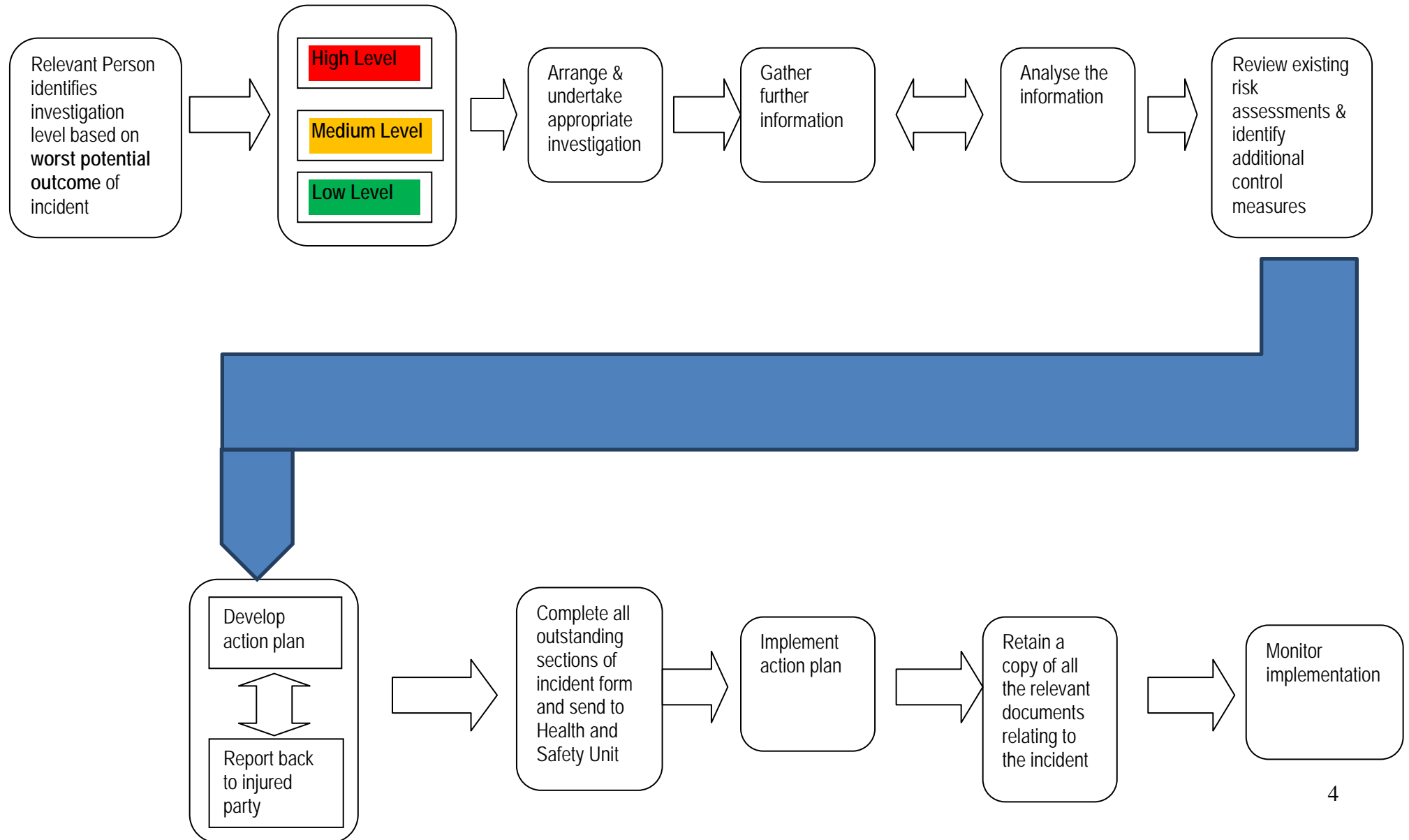
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Guidance for the Reporting of Accidents and Incidents

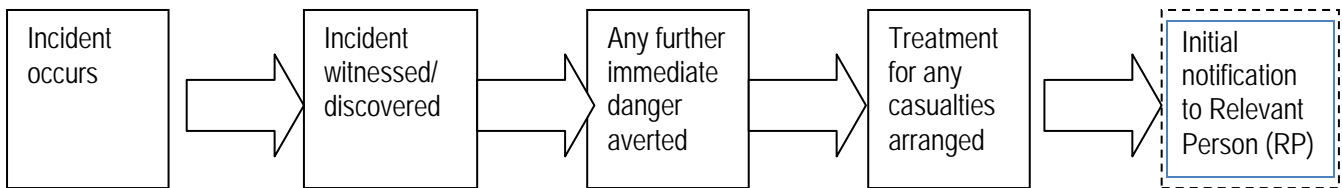
Incident Reporting Process



Incident Investigation Process



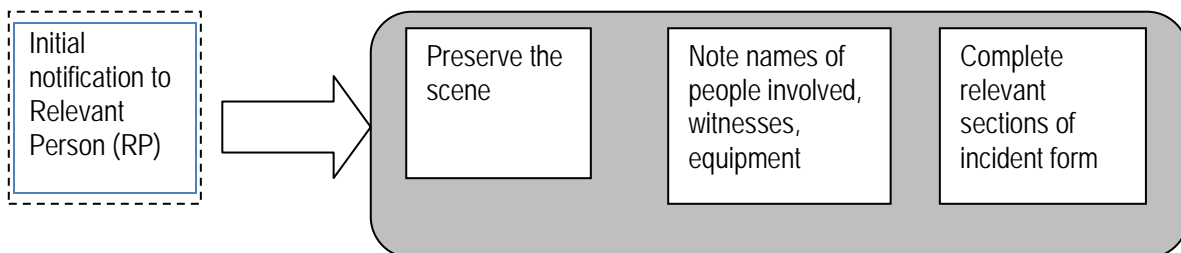
1 Response, Communication and Notification



1.1 Immediate Response by the Organisation

The scale of the response will be dependant upon the seriousness of the incident and could range from contacting a first aider to contacting the emergency services

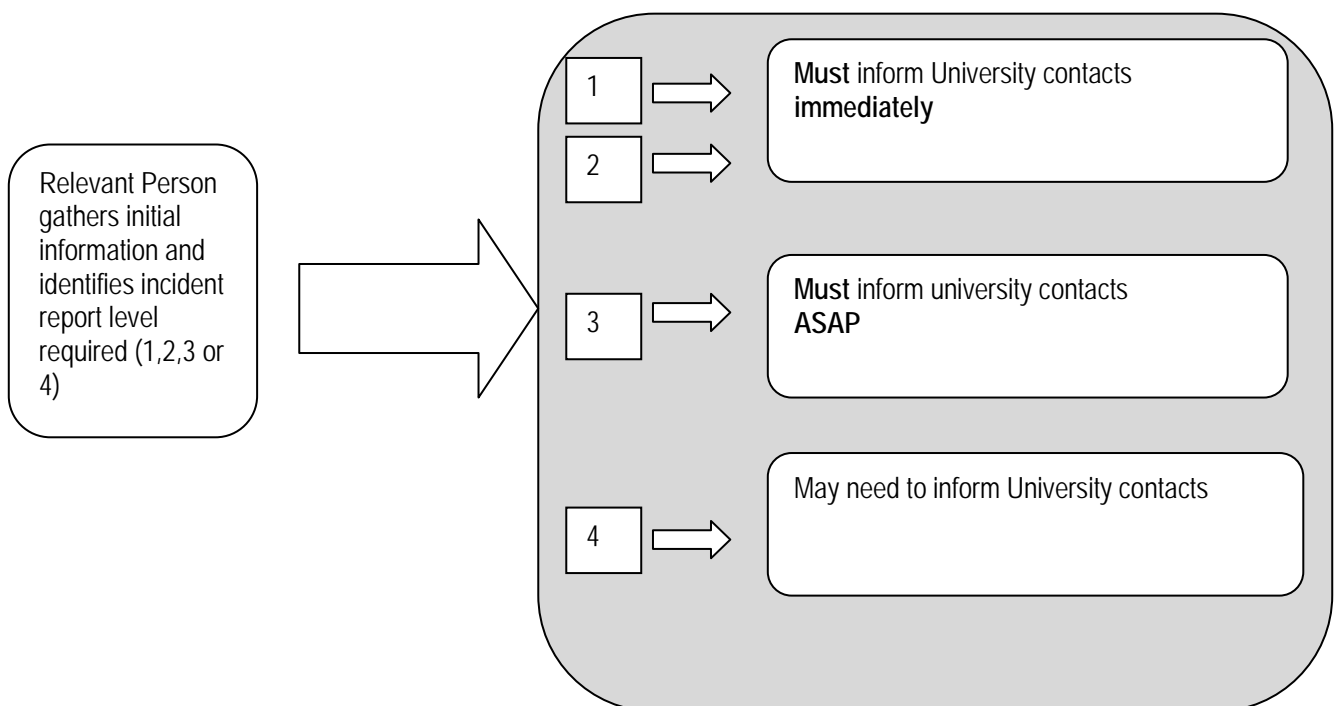
- Ensure the injured person is safe and relevant first aid treatment is provided
- The actual person making the initial notification to the relevant person can vary but could include a person involved in the incident, a witness to the incident or a person who discovers the incident.
- All incidents should be notified to a Relevant Person (RP) as soon as possible so that they can decide what further action may be necessary. The initial notification should be made verbally and then followed up by formally recording the details on an incident report form
- Who the Relevant Person is may vary depending on the circumstances of the incident and could include the line manager or academic tutor of the activity that resulted in the incident occurring or the department head. If there is any doubt then the Health and Safety team should be contacted for advice during normal working hours. After working hours please ring the health and safety team main number (0)161 247 3317 Where you will be given further details on who to contact out of hours.
- Ensure the area is made safe and if any equipment is involved ensure the equipment is retained and isolated and ensure any relevant documentation is copied for the incident investigation



1.2 Reporting the Accident/ Incidents

- On being notified of an incidents the Relevant Person will need to identify the incident report level(1-4) required based on the information know at the time and the Incident Report Level Guide

- Initial Details should be established such as;
 - Where and when did it happen
 - Who was involved details if injuries/witnesses
 - A brief description of what was being done at the time/what happened/ what has been discovered
 - Any action taken/ proposed (i.e. emergency services called, values to be shut off)
- If further information needs to be obtained before the incident level can be identified or if information comes to light during the investigation that means that the incident report level changes the relevant person must ensure any required reports are made as soon as it has been identified that the incident reporting level has changed.
- Ensure that support mechanisms are available for people who have, or may have been, exposed to traumatic events



	Incident Report Levels
Level 1 High Risk Rating 16 and above	<p>Any incident directly connected with the activities of the University, or on University owned sites, where:</p> <ul style="list-style-type: none"> • An employee (or Self employed person working on University premises) is killed. Or A member of the public is killed. • An incidents at this level will require immediate reporting to external agencies and key University contacts will need to be notified and briefed <p>Immediately Phone during working hours the Health and Safety Unit on 0161 247 3317. Out of hours please ring the same number where the out of hours contact details for the health and safety advisor will be provided</p>
Level 2 High Risk Rating 12 -15	<ul style="list-style-type: none"> • Any incident that results in a major injury or dangerous occurrence as detailed in RIDDOR(insert link) Or a member of the public is taken directly to hospital • University contacts Key University contacts will be notified and briefed • Immediately Phone during working hours the Health and Safety Unit on 0161 247 3317 to initiate appropriate notifications (i.e. HSE, Trade Union) Out of hours please ring the same number where the out of hours contact details for the health and safety advisor will be provided
Level 3 Medium Risk Rating 8-10	<ul style="list-style-type: none"> • Any incident that results in , or is likely to result in, an over three day injury or a reportable disease as detailed in RIDDOR (insert hyperlink) • University contacts Key university contacts will need to be notified and briefed • Contact: Health and Safety Services ASAP to initiate appropriate notifications. Out of hours please contact the Health and Safety unit the next working day
Level 4 Low Risk Rating below 6	<ul style="list-style-type: none"> • Any other incidents that does not fall into levels 1,2 or 3. • University contacts may need to be notified. The relevant person should use their discretion to decide if any notifications are required giving consideration to incidents that can or could affect other employees or bring substantial press, media, public or pressure group interest.

1.3 Media Involvement –

What to do in the event of an emergency? (crib sheet)

Is it an emergency?

Emergencies cover a wide range of possible incidents, including: accidents, fatalities, natural disasters, fires, bomb threats, health alerts, public order incidents, crime and more intangible situations which could bring the university into disrepute.

EM1 (Relates to level 1 Incident Report Level & Level 2) – High risk of external visibility/awareness – fire, flood, spillage/pollution/contamination, bomb/terrorism, staff/student death(s), demonstrations, serious complaints, legal action.

EM2 (Relates to level 3 Incident Report Level) – Medium risk of external visibility/awareness. These are incidents which could attract external attention or intervention, but could go either way. For utilities failure, example spillage/pollution/contamination, minor accident, small fire, flood or leak, complaint or legal action.

EM3 (relates to level 4 Incident Report Level) – Little or no risk of external visibility/awareness. These are incidents which will be dealt with in-house and may involve misconduct, petty crime, poor customer service or minor complaints or accidents.

Who do I contact?

In EM1 and EM2 scenarios, the Press Office must be informed immediately. Consult your Emergency contact list - available from Carolyn Highton x3397. (Any changes in staff or their mobile or home telephone numbers must be notified to the Services Director as soon as possible.)

In EM3 situations, please contact your line manager.

Press Officers (office and out of hours)

Press officer ext 3406 mobile 07748 111322
ext 2184 mobile

Director of Marketing and Communications ext 3381 mobile 07515457633

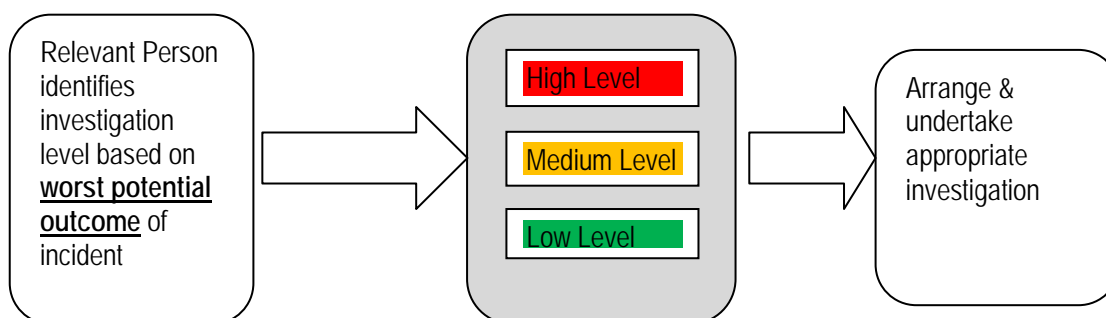
Please contact these colleagues immediately. REMEMBER: Emergency incidents can quickly escalate and the university needs to act quickly in order to keep abreast of the situation.

For a full list of other colleagues to contact in the event of an Emergency, please see the Complete Emergency Management Plan

Should I answer any media questions?

Any member of staff who is contacted by the media or other external organisation must not respond to any questions and refer them to the Press Office

2 Incident Investigation



An investigation should commence at the earliest opportunity. This is good practice and also common sense as memory is at its best and motivation can be greatest immediately after an incident.

Effective investigations have systematic and structured approaches which involve analysing all available information (physical, verbal and written) to identify what went wrong and determine what steps must be taken to prevent a re-occurrence.

High Level = Incident Report Level 1 and 2 Incident Grade 12 and above

Medium Level = Incident Level 3 Incident Grading 8 to 10

Low Level = Incident Level 4 Incident Grading 6 and below

2.1 Incident Grading and Appropriate Levels of Investigations

After being notified of an incident occurring and obtaining basic information of what happened, the Relevant Person should identify and undertake the level of investigation required based on the grading of the incident. This must be based on the outcome of the incident at the time, the actual injury and the potential likelihood of the incident reoccurring. The grading matrix below.

Risk Grading Matrix

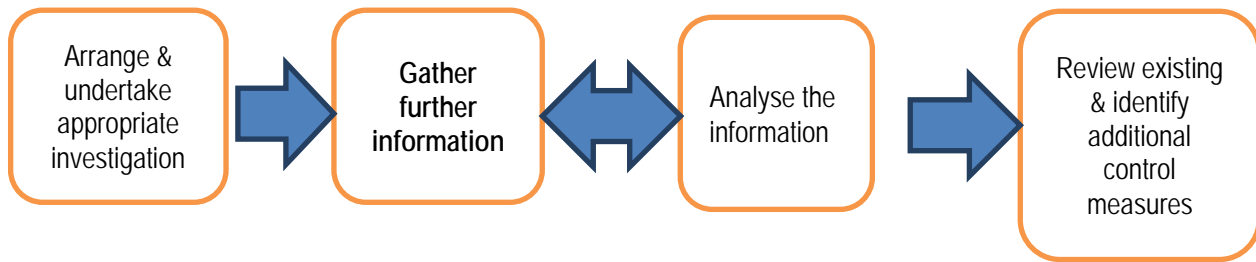
Likelihood	Impact				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Measures of Likelihood

Level	Descriptor	Description
1	Rare	May occur only in exceptional circumstances
2	Unlikely	Not expected but could occur at some time
3	Possible	May/will occur at some time
4	Likely	Will probably occur but nor a persistent issue
5	Almost Certain	Likely to occur on many occasions, a persistent issue

Measures of Impact

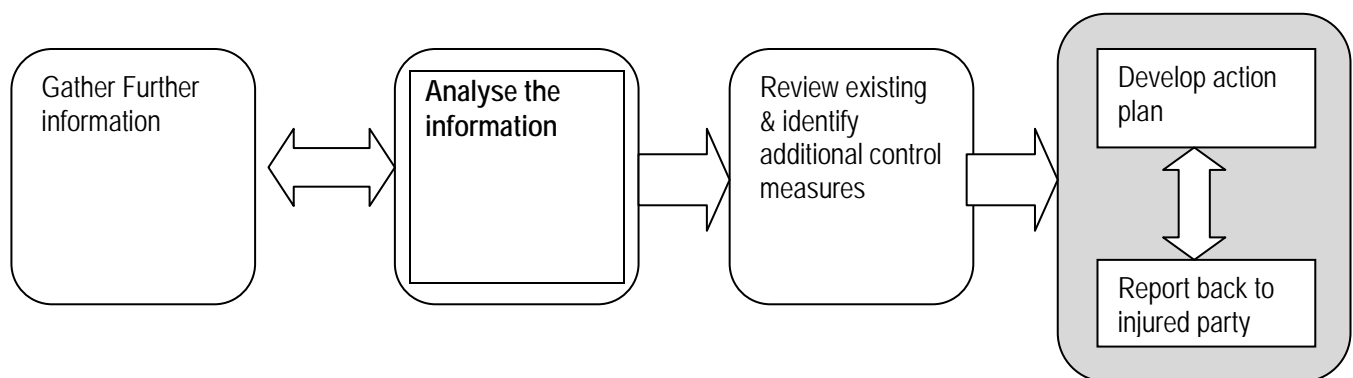
Descriptor	Insignificant = 1	Minor = 2	Moderate = 3	Major = 4	Catastrophic = 5
Injury (physical)	Incident leading to a minor injury not requiring first aid	Minor injury requiring first aid. Short term harm < 7 days absence	Semi-permanent injury > 7 days staff absence	Major injury/ long term incapacity or disability (e.g. loss of limb) long term sickness > 4 weeks	Incident leading to death or involving a number of people seriously injured.
Level of Investigation	Low level undertaken by relevant team leader/ manager	Low level undertaken by relevant team leader/ manager	Medium level undertaken by relevant team leader/ manager and another team leader/manager	High level undertaken by relevant team leader/ manager/ the immediate manager, TU representative and support from the Health and Safety Unit	High level the Director of HR will appoint and investigation team consisting of a member of the directorate or executive supported by a senior manager and the health and safety advisor and TU representative



2.2 Investigation

2.2.1 Note not all investigations will need to be investigated to the same extent or depth. The amount of time and effort spent on information gathering should be proportionate to the level of investigation. Most investigations will be undertaken by the relevant person however high level investigations may include the involvement of the Trade Union safety representatives and Health and Safety Unit.

- All relevant information should be gathered
- The incident scene should be visited and inspected (when safe to do so). Photographs/ videos should be taken as appropriate
- If equipment is involved this should be taken to out of use until deemed safe to use
- Any relevant documentation or polices should be gathered
- All witness should be identified and statements taken



2.2.2 Effective analysis must be objective and unbiased and involves an examination of all the information to determine

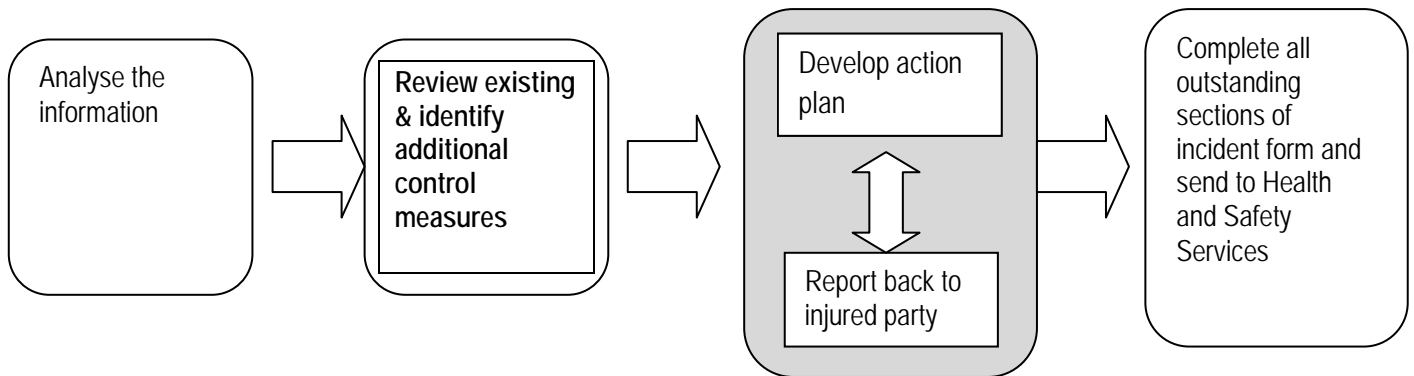
- What happened?
- How did it happen?

- What allowed it to happen?

2.2.3 Preconceptions regarding the process, equipment of people involved can result in the real causes of the incident being missed. The sequence of events needs to be established to establish the key facts. This is best done in a time line see appendix D which also contains check list for investigations of incidents.

Immediate causes	The immediate cause of the incident. E.g. A persons hand come into contact with a moving unguarded blade.
Unsafe Conditions	Any unsafe condition(s) that contributed to the incident occurring. E.g. A machine with an unguarded blade being available for use
Unsafe Acts	Any unsafe act(s) that contributed to the incident occurring. E.g. Actually using a machine with an unguarded blade.
Root causes	The root cause(s) that allowed the unsafe condition(s) and unsafe act(s) to exist. E.g., an inadequate safe system of work, lack of training, no maintenance/ inspection routine, production issues,

2.3 Investigation Report/ Remedial Action



2.3.1 Where an incident has occurred the existing control measures may be inadequate. As such all risk assessments relating to the activity must be reviewed and any potential additional risk control measures that could prevent the incident reoccurring should be identified. Any subsequent changes to risk assessments as a result should be documented.

2.3.2 They should be considered according to the order in the following hierarchy of risk control which, as well as being in order of effectiveness to control risks, is also in order of the minimum amount of managerial effort required to maintain them.

Hierarchy of risk control	
Eliminate the risk	Avoid the risk altogether by removing the hazard or no longer undertaking the activity
Substitute the risk	Reduce the risk by replacing the hazard or activity with one which entails a lower risk
Control the risk (Physical)	Control the risk by physical isolation or separation of people from the hazard
Control the Risk (Procedural)	Control the risk by procedural methods which are understood and effectively implemented; safe systems of work, information, training, instruction, supervision.
Protect the individual	Protect the individual by the provision of personal protective equipment

To assist in preventing a recurrence of the incident the additional risk control measures identified must address the acts, conditions and root causes that led to the incident. The root causes analysis should consider the following areas to ensure all causes of the accident are identified.

Human Factors: *tend to be those issues that are unique to the person persons involved in the incident. They, like individual factors are often grouped into social and cultural factors.*

Individual Factors: *these are factors that the individual(s) involved in the incident bring that are unique to them. They include psychological factors, home factors, work relationship factors and many more*

Task Factors: *are those that support and aid in the safe and effective delivery of the tasks or work*

Communication Factors: *generally concerns any aspect of communication (verbal, written or non-verbal) that affected task completion/poor performance.*

Team and Social Factors: *predominantly involve communication type issues. However, management style, traditional hierarchical structures and lack of respect for less senior members of the team can significantly affect the cohesiveness of the team. Perception of role – both own and others also affects team functioning.*

Education and Training Factors: *the availability of and quality of the training programmes available to staff can directly affect their ability to perform to their job*

Equipment and Resource Factors: *in this context we look at the reliability of equipment Resource both in terms of appropriately skilled personnel, the implementation of training regimes, the purchasing of new equipment*

Working Conditions: *are all those factors affecting your ability to function at optimum levels in the work place eg uncomfortable heat, poor lighting; noise from equipment, building works etc. overcrowding*

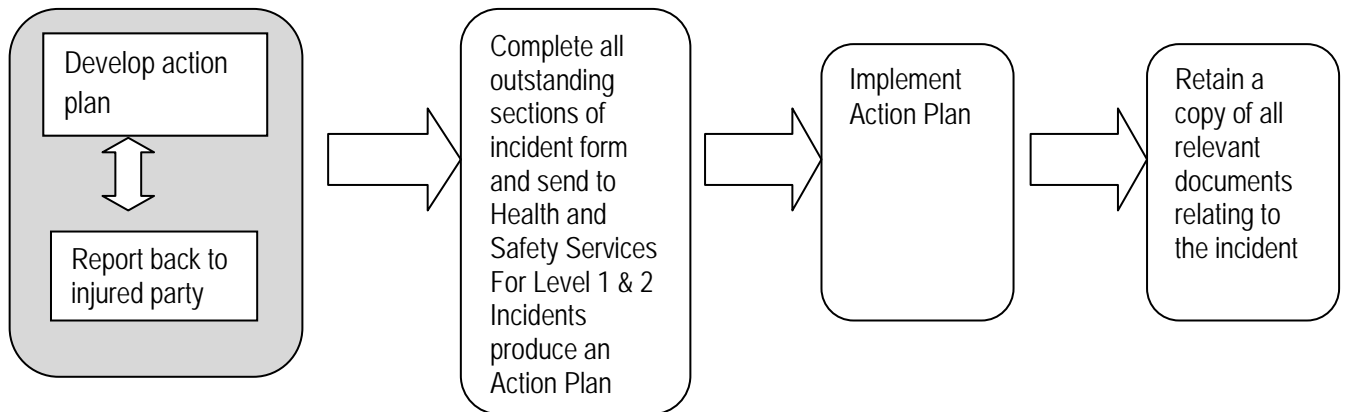
Organisational and Strategic Factors: *these are factors that are either inherent or imbedded within the organisation. These factors can lie dormant and unrecognised within an organisation, or they might be recognised but not viewed as priority because of other pressing concerns - such as financial performance targets*

Some of the control measures identified may be more difficult to implement and others but this should not prevent them from being considered. In many cases suitable risk control measures will involve a mixture of methods reference should be given to sources of useful information including industry specific guidance and best practice.

Appendix C contains causation codes that should be used as an aid in the investigation.

When deciding on which control measures to recommend reference must be made to any specific legal standard that apply.

2.4 Recommendations and Action Planning



- 2.4.1 When the control measures have been identified and agreed they must be prioritised and placed into an action plan and implemented (See Report Format and Action Plan Template in appendix E)
- 2.4.2 The action plan needs to be clear about what needs to be done and by whom with SMART objectives (Specific, Measurable, Achievable, Realistic and Timed) .The remaining sections of the incident form should be completed and sent to the Health and Safety Team.
- 2.4.3 The action plan must be taken to the Faculty/ Service Health and Safety panel for approval and monitoring.
- 2.4.4 The Conclusions of the investigation and a summary of the actions planned/ taken should be communicated to the injured party and any other relevant groups (e.g. faculties, facilities, technical services with similar activities).

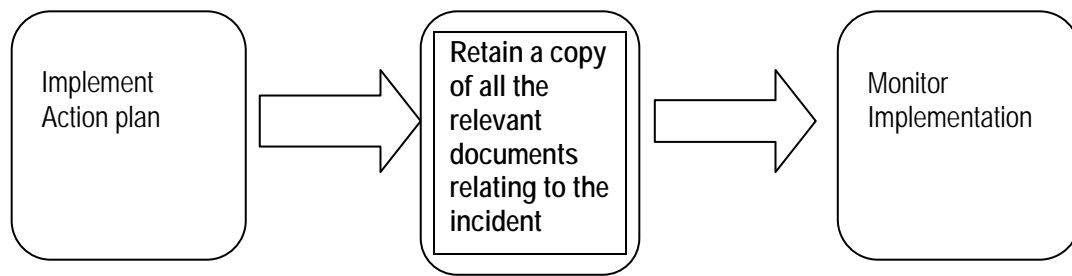
2.5 Monitoring of Action Plans

The action plan must be monitored by the Health and Safety panel or relevant committee/ group and once the action plan is completed the action panel needs to be signed off by the Health and Safety Panel.

Where actions have not met their timescales the health and safety panel must agree any extension to the timescale based on the risk. Where action plans are not completed to timescale these need to be reported to the University Health and Safety Committee.

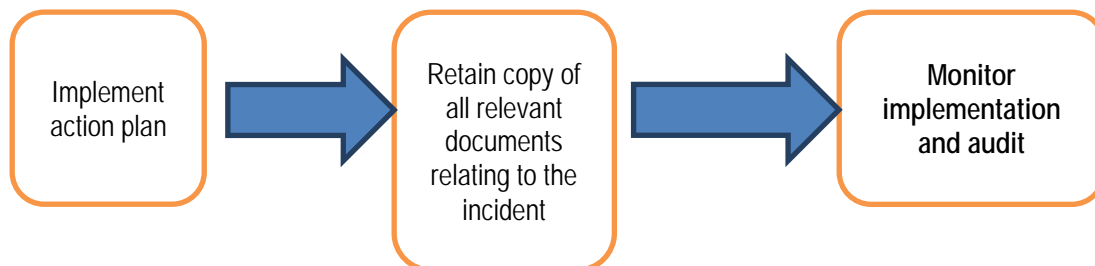
Employees and their representatives must be kept informed of how the implementation of the action plan is progressing.

3 Record Keeping



3.1 Documents must be kept for a minimum of 4 years as they may be requested for inspection by the Health and Safety Executive or may be required in the event of a litigation claim for compensation (note that claims for compensation can, generally, be made up to 3 years from the date of the incident occurring). Any of the documents that contain personal information will be subject to the provisions of the Data Protection Act and should be kept accordingly.

5. Monitoring an Review



5.1 The implementation of the action plan must be monitored and subsequently reviewed to ensure the remedial actions identified have been adequate, appropriate and implemented.

5.2 Once implemented the action plan needs to be signed off and the effectiveness of the actions need to be monitored and audited by the relevant health and safety panel and in the case of serious incidents by the university health and safety committee.

5.3 The University Health and Safety committee will receive on a termly basis quarterly accidents statistics with trend analysis, and information on lost time accidents and remedial action taken to prevent the reoccurrence of accidents. The committee with also receive and annual report on accidents statistics.

Appendix A RIDDOR

Definitions of incidents requiring notification to the Health and Safety Executive (HSE)

The HSE require notification of work related activities resulting in

- **Death or Major injury**
- **Dangerous Occurrence**
- **Over three day injury (From the 6th April subject to Parliamentary approval the three day will be replace by over 7 days incapacitation)**
- **Reportable disease**

Applies if:

An employee(pr self employed person working on University premises) is killed or suffers a major injury (including as a result of physical violence).

Or

An incident directly connected with the activities of the University where a student/ member of the public is killed or taken to hospital

Reportable major injuries include:

- **Fracture other than to fingers, thumbs or toes**
- **Amputation**
- **Dislocation of the shoulder, hip, knee or spine**
- **Loss of sight (temporary or permanent)**
- **Chemical or hot metal burn to the eye r any penetrating injury to the eye**
- **Injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours**
- **Any other injury leading to hypothermia, heat induced illness or unconsciousness, or requiring resuscitation or admittance to hospital for more than 24 hours**
- **Unconsciousness caused by asphyxia or exposure to a harmful substance or biological agent**
- **Acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or**

	<p>through the skin</p> <ul style="list-style-type: none"> • Acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Over 7 day injury</p>	<p>Applies to an incident with work (including an act of physical violence) where an employee (or self employed person working on University premises) is away from work for more than 7 days or is unable to carry put their full range of duties for more than 7 days. The 7 day period commences on the first day after the incident, irrespective of how little time had been worked on the day of the incident. If the first full days falls on a weekend or rest day this should still be counted if the employee would be unable to carry out normal duties.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Reportable disease</p>	<p>Applies when a doctor notifies the University in writing that an employee is suffering from a reportable work related disease.</p> <p>Reportable diseases include</p> <ul style="list-style-type: none"> • Certain poisonings • Some skin diseases such as occupational dermatitis, skin cancer, chrome ulcer, oil folliculitis/ acne • Lung disease including occupational asthma, farmer lung, pneumoconiosis, asbestosis, mesothelioma • Infections such as leptospirosis, hepatitis, tuberculosis, anthrax, legionellosis and tetanus <p>Other condition such as</p> <ul style="list-style-type: none"> • Hand arm vibration syndrome • Certain musculoskeletal disorders • Decompression illness • Occupational cancer

Dangerous occurrence

If something happens which does not result in a reportable injury, but which clearly could have done, or may be possible classed as a dangerous occurrence.

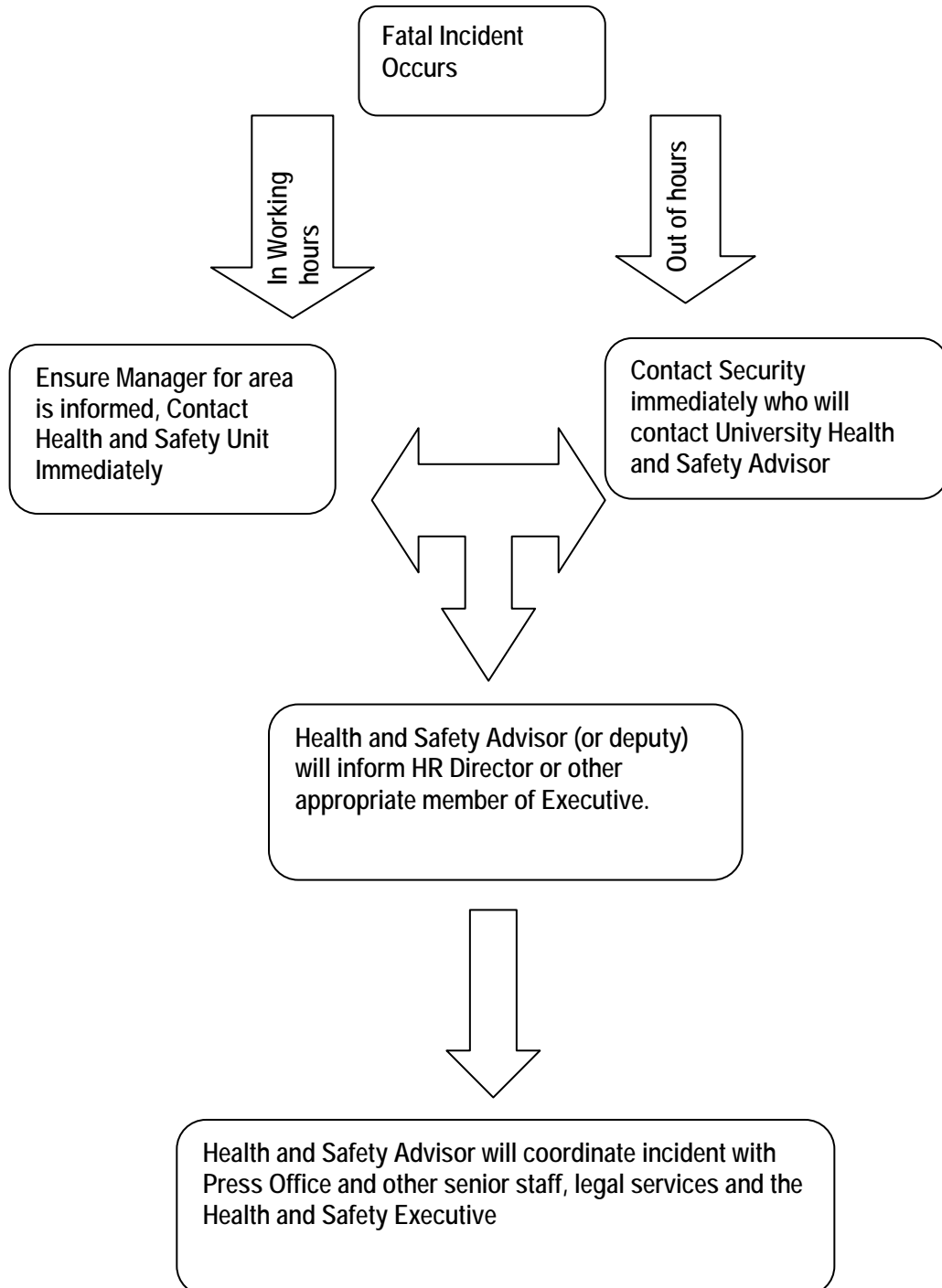
Reportable dangerous occurrences include

- Collapse, overturning or failure of load bearing parts of lifts and lifting equipment
- Explosion, collapse or bursting of any closed vessel or associated pipe work
- Electrical short circuit or overload causing fire or explosion
- Malfunction of breathing apparatus while in use or during testing immediately before use
- Collapse or partial collapse of a scaffold over five metres high or erected near water where there could be a risk of drowning after a fall

Unintended collapse of any building or structure under construction, alteration or demolition where over five tonnes of material falls, a wall or floor in a place of work, any false work.

Appendix B

Fatal Incident Protocol



Appendix C Causation Factor Codes

Use the codes to complete the causation factors. Avoid the use of codes 01,29,59 and 79 wherever possible. If no other code is relevant, a full explanation must be given

Code	Description
Organisational Factors	
01	No Reasonably Practical Precautions Available
10	Inadequate Standard Of Training Or Instruction
11	Inadequate Supervision
12	Inadequate Standard Of Maintenance
13	Failure To Provide A PTW System (Permit To Work)
14	Failure Of A PTW System
15	Poor Control Of Physical Standards
16	Unsafe System Of Work For Routine Job Production
17	Unsafe System Of Work For Maintenance Job
18	Unsafe System Of Work For Transient Job
19	Inadequate Traffic Control System Including Separation Of Vehicles & Persons
29	Other - E.g. Poor/Inadequate Planning Of Job
Physical Factors	
30	Guarding Or Safety Devices: Not Provided
31	Guarding Or Safety Devices: Fallen Into Disuse
32	Guarding Or Safety Devices: Removed and Not Replaced
33	Guarding Or Safety Devices: Failure
34	Guarding Or Safety Devices: Inadequate
35	Electrical Hardware Including Unearthed, Uninsulated, Overload, Uncovered Short. Include For Resultant Fires
36	Defective Equipment, Material, Plant (Inc. Pipework) Or Instrumentation Fault
37	Structural Or Physical Aspects Of Premises, Building Including Fragile Materials, Roof Edge Protection
38	Poor Housekeeping
39	Fault In Any Working Platform Or Temporary Workplace (Not 34 Above) But Inc. Lack Of Edge Protection
40	Any Access/Egress Fault Including Defective, Unsuitable
41	Poor Control Of Toxic Substances Or Asphyxiants
42	Poor Control Of Flammable Substances In Use, Storage Or Transport
43	Inadequate Standard Of Design Or Construction
44	Inadequate Standard Of Installation
45	Illumination/Heat/Noise
46	Poor Stacking Or Storage Including Insecure Loads Or Equipment
47	Personal Protective Equipment (PPE) Not Provided Or Failed
48	Weather Conditions
49	Robotic Failure Or Control System Runaway
50	Inadequate Clearance Or Space For Persons Or Machinery
59	Other Physical Factors
Employee / Trainee Or Other Persons' Contribution	
60	Loss Of Concentration
61	Defeating Safety Devices
62	Guarding Or Safety Device Provided But Not Used
63	Using Equipment Obviously Defective
64	Improper Use Of Equipment Including Interference With Equipment Or Appliance
65	Failure To Comply With Or Misinterpretation Of Instructions Including Failure To Isolate Danger
66	Failure To Use Available Personal Protective Equipment

67	Failure To Give Necessary Warning To Others
68	Going Into Hazardous Situations E.g. Confined Spaces
69	Employee / Trainee Judgement/Error
70	Assault
71	Horseplay
72	Working Under The Effects Of Alcohol Or Drugs
73	Using Unsafe Or Dangerous Methods Of Handling Or Lifting
74	Riding Or Standing In Unsafe Position
75	Arson. Burglary. Vandalism
76	Medical Or Physical Condition Of Significance
79	Other Including Insufficient Information To Identify Cause

Appendix D

CHECKLIST FOR ACCIDENT INVESTIGATION

Use the following checklist to structure investigations and written reports. It is intended as a guide. It is not comprehensive and it will not always be necessary to consider all the points in the checklist. Be sure to establish at an early stage whether immediate action is needed. For example, it may be necessary to withdraw equipment from use immediately or stop an activity.

Be guided by the significance of the accident when deciding how deeply to investigate it. Consider not only the actual outcome, but also what the potential outcome might have been. Could things have turned out a lot worse? The more serious the event, or the greater its potential, the more effort that needs to be put into the investigation.

1 Obtain basic facts

- Names of injured/ill employee(s)/witnesses/people early on the scene
- Condition of any equipment
- Any chemicals / substances in use or present
- Layout of area
- Place, time, conditions
- Extent of any injury / ill health / damage / disruption
- Make use of camera, sketches, measurement to record the undisturbed scene

2 Establish circumstances

- What was being done at the time and what happened?
- Immediate causes
- Events leading up to the incident
- Any evidence linking case of ill health to work
- Competence, e.g. what instructions and training were given before the event and how much experience in the job did the people involved (including supervisors) have? Were they aware of the dangers associated with the activity?
- What were the established methods of carrying out the task? Were they adequate? Were they being followed?
- Behaviour and actions of individuals
- Role of manager/ supervisors. Had those involved in the accident been told to carry out the particular task/activity or were they acting on their own initiative?
- What was the worst that could have happened?
- Has something similar happened before?
- Could it happen again?

3 Identify preventive measures

- Review the risk assessment for the activity. What precautions should have been in force? What training should those carrying out the activity have received?
- What precautions were actually taken. Compare them with those which should have been taken. What training was actually given? Compare it with training which should have been given.

4 Establish whether the initial response to the accident was adequate

- Was prompt and appropriate action taken (such as making safe and dealing with any continuing risks, electrical isolation, suitable fire fighting, effective first-aid response and correct spillage procedures)?

5 Identify the underlying causes

These might include:

- Management or supervision failure
- Lack of competence
- Inadequate training
- Shortcomings in original design of equipment or facilities
- Absence of a system for maintenance

6 Determine action needed to prevent a recurrence

In deciding on the right course of action, think whether the outcome could have been more serious and what prevented this from happening.

Reappraise the precautions derived from the risk assessment - do they satisfy the intentions of the Universities health and safety policy and do they meet the recommendations of any authoritative guidance?

If the intended precautions appear adequate but they were not fully implemented, why was this? What needs to be done to ensure necessary precautions are taken in the future? Actions to prevent a recurrence might include

- improve physical safeguards
- introduce better test and maintenance arrangements
- improve work methods
- provide and use personal protective equipment
- make changes to supervision and training arrangements
- review similar dangers elsewhere in the University of Faculty
- review procedures involving outside contractors
- improve inspection systems

Suggested questions to ask when investigating an accident. These questions are not exhaustive but this check list should be used to help in an the investigation of an incident.

Question Yes No N/A

	Yes	No	N/A
Section 1 — Task			
Was a safe work procedure used?			
Had conditions changed to make the normal procedure unsafe?			
Were the appropriate tools and materials available?			
Were the appropriate tools and materials used?			
Was the equipment involved designed for the task?			
Should another type of equipment be used for the task performed?			
Were safety devices working properly?			
Was "lock out" used when necessary?			
Section 2 — Equipment and Material			
Was there an equipment failure? If yes then explain below:			
Was the machinery poorly designed?			
Is this machine equipped with guards?			
Are the guards functioning properly?			

Has the machine been maintained?			
Were hazardous substances involved?			
Were they clearly identified?			
Was a less hazardous alternative substance possible and available? If yes then explain.			
Was the raw material substandard in some way?			
Should personal protective equipment (PPE) have been used?			
Was the PPE used?			
Section 3 — Environment			
What were the weather conditions?			
Was poor housekeeping a problem?			
Was it too hot or too cold?			
Was noise a problem?			
Was there adequate light?			
Were toxic or hazardous gases, dusts, or fumes present?			
Section 4 — Personnel			
Were workers experienced in the work being done?			
Had they been adequately trained? Documented?			

Can they physically do the work?			
Section 5 — Management			
Were safety rules communicated to and understood by all employees/students			
Were written procedures available?			
Were they being enforced?			
Was there adequate supervision?			
Had hazards been previously identified?			
Had procedures been developed to overcome them?			
Were unsafe conditions corrected?			
Was regular maintenance of equipment carried out?			
Were regular safety inspections carried out?			
Where was the supervisor at the time of the accident?			
What was the supervisor doing at the time of the accident?			
What did you see? Hear?			
In your opinion, what caused the accident?			
How might similar accidents be prevented in the future?			

Time Line Template

When gathering information following an incident there can a lot of information to sort through. A time line can help map that information in a chorological way, so information is checked, gaps identified and facts checked. A time line might start before well before an incident, e.g. the last maintenance check on a piece of machinery or it may start at the exact time of the incident or indeed in the hours leading up to the incident.

Event date and time		
Event		
Supplementary Information		

The event date and time are completed in the first two boxes of the table. Please note that date and time can be supplemented with a generic term like day or month if it is considered more appropriate. Any further information can be added to supplementary information box.

Appendix E

HEALTH AND SAFETY INCIDENT INVESTIGATION REPORT

Health and Safety Services Incident Number:	
RIDDOR Reference (if applicable):	
Date of Incident:	
School/Directorate:	
Department/Area:	
Name of Injured Person (if applicable):	
Injured Person contact details (if not already provided on Incident Report Form) :	
Date(s) of investigation:	
Investigated by:	
Persons contributing to the investigation:	

1. INCIDENT DETAILS - gather the facts
1.1 Circumstances & sequence of events
1.2 Injury / ill health / damage sustained & treatment given:

1.3 Details of plant / equipment / substances / location (include photographs and sketches)

1.4 Witnesses (attach statements)

1.5 Management / emergency response to the incident

2. INVESTIGATION FINDINGS

2.1 Immediate cause(s)

2.2 Underlying and contributory factors

2.4 Comments

2.3 Recommendations and conclusion (what action is needed, by when and by whom?)

Name of Author:

Date of Report:

Guidance for the Reporting of Accidents and Incidents

Accident Investigation Actions Template

Action Required	Lead Person	Time Scale	Progress