APPENDIX 2

CAERPHILLY COUNTY
BOROUGH COUNCIL

CORPORATE MANAGEMENT ARRANGEMENTS FOR ACCIDENT REPORTING AND INVESTIGATION

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Contents

NOTE

Wherever the designation "manager" is used throughout this policy, it is taken to mean Head of Service, Head Teacher, Line Manager, Supervisor and the Officer in charge or anyone who has responsibilities for employees in the course of their work.

1. CORPORATE MANAGEMENT ARRANGEMENTS – ACCIDENT/ INCIDENT REPORTING

A quick reference follow chart of these arrangements is available within Appendix 4.

1.1 Accident/Incidents:

1.1.2 All accidents and incidents must be reported and recorded. Fatal accidents and those resulting in a Major Injury must be reported to the Directorate Health and Safety Officer (or the Corporate Health and Safety Unit where the Directorate Health and Safety Officer is not available) and the HSE by the quickest means. This should then be followed up with the completion of the Corporate Accident/Incident Report Form as detailed Appendix 5

1.1.3 All accident/incidents must be reported internally using the Corporate Accident / Incident report form. This must be completed and copies forwarded to the Directorate Health and Safety Officer, and any others as detailed within Directorate arrangements within 2 working days as detailed within the guidance sheet 24 – Accident/Incident Reporting Guidance (see Appendix 5).

1.1.4 Where necessary and safe to do so apply immediate corrective actions to prevent a secondary accident. Where significant injury has occurred care should be taken not to disturb the scene of the accident until the accident investigation has been completed.

1.1.5 All accident and incidents must be recorded on the authority's accident database system. Directorate arrangements will specify how this is to be achieved within each directorate.

1.2 Notification and Reporting to the HSE:

1.2.1 Under Regulation 3 of the Reporting of Injuries and Dangerous Occurrences Regulations (RIDDOR) 1995 the following accidents/incidents are reportable to the HSE:

1.2.1.1 Any person dies as a result of an accident arising out of or in connection with work,

1.2.1.2 Any person at work suffers a major injury, (*see Appendix 1)* e.g. fracture, amputation, as a result of an accident arising out of or in connection with work.

1.2.2 Any person not at work suffers an injury as a result of an accident arising out of or in connection with work and that

person is taken from the scene of the accident directly to a hospital for treatment in respect of that injury;

1.2.3 There is a dangerous occurrence, (*See Appendix 2*) e.g. the failure of a lift, crane etc.

1.2.4 Any person at work who suffers an injury which prevents them attending work or from undertaking their normal duties from more than 3 consecutive days

1.2.5 Where incidents are reported to the HSE copies of the associated forms (i.e. F2508, F2508A) must be saved onto the authority's accident database.

1.3 Death

1.3.1 The death of any person, whether or not they are at work, must be reported if it results from an accident arising out of or in connection with work. It should be reported to the Directorate Health and Safety Officer (or the Corporate Health and Safety unit in their absence) and the HSE by the quickest practicable means and followed up by written report (both internal and F2508 where required) within 10 days.

1.3.2 If an employee dies after some delay as a result of an injury which is reportable, then the Directorate Health and Safety Officer must inform the HSE about the death in writing, provided it occurs within a year of the date of the accident.

1.3.3 Section 1.3.2 only applies to employees; the death is not reportable if someone other than an employee i.e. a pupil at a school or a pedestrian subsequently dies after some delay as a result of a reportable accident or in connection with the work activity of someone else.

1.4 Major injury (reportable to the HSE)

1.4.1 The reportable major injuries are set out in Schedule 1 of the RIDDOR regulations. *See Appendix 1* for details.

1.4.2 In the event of a major injury an initial report should be made to the HSE via a Health and Safety Officer. An Accident/Incident Report Form must be completed and forward to the Directorate Health and Safety Officer, and others as detailed within your Directorate Arrangements within 2 working days.

1.4.3 The Directorate Health and Safety Officer will ensure the HSE is notified and the accident/incident reported within the required timescale, by ensuring the completion and submission of the required F2508 form.

1.4.4 Following a major injury the Manager must ensure that accident investigations are undertaken as detailed within guidance sheet 22 (see Appendix 6)

1.5 Dangerous Occurrence

1.5.1 If an incident occurs which does not result in a reportable injury, but had the potential to, then it may be a Dangerous Occurrence, which must be reported immediately to the Directorate Health and Safety Officer (or the Corporate Health and Safety Unit if they are unavailable) and followed up with the submission of the Accident/Incident Report form to the Directorate Health and Safety Officer within 2 working days.

1.5.2 Dangerous Occurrences to be reported to the HSE are defined in Schedule 2 of the RIDDOR regulations and summarised in appendix 2 of this document.

1.5.3 The Directorate Health and Safety Officer must inform the HSE of a dangerous occurrence immediately by telephone or via the Internet and where required follow up in writing with the approved F2508 form.

1.5.4 Following a Dangerous Occurrence, the Manager must ensure that an investigation is undertaken as detailed within CHSU guidance sheet 22. (see appendix 6)

1.6 Incidents of Violence and/ or Aggression:

1.6.1 An ‘accident’ has been defined as including ‘an act of non-consensual physical violence against a person at work’. This makes injuries to workers arising from such acts reportable if they fall into one of the categories listed *under 1.2 of this management arrangement*.

1.6.2 All violent incidents should be reported on the Corporate Violent Incident Report Form in accordance with the Corporate Violence at Work Policy and Corporate Management Arrangements. Incidents of violence which result in physical injury must also be reported on the Corporate Accident / Incident Report form and investigated as required.

1.7 Over-3-day accidents/Incident:

1.7.1 An over-3-day injury is one which is not ‘*major*’ but results in the injured person being away from work or unable to do the full range of their normal duties for more than three consecutive days, (e.g. placed on light duties.)

1.7.2 When calculating *'more than three consecutive days'* the actual day of the accident/incident should not be counted, only the period after it. Any days the injured person would not normally have been expected to work, such as weekends, rest days or holidays, must be included.

1.7.3 Some situations will include days when the injured person would not normally have been expected to work. Determining whether they would have been unable to do their normal range for 'more than three consecutive days' may therefore involve a degree of judgement. It may be necessary to ask the injured person if they would have been able to carry out all of their duties if they had been at work. Examples are provided within Accident Reporting an Investigation Guidance sheets 22 and 24. (See Appendix 5 & 6)

1.7.4 All incidents of this type must be reported using the Corporate Accident/Incident Report Form and investigated as per the Corporate Guidance Sheet 22. (See Appendix 6)

1.8 Reporting of cases of Diseases, or occupational ill health:

1.8.1 The Authority is required to report cases of certain diseases, or occupational ill health, which are linked with specified work activities.(see appendix 3 for summary)

1.8.2 Managers must report suspected or confirmed occupational disease or ill health using the corporate Accident/Incident Report Form as detailed within 1.1.2. to the Directorate Health and Safety Officer. A copy of which should also be sent to Occupational Health along with an OH 1 referral form for the individual.

1.8.3 When the Directorate Health and Safety Officer receives written statements by a Doctor they should check against Schedule 3 of the RIDDOR regulations whether a report is to be made.

1.8.4 The Directorate Health and Safety Officer will make a report, to the HSE if they receive, in respect of an employee a written diagnosis of one of the reportable occupational diseases as detailed in the RIDDOR Regulations.

1.8.5 If a report is to be made the Directorate Health and Safety Officer must inform the HSE in writing on the approved form F2508A within 10 working days. Details of the report and a copy of the F2508A form must be submitted onto the Authority's accident database.

1.8.6 Where reports of disease/ occupational ill health are received, or confirmed, by the Occupational Health Department, details must

be provided to the Directorate Health and Safety Officers to enable the F2508A form to be submitted to the HSE.

2 CORPORATE MANAGEMENT ARRANGEMENTS - ACCIDENT INVESTIGATION

2.1 Accident/Incident Investigations

2.1.1 All accidents/incidents must be investigated.

2.1.2 The amount of time spent investigating an accident/incident is a management decision; however the level of detail in the investigation should be proportionate to the severity and consequences of the accident/incident or the potential severity and potential consequences of the near miss e.g. simple accidents may require simple and straight forward accident investigations involving minimal time and effort. The level of investigation required must be determined by a Manager and must meet the minimum requirements as specified with the Corporate Accident/Incident Investigation Guidance as detailed within guidance sheet 22. (See appendix 6)

2.1.3 The Directorate Health and Safety Officer and / or the Corporate Health and Safety Unit may assist, where required, in the accident/incident investigation. This should be done following the guidance contained within Guidance Sheet 22 (Appendix 6). The severity of the accident/incident should be reflected in the decision. Where the accident is reportable under RIDDOR, or could result in a civil claim, the Directorate Health and Safety Officer and/or the Corporate Health and Safety Unit should be involved in the investigation.

2.1.4 When deciding who to involve in the accident/incident investigation the manager should following the Corporate Accident/Incident Investigation Guidance sheet, which specifies a minimum requirement. It is a management decision on who else should be involved and will depend on the accident/incident circumstances and initial investigation findings.

2.2 Purpose of Accident/Incident Investigation

2.2.1 The purpose of an accident/incident investigation is to identify the immediate and underlying ‘root’ cause(s) of the accident/incident and to develop and implement preventative steps to ensure that a similar accident/incident does not happen again.

2.3 The Investigation:

2.3.1 The accident/incident investigation process involves 5 main steps:

1. Ensure accident/ incident is reported and deal with the immediate accident / incident scene
2. Information Gathering
3. Analysis of the information
4. Identification of Risk Control Measures
5. Create an action plan to implement the recommendations.

2.3.2 Accident investigation should be undertaken by completing the Corporate Accident / Incident Investigation Form and by following the guidance contained within Guidance Sheet 22 (see appendix 6) Where remedial actions are highlighted as being necessary following accident investigation these should be included in part 4 of the investigation form along with estimated completion dates.

2.3.3 On completion of the Corporate Accident / Incident Report and Investigation Forms copies must be sent to the Directorate Health and Safety Officer within 2 working days.

2.4 Auditing

2.4.1 Both the Directorate Health and Safety Officers and the CHSU will audit service areas to ensure compliance with this policy. Auditing activities will be undertaken via a number of means, which may include:

- Formal compliance audits
- Reviews of submitted accident forms
- Review of completed accident investigations
- Follow up to ensure that remedial actions have been implemented
- Statistical analysis of accident data.

3 SUPPORTING DOCUMENT:

3.1 Guidance

3.1.1 RIDDOR Explained – HSE Guidance
ISBN 0 7176 1077 2 INDG 73(rev1)

3.1.2 The Management of Health and Safety at Work Regulations 1999 ISBN 0 7176 2488 9

3.1.3 Investigating accidents and incidents – HSE Guidance
ISBN 0 7176 2827 2 HSG245

3.1.4 Accident and Incident Investigation Corporate Health and Safety Unit Guidance note sheet 22.

3.1.5 Accident and Incident reporting guidance sheet number 24.

Appendix 1 - Schedule of Major Injuries.

Major Injuries

Regulation 2(1)

1. Any fracture, other than to the fingers, thumbs or toes.

2. Any amputation.

3. Dislocation of the shoulder, hip, knee or spine.

4. Loss of sight (whether temporary or permanent).

5. A chemical or hot metal burn to the eye or any penetrating injury to the eye.

6. Any injury resulting from an electric shock or electrical burn (including any electrical burn caused by arcing or arcing products) leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours.

7. Any other injury -

   (a) leading to hypothermia, heat-induced illness or to unconsciousness,

   (b) requiring resuscitation, or

   (c) requiring admittance to hospital for more than 24 hours.

8. Loss of consciousness caused by asphyxia or by exposure to a harmful substance or biological agent.

9. Either of the following conditions which result from the absorption of any substance by inhalation, ingestion or through the skin -

   (a) acute illness requiring medical treatment; or

   (b) loss of consciousness.

10. Acute illness which requires medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material.

Appendix 2 - Summary of Dangerous Occurences.

Summary of Dangerous Occurrences

- The full list of dangerous occurrences can be found under Regulation 2(1) under the RIDDOR Regulations

Part I General

Lifting Machinery, etc

1. The collapse of, the overturning of, or the failure of any load-bearing part of any -

   (a) lift or hoist;

   (b) crane or derrick;

   (c) mobile powered access platform;

   (d) access cradle or window-cleaning cradle;

   (e) excavator;

   (f) pile-driving frame or rig having an overall height, when operating, of more than 7 metres; or

   (g) fork lift truck.

Pressure Systems

2. The failure of any closed vessel (including a boiler or boiler tube) or of any associated pipework, in which the internal pressure was above or below atmospheric pressure, where the failure has the potential to cause the death of any person.

Overhead Electric Lines

3. Any unintentional incident in which plant or equipment either -

   (a) comes into contact with an un-insulated overhead electric line in which the voltage exceeds 200 volts; or

   (b) causes an electrical discharge from such an electric line by coming into close proximity to it.

Electrical Short Circuit

4. Electrical short circuit or overload attended by fire or explosion which results in the stoppage of the plant involved for more than 24 hours or which has the potential to cause the death of any person.

Breathing Apparatus

5. (1) Any incident in which breathing apparatus malfunctions –

   (a) while in use, or

(b) during testing immediately prior to use in such a way that had the malfunction occurred while the apparatus was in use it would have posed a danger to the health or safety of the user.

(2) This paragraph shall not apply to breathing apparatus while it is being

(a) maintained or tested as part of a routine maintenance procedure.

Collapse of Scaffolding

6. The complete or partial collapse of -

(a) any scaffold which is –

(i) more than 5 metres in height which results in a substantial part of the scaffold falling or overturning; or

(ii) erected over or adjacent to water in circumstances such that there would be a risk of drowning to a person falling from the scaffold into the water; or

(b) the suspension arrangements (including any outrigger) of any slung or suspended scaffold which causes a working platform or cradle to fall.

Fairground Equipment

7. The following incidents on fairground equipment in use or under test -

(a) the failure of any load-bearing part;

(b) the failure of any part designed to support or restrain passengers; or

(c) the derailment or the unintended collision of cars or trains.

Appendix 3 - Brief summary of Reportable Diseases.

Summary of Reportable diseases

Reportable in some circumstances, check with your Directorate Health and Safety Officer and for the dull list please refer to Regulation 5 of the RIDDOR Regulations.

Part I Occupational diseases

	Column 1 Diseases	*Column 2 Activities*
	Conditions due to physical agents and the physical demands of work	
1.	Cataract due to electromagnetic radiation.	Work involving exposure to electromagnetic radiation (including radiant heat).
2.	Cramp of the hand or forearm due to repetitive movements.	Work involving prolonged Periods of handwriting, typing or other repetitive movements of the fingers, hand or arm.
3.	Subcutaneous cellulitis of the hand (beat hand).	Physically demanding work causing severe or prolonged friction or pressure on the hand.
4.	Bursitis or subcutaneous arising at or about the knee due to severe or prolonged external friction or pressure at or about the knee (beat knee).	Physically demanding work cellulitis causing severe or prolonged friction or pressure at or about the knee.
5.	Bursitis or subcutaneous cellulitis arising at or about the elbow due to severe or prolonged external friction or pressure at or about the elbow (beat elbow).	Physically demanding work causing severe or prolonged friction or pressure at or about the elbow.
6.	Traumatic inflammation of the tendons of the hand or forearm or of the associated tendon sheaths.	Physically demanding work, frequent or repeated movements, constrained postures or extremes of extension or flexion of the hand or wrist.
7.	Carpal tunnel syndrome.	Work involving the use of hand-held vibrating tools.

8.	Hand-arm vibration syndrome.	Work involving: (a) the use of chain saws, brush cutters or hand-held or hand-fed circular saws in forestry or woodworking; (b) the use of hand-held rotary tools in grinding material or in sanding or polishing metal; (c) the holding of material being ground or metal being sanded or polished by rotary tools; (d) the use of hand-held percussive metalworking tools or the holding of metal being worked upon by percussive tools in connection with riveting, caulking, chipping, hammering, fettling or swaging; (e) the use of hand-held powered percussive drills or hand-held powered percussive hammers in mining, quarrying or demolition, or on roads or footpaths (including road construction); or (f) the holding of material being worked upon by pounding machines in shoe manufacture.
Infections due to biological agents		
9.	Anthrax.	(a) Work involving handling infected animals, their products or packaging containing infected material; or (b) work on infected sites.
10.	Brucellosis.	Work involving contact with: (a) animals or their carcasses (including any parts thereof) infected by brucella or the untreated products of same; or (b) laboratory specimens or vaccines of or containing brucella.
11.	(a) Avian chlamydiosis.	Work involving contact with birds infected with chlamydia psittaci, or the remains or untreated products of such birds.

	(b) Ovine chlamydiosis.	Work involving contact with sheep infected with chlamydia psittaci or the remains or untreated products of such sheep.
12.	Hepatitis.	Work involving contact with: (a) human blood or human products; or (b) any source of viral hepatitis.
13.	Legionellosis.	Work on or near cooling systems which are located in the workplace and use water; or work on hot water service systems located in the workplace which are likely to bovine animals or their meat products or pigs or their meat products be a source of contamination.
14.	Leptospirosis.	(a) Work in places which are or are liable to be infested by rats, field mice, voles or other small mammals; (b) work at dog kennels or involving the care or handling of dogs; or (c) work involving contact with bovine animals or their meat products or pigs or their meat products.
15.	Lyme Disease.	Work involving exposure to ticks (including in particular work by forestry workers, rangers, dairy farmers, game keepers and other persons engaged in countryside management).
16.	Q fever.	Work involving contact with animals, their remains or their untreated products.
17.	Rabies.	Work involving handling or contact with infected animals.
18.	Streptococcus suis.	Work involving contact with pigs infected with streptococcus suis, or with the carcasses, products or residues of pigs so affected.
19	Tetanus.	Work involving contact with soil likely to be contaminated by animals.
20.	Tuberculosis.	Work with persons, animals,

		human or animal remains or any other material which might be a source of infection.
21.	Any infection reliably attributable to the performance of the work specified in the entry opposite hereto.	Work with micro-organisms; work with live or dead human beings in the course of providing any treatment or service or in conducting any investigation involving exposure to blood or body fluids; work with animals or any potentially infected material derived from any of the above.

Conditions due to substances

22.	Poisonings by any of the following: (a) acrylamide monomer; (b) arsenic or one of its compounds; (c) benzene or a homologue of benzene; (d) beryllium or one of its compounds; (e) cadmium or one of its compounds; (f) carbon disulphide; (g) diethylene dioxide (dioxin); (h) ethylene oxide; (i) lead or one of its compounds; (j) manganese or one of its compounds; (k) mercury or one of its compounds; (l) methyl bromide; (m) nitrochlorobenzene, or a nitro- or amino- or chloro-derivative of benzene or of a homologue of benzene; (n) oxides of nitrogen; (o) phosphorus or one of its compounds.	Any activity.
23.	Folliculitis.	Work involving exposure to mineral oil, tar, pitch or arsenic.
24.	Acne.	Work involving exposure to mineral oil, tar, pitch or arsenic.

25.	Skin cancer.		Work involving exposure to mineral oil, tar, pitch or arsenic.
26.	Pneumoconiosis (excluding		1. Sand blasting by means of compressed air with the use of quartzose sand or crushed silica rock or flint or substantial exposure to the dust arising from such sand blasting. 2. The use or preparation for use of an abrasive wheel or substantial exposure to the dust arising therefrom. 4.Boiler scaling or substantial exposure to the dust arising therefrom.
27.	Mesothelioma.	}	(a) The working or handling of asbestos or any admixture of asbestos;
28.	Lung cancer.	}	(b) the manufacture or repair of asbestos textiles or other articles containing or composed of asbestos;
29.	Asbestosis	}	(c) the cleaning of any machinery or plant used in any of the foregoing operations and of any chambers, fixtures and appliances for the collection of asbestos dust; or (d) substantial exposure to the dust arising from any of the foregoing operations.

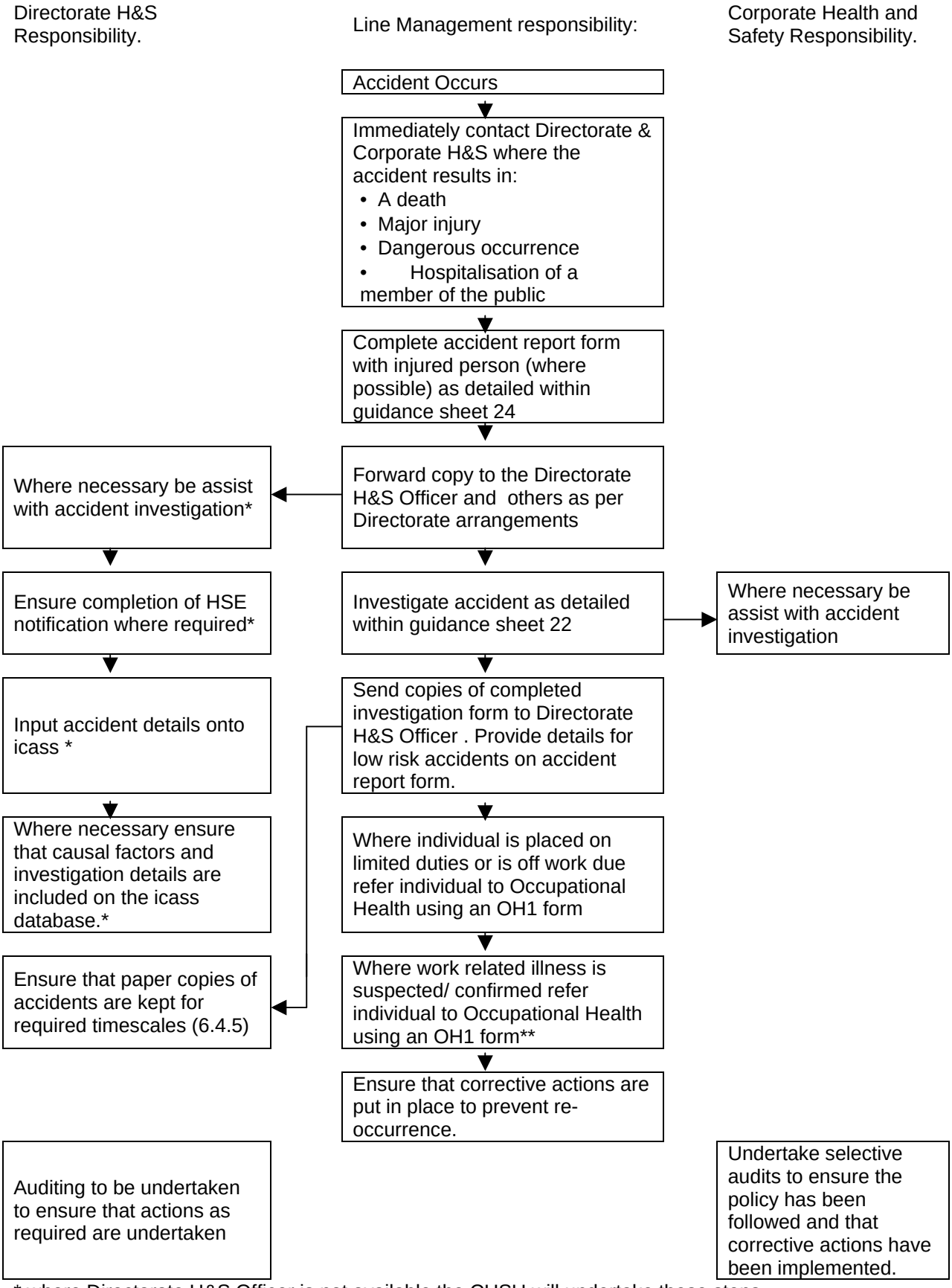
30.	Occupational dermatitis.	Work involving exposure to any of the following agents: (a) epoxy resin systems; (b) metalworking fluids; (c) cement, plaster or concrete; (d) acrylates and methacrylates; (e) glutaraldehyde; (f) biocides, anti-bacterials, preservatives or disinfectants; (g) organic solvents; (h) antibiotics and other pharmaceuticals and therapeutic agents; (i) strong acids, strong alkalis, strong solutions (eg brine) and oxidising agents including domestic bleach or reducing agents; (j) soaps and detergents; (k) plants and plant-derived material including in particular especially the daffodil, tulip and chrysanthemum families, the parsley family (carrots, parsnips, parsley and celery), garlic and onion, hardwoods and the pine family;

	(l) fish, shell-fish or meat; (m) sugar or flour; or (n) any other known irritant or sensitising agent including in particularany chemical bearing the warning “may cause sensitisation by skin contact” or “irritating to the skin”.
31. Extrinsic alveolitis (including farmer’s lung).	Exposure to moulds, fungal spores or heterologous proteins during work in: (a) agriculture, horticulture, forestry, cultivation of edible fungi or maltworking; (b) caring for or handling birds; or (c) handling bagasse.
32. Occupational asthma.	Work involving exposure to any of the following agents: (a) isocyanates; (b) fumes or dust arising from the manufacture, transport or use of hardening agents (including expoxy resin curing agents) based on phthalic anhydride, tetrachlorophthalic anhydride, trimellitic anhydride or triethylene-tetramine; (c) fumes arising from the use of rosin as a soldering flux; (d) proteolytic enzymes; (e) animals including insects and other arthropods used for the purposes of research or education or in laboratories; (f) wood dust; (g) animals including insects and other arthropods (whether in their larval forms or not) used for the purposes (h) of pest control or fruit cultivation or the larval forms of animals

used for the purposes of research or education or in laboratories;

(i) any other sensitising agent, including in particular any chemical bearing the warning “may cause sensitisation by inhalation”.

Appendix 4- Schedule Quick Reference Flow Chart



* where Directorate H&S Officer is not available the CHSU will undertake these steps
** Occupation Health will deal with the OH1 form as per their OH1 Procedure

Appendix 5- Accident Reporting Guidance

CORPORATE HEALTH AND SAFETY UNIT GUIDANCE SHEET – 024

ACCIDENT/INCIDENT REPORTING GUIDANCE - COMPLETION OF THE NEW ACCIDENT REPORT FORM.

1. When does this form have to be completed?

The purpose of the form is to ensure that all accidents/incidents are recorded. The injured person or line manager (or designee) should complete part one immediately following the incident. The supervisor/manager of the work activity or area should complete part two as soon as possible. Completed forms must be sent to the Directorate Health and Safety Officer within 2 working days , as detailed below, Note: There may be specific arrangements within your directorate that specify additional copies have to be sent to others

Health and Safety Contacts:

Education and Leisure	–	Directorate Health and Safety Office, Penallta House, Tredomen. Tel: 01443 864865
Environment	–	Directorate Health and Safety Office, Tredomen House. Tel: 01443 863765
Social Services	–	Directorate Health and Safety, Social Services Offices, Hawtin Park. Tel: 01443 864623
Chief Executives	–	Directorate Health and Safety Office, Tredomen House. Tel: 01443 864384

In addition to the accident/incident report form there is a new accident/incident investigation form. Part 2 of this report form links to the completion of the new accident/incident investigation form. The investigation form is required to be completed (Parts A&B) when an accident/incident requires a report to the Health and Safety Executive (HSE). Section 3 of this guide provides an explanation of when and who and to what level accident are to be investigated. A further guidance note 'completion of the investigation form' should be used when completing the investigation form.

2. Understanding the terminology of the form:

Accident – An event that results in injury or ill health.

Incident – An event, which does not cause harm, but has the potential to cause injury or ill health.

On an Authority Site – The answer will be 'yes' if the accident/incident occurs on an authority premises, which is owned and managed by the Authority. This would include corporate premises, schools, libraries, community/leisure centres, housing offices and day centres. The answer would be 'no' if the accident happened for example within a domestic property (even if rented from the Authority), or on the highway.

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

Fatal – Work-related death

Major injury – As defined by RIDDOR Schedule 1. Includes fractures (other than fingers and toes), amputations, loss of sight, a burn or penetrating injury to the eye, any injury or acute

illness resulting in unconsciousness or requiring admittance to hospital for more than 24 hours. A list of major injuries is available within the accident reporting corporate management arrangements.

Over 3 day injury – When following an accident / incident the injured person is unfit for their normal work for longer than 3 days (not including the day of the accident, but including weekends or days off shift). This includes absence from work or individuals that are placed on light or restricted duties.

Minor Injury – All other injuries, which are not covered by other categories, for example sprain, cut or bruise.

Ill Health – Where the person affected by the work activity and is unable to carry out their usual duties for more than 3 days (not including the day of the accident, but including weekends or days off shift).

Dangerous Occurrence – One of a number of specific, reportable events as defined in RIDDOR. A list of dangerous occurrences is available within the accident reporting policy.

Violence Incident – Where an injury has occurred following an incident of violence towards an employee. This applies to physical assault incidences only and the accident form must be completed in conjunction with the Violent Incident (VI) report form.

RIDDOR Reportable – A fatality, specified major injury, over 3 day lost time injury or a specified dangerous occurrence as defined by the RIDDOR Regulations.

3. Investigation level:

High – A high level investigation will involve a team approach to complete the accident investigation form. This investigation should involve a relevant line manager or supervisor, Directorate Health and Safety Officers and employee representatives (where appropriate). The outcomes and findings of the investigation must be reported to senior management (Head of Service or above) and the Corporate Health and Safety Unit. The investigation will look for immediate, underlying and root causes.

Medium – A medium level investigation will involve completion of the accident investigation form by the relevant supervisor or line manager. The Directorate Health and Safety Officer and employee representatives (where appropriate) should be involved in identifying immediate, underlying and root causes.

Low - A low level investigation will involve a short investigation by the relevant supervisor or line manager into the circumstances and immediate underlying root causes of the incident in order to try and prevent a reoccurrence and to learn any general lessons. It is not necessary to complete the investigation form for low-level investigations however investigation findings should be provided on the report form.

The table below will assist you in determining the level of investigation required. It is important not only to take into account the actual consequence of the accident but also the potential consequences, for example in the case of a scaffold collapse, minor injuries may have occurred, however this would have the potential to cause major or fatal injuries. It should also be noted that these are the minimum number of people to be involved in the investigation and that others may be required depending on the nature of the incident, for example an Engineer if technical input is required.

Accident category	Recommended investigation level	Those involved within the investigation	Paperwork to be completed
Non reportable accident/incident (minor injury, no potential for major injury or fatality)	Low level	Supervisor/Line Manager	Accident report form, including investigation finds within details section.
Over 3 day injury	Medium level	Supervisor/ Line Manager, Directorate Health and Safety Officer, Employee Representative (where appropriate) Occupational Health should be involved in the case of an industrial disease.	Accident report form and Accident Investigation Form
Major injury or specified industrial disease	Medium level		
Any accident /incident where potential for fatality	High level	Supervisor/ Line Manager, Directorate Health and Safety Officer, Employee Representative (where appropriate), finding and recommendations of the investigation must be reported to Senior Management and CHSU	
Fatality	High level		

Completing the form:

Over the next pages is a template of how the Accident/Incident report form should be completed.

Accident/Incident report form.

The purpose of this form is to record all accidents/incidents. The individual or supervisor for the work activity involved should complete part one immediately. The supervisor/manager of the work activity should complete part two as soon as possible. Completed forms must be sent, within 2 working days, to Directorate H&S Officer and a copy to the Corporate H&S Unit. Those areas marked with an * must be completed before the form is submitted.

PART 1 – INITIAL ACCIDENT REPORT

Reported by Name / Job Title (person completing the form): *Insert name of individual reporting the accident*

When did Accident Happen? Date*: *Actual accident date* Time*: *Insert Time using 24 hour clock*

Who was Injured:							
Name:**Injured Persons (IP) name*	Directorate: *Where IP works*			Service area: *Where IP works*			
Male ☐ Female ☐ *Tick as appropriate*	DOB: *insert Date of Birth*			Staff Number: *insert where employee*			
Date / Time reported: *insert date and time (24hr)*	Did injured person report sick *: *Tick as appropriate*			Expected over 3 day injury*: *Tick as appropriate*			
	Yes	☐	**No** ☐	**Yes**	☐	**No**	☐
Occupation*: insert job title*	Address details: *insert address details*						

Was the injured Person:* *Tick as appropriate*

An Employee ☐ A Pupil ☐ On Work Experience ☐ A Contractor ☐

Member of the Public (inc Volunteer) ☐ On a Training Scheme ☐ Service User/Client ☐

Where did incident happen*:

On an Authority Site ☐ specify where:
Tick, where accident happened on an Authority Site and provide exact details of where accident happened

If not on an Authority site, please provide details of location: *Prove address/ location of accident eg. Residential address including postcode if possible*

Brief details of the Incident* (What, where, who, and emergency measures taken. Provide details of any vehicles/ equipment involved) Please continue on additional sheet if required.

Provide details of the incident. Ensure that details are provided on what exactly happened, what / who was involved, what immediate actions were taken.

For low-level investigations please provide details of the likely root cause and any outstanding actions to be completed to prevent a reoccurrence.

What Personal Protective Equipment was being worn at the time:

Detail what PPE was being worn by the IP.

Where applicable please indicate first aid treatment received/administered by:

Detail any treatment administered

For low-level accidents please indicate what remedial actions have been taken. (for medium and high level accidents please refer to the accident investigation guidance) e.g. Training, Risk assessment review. Include details of remedial actions to be taken.

About the injury – Please list all injuries if more than one

What was the injury?* *– Choose From*

Amputation	*Asphyxia/Poison*
Loss of Sight	*Strain*
Fracture	*Superficial*
Dislocation	*Multiple – please list*
Concussion	*Electric Shock*
Laceration	*Natural Causes*
Contusion/bruise	*Other known – specify*
Burn/scald	*Other not known*

What part of the body was injured?* *– Choose From*

EYE	*Hand (s)*
Ear	*Wrist*
Face – Other parts	*Arm (s)*
Head	*Toe*
Neck	*Foot*
Back	*Ankle*
Trunk	*Leg*
Finger(s)	*Unspecified*

Involved Persons/Witness Information: - *Please complete witness information*

Name: Staff Number / D.O.B: *insert staff number or date of birth if known*

Address:

Signed Date

Name: Staff Number / D.O.B:

Address:

Signed Date

Injured Persons Declaration *Injured Person to sign*

I certify to the best of my knowledge that these details are correct.

Name	Signature	Date/ Time

Reported To (line manager)	Date/ Time
Insert line managers name	*Insert date and time (24hr)*

PART 2 – INITIAL ACCIDENT ASSESSMENT (to be completed by Manager/ Supervisor)

Incident Type*: *Tick which applies (see definitions in section 2)*

Fatality ☐	Major Injury ☐ e.g. fracture	Over 3 day injury ☐	Minor Injury ☐	Ill Health ☐ e.g. industrial disease	Dangerous Occurrence ☐	Violent Incident ☐

Is Incident RIDDOR Reportable? (Or expected to result in an over 3 day injury)*	Yes / No *delete as appropriate (see definitions in section 2)*

Investigation level required (see guidance note) *Tick which applies (see explanation in section 3)*

High Level ☐	Medium Level ☐	Low Level ☐

Part 2 Completed by: *insert name*	Date: *insert date*
Further Investigation required?	Yes/No *delete as appropriate*
Investigation to be completed by:	*Insert names of individuals to carry out investigation*
(Please refer to accident investigation guidance)	

Appendix 6- Accident Investigation Guidance

CORPORATE HEALTH AND SAFETY UNIT GUIDANCE SHEET – 022

ACCIDENT AND INCIDENT INVESTIGATION - GUIDANCE FOR LINE MANAGERS AND THOSE UNDERTAKING ACCIDENT/INCIDENT INVESTIGATION.

The issue
Understanding how and why an accident has occurred is the only way in which effective steps can be taken to prevent a similar accident happening.

What do I need to know?
Accidents and incidents must be reported by completing Part 1 of the Accident/Incident Report form and passed to the injured persons line manager (and/ or in case of building issues manager in control of premises). Further details on accident reporting can be found in the guidance document,' Accident/Incident Reporting Guidance Sheet – 024'.

All managers must investigate any accidents, incidents or near misses involving their staff. The purpose of this investigation is not to apportion blame but to understand what went wrong and how it can be put right. It will also help prevent similar accidents / incidents happening. The investigation should include all those involved in the accident or incident and, depending on the level of seriousness could also include union H&S representatives, health and safety officers and senior managers.

The level of detail in the investigation should be proportionate to the severity of the accident of the potential severity of the near miss. Further information is provided in the section 'Investigation Levels'.

Benefits arising from an investigation

A number of benefits can be realised by conducting good accident investigations, these include:

- The prevention of further instances. If a second serious accident occurs the enforcement authorities are likely to take a firm line if similar accidents have been ignored.
- The prevention of business losses due to disruption or stoppage to service provision and/or the costs of criminal and civil actions.
- An improvement in employee morale and attitude towards health and safety.
- The development of management skills that can be applied to other areas of the Authority.

The legal position
The Management of Health and Safety at Work Regulations 1999, regulation 5, requires employers to plan, organise, control, monitor and review health and safety arrangements. An accident or even a near miss suggests that the risk control measures are inadequate and therefore an investigation is critical to ensure that the events leading to the accident are changed to reduce the likelihood of a similar accident occurring.

Claims

Some accidents may give rise to injury following which a civil claim for damages may occur against the Authority. It is essential if a serious accident occurs that Risk Management are notified as soon as possible. Certain documentation will be required in the event of a claim so copies of accident book entries/ report form, investigation forms, risk assessments, maintenance records etc. should be kept for a minimum of four years following an accident.

(Note this time limit is longer in the case of work related disease (minimum 40 Years), or those that were under 18 at the time of the accident (until the individual is 22)).

Investigation Levels.
It is important not only to take into account the actual consequence of the accident but also the potential consequences. For example in the case of a scaffold collapse minor injuries may have occurred, however this incident has the potential to cause major or fatal injuries. It should also be noted that the people stated below are the minimum number of people to be involved in the investigation and that others may be required depending on the nature of the incident, for example the Back Care Adviser if a major injury occurred due to manual handling or an Engineer if technical input is required.

There are three levels of investigation:

Low - A low level investigation will involve a short investigation by the relevant supervisor or line manager into the circumstances and immediate underlying root causes of the incident in order to try and prevent a reoccurrence and to learn any general lessons. It is not necessary to complete the investigation form for low-level investigations however investigation findings should be provided on the report form. Most accidents will fall into this category.

Medium – A medium level investigation will involve completion of the accident investigation form by the relevant supervisor or line manager. The Directorate Health and Safety Officer and employee representatives (where appropriate) should be involved in identifying immediate, underlying and root causes.

High – A high level investigation will involve a team approach to complete the accident investigation form. This investigation should involve a relevant line manager or supervisor, Directorate Health and Safety Officers and employee representatives (where appropriate). The outcomes and findings of the investigation must be reported to senior management (Head of Service or above) and the Corporate Health and Safety Unit. The investigation will look for immediate, underlying and root causes.

The table below will assist you in determining the level of investigation required:

Accident category	Recommended investigation level	Those involved within the investigation	Paperwork to be completed
Non reportable accident/incident (minor injury, no potential for major injury or fatality)	Low level	Supervisor/Line Manager	Accident report form, including investigation finds within details section.
Over 3 day injury	Medium level	Supervisor/ Line Manager, Directorate Health and Safety Officer, Employee Representative (where appropriate) Occupational Health should be involved in the case of an industrial disease.	Accident report form and Accident Investigation Form
Major injury or specified industrial disease	Medium level		
Any accident/ incident where potential for fatality	High level	Supervisor/ Line Manager, Directorate Health and Safety Officer, Employee	

Fatality	High level	Officer, Employee Representative (where appropriate), finding and recommendations of the investigation must be reported to CMT and CHSU	

Understanding the terminology:

Accident – An event that results in injury or ill health.

Incident/Near Miss – An event, which does not cause harm, but has the potential to cause injury or ill health.

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

Fatal – Work-related death

RIDDOR Reportable – A fatality, specified major injury, over 3 day lost time injury or a specified dangerous occurrence as defined by the RIDDOR Regulations.

Major injury – As defined by RIDDOR Schedule 1. Includes fractures (other than fingers and toes), amputations, loss of sight, a burn or penetrating injury to the eye, any injury or acute illness resulting in unconsciousness or requiring admittance to hospital for more than 24 hours. A list of major injuries is available within the accident reporting policy.

Over 3 day injury – When following an accident / incident the injured person is unfit for their normal work for longer than 3 days (not including the day of the accident, but including weekends or days off shift). This includes absence from work or individuals that are placed on light or restricted duties.

Minor Injury – All other injuries, which are not covered by other categories, for example sprain, cut or bruise.

Ill Health – Where the person affected by the work activity and is unable to carry out their usual duties for more than 3 days (not including the day of the accident, but including weekends or days off shift).

Dangerous Occurrence – One of a number of specific, reportable events as defined in RIDDOR. A list of dangerous occurrences is available within the Accident Reporting Policy and on the intranet.

Violent Incident – Where an injury has occurred following an incident of violence towards an employee. This applies to physical assault incidences only and the accident form must be completed in conjunction with the Violent Incident (VI) report form. In cases of verbal abuse, where there is no physical injury, only the Violent Incident form is to be completed.

Risk Control Measure – Workplace precautions that are in place or those that can be introduced to reduce the risk to an acceptable level.

Immediate Cause – This is the agent, unsafe condition or practices that contributed to the caused of the incident. For example the blade of a machine, as the guard was removed. More than one immediate cause may apply.

Root Cause – This is the failure from which all other failings grow. This is often remote from the accident/incident itself, for example failure to identify training needs or inadequate supervision.

What does accident investigation involve?

An investigation will involve an analysis of all the information available. The process take into account, physical (scene of the accident), verbal (witness accounts) and written (risk assessments, procedures etc) information and looks to determine what went wrong so that actions can be identified that will prevent the incident from happening again. It is important to be open, honest and objective throughout the investigation process. Pre-conceived ideas about the process, the equipment, or the people involved in an incident may blind you to the real causes. Question everything, be wary of blaming individuals. The severity of the accidents will determine the depth of, and amount of time spent undertaking, the investigation. Minor low risk accidents should be investigated, however this should not be time consuming or onerous and findings included on the accident report form rather than completing an accident investigation form.

The process:

The accident investigation process involves 5 main steps:

- Ensure accident/ incident is reported and deal with the immediate accident / incident scene
- Information Gathering
- Analysis of the information
- Identification of Risk Control Measures
- Create an action plan to implement the recommendations.

Appendix 1 provides a step-by-step guide to accident investigation.

Appendix 2 contains an example of how the Accident / incident Investigation form should be completed.

In cases of severe accidents or incidents please contact your Directorate Health and Safety Officer immediately.

Contacts

In the event of you needing advice/further information on accident investigation please contact either the Corporate Health and Safety Officer or your Directorate Health and Safety Officer as detailed below:

Corporate Health and Safety Unit – 01443 873708
Education/Leisure – 01443 864865
Environment – 01443 873765
Chief Executives – 01443 864384
Social Services – 01443 864623

Appendix 1 – The Accident / Investigation process

NB – The level of detail required in each accident investigation will be proportionate to the severity of the accident.

Step 1 – Ensure accident/ incident is reported and deal with the immediate accident / incident scene

- If applicable take any first aid action as necessary following the accident
- If applicable make the area safe
- If necessary seal the area of the accident off to preserve the scene
- Note the names of the person (s) involved, obtain details of any equipment involved and make a note of witnesses
- Inform the Directorate Health and Safety Officer and the Corporate Health and Safety Unit, if necessary
- Complete accident/incident report form (refer to guidance note GS002)

Step 2 – Information Gathering

The accident/incident investigation form should be used to obtain the information necessary to analyse the accident / incident. The information should be supported, where necessary with photographs, witness statements (signed by the witness) and sketches / diagrams. The accident/incident investigation form contains a list of question that will lead the investigator through the investigation process, however discovering exactly what happened can involve a bit of detective work. The investigation should begin straight away, or as soon as practical as it is important to capture information as soon as possible to prevent it from being corrupted e.g. items moved, guards replaced.

The following questions are asked on the accident/incident investigation form:

1 Where and when did the accident happen?
Details of where and when (date and time) the accident/ incident occurred.

2 Who was injured and how?
Provide details of who was injured, and how the injury occurred.

3 How did the adverse event happen? (note any equipment involved)
Describe the chain of events leading up to, and immediately after, the accident/incident. Often a number of chance occurrences and coincidences combine to create the circumstances in which an accident/incident happened. All these factors should be recorded here in chronological order.

The chain of events can be established by talking to the injured person, eye witnesses, line managers, health and safety representatives and fellow workers to find out what happened and who did what. Be objective; avoid apportioning guilt, assigning responsibility or making snap judgements on the probable cause.

Plant and equipment that had a direct bearing on the incident must be identified clearly. Note all the details of the equipment; note the position of the machinery controls immediately after the event.

4 What activities were being carried out at the time?

The work that was being done just before the accident/incident happened could often cast light on the conditions and circumstances that caused something to go wrong. Provide a good description, including any relevant details.

5 Was there anything unusual or different about the working conditions? If so, what?

Accident/incidents often happen when something is different. When faced with 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, was the way that change, temporary or otherwise, was introduced a contributory factor? Were workers and supervisors sufficiently trained/experienced to recognise and adapt to the changing circumstances?

6 Were there adequate risk assessments and safe working procedures? Were they being followed?

Accidents/ incidents often happen when there are no risk assessments or safe working procedures, or where these have been inadequately completed or not correctly followed.

What was it about the normal practices that proved inadequate? Was the risk assessments and safe working procedures in place and were they being followed? If not, why not? Was there adequate supervision and were supervisors themselves sufficiently trained and experienced? It is important to pose these questions without attempting to apportion blame, assign responsibility or stipulate cause.

7 What injuries or ill health effects were caused? How did the injury occur and what caused it?

It is important to note which parts of the body were injured and the nature of the injury. Be as precise as you are able. If the site of the injury is halfway between the elbow and shoulder joint on the right arm – describe in this much detail. Where more than one injury occurred ensure that details are provided for each injury location and type.

The way in which the person was injured should also be detailed here. Provide details of the harmful object that caused the injury and the way in which the injury was sustained. For example a hand held knife may have caused the injury; the way in which the injury occurred was that the person cut themselves when losing their grip on the knife.

Where the injured person became unconscious, required resuscitation, remained in hospital for more than 24 hours, or was taken from the scene of the accident to a hospital the relevant box should be completed.

8 Was the risk known? If so, why wasn't it controlled? Why not? Did controls fail? If so why?

The aim is to find out why the sources of danger may have been ignored, not fully appreciated or not understood. Establish 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 make note of what was said and who said it, so that potential gap in the communication flow may be identified and remedied.

The existence of a written risk assessment for the activity will help to reveal what was known of the associated risk. A judgement can then be made as to whether the risk assessment was 'suitable and sufficient' and whether the control measures identified as being necessary were adequately put into place.

9 Did the organisation and arrangement of the work influence the accident/ incident?

The organisational arrangements set the framework within which work is undertaken. Here are some examples that you may wish to consider, there are however many more:

- Standards of supervision and on-site monitoring of working practices may be less than adequate.
- Lack of skills or knowledge ensures that no one intervenes in the event of procedural errors.
- Inappropriate working practices may mean that certain steps are omitted because they are too time consuming or too difficult.
- Lack of planning may mean that some tasks are not done, are done too late, or are done in the wrong order.
- Employee's actions and priorities may be a consequence of the way in which they are paid or rewarded e.g. job and finish, piece rate.
- High targets may result in safety measures being degraded and employees working too fast.

10 Was the maintenance and cleaning sufficient? If not why not?

Lack of maintenance and poor housekeeping are common accident/incident causes. Was the state of repair and condition of the workplace, plant or equipment such that it contributed or caused the accident/incident? You should observe the location of the accident/incident as soon as possible after the event and judge whether the general condition or state of repair of the premises, plant or equipment is below what it expected. Those working in the area, together with any witnesses should also be asked for their opinion. They will have a good idea if working conditions have deteriorated over time. Consider the following factors:

- Badly maintained machines or tools.
- Noisy environment
- Uneven floors
- Badly maintained lighting
- Poorly stored materials
- Ice, dirt other contamination of walkways, starts etc

11 Were the people involved competent and suitable? Detail competencies.

Training provides individuals with the necessary knowledge, skills and hand-on experience that allow them to carry out their work efficiently and safety. Consider the following factors:

- A lack of training and instruction may have meant that tasks were not undertaken correctly
- Lack of understanding of the usual routines and procedures with the area
- Lack of respect for the risks involved due to ignorance or complacency of the potential consequences.
- Immaturity, inexperience and lack of awareness amongst young workers

Individuals should also match their work in terms of health, strength, metal ability and physical stature.

12 Did the workplace layout influence the accident/incident? Explain how?

The physical layout of the surroundings can affect health and safety, for example; Injuries can occur due to sharp table edges. The workplace should be arranged in such as way that safe working practices are encouraged; can they see what their colleagues are doing? Are there clear walkways? Do these segregate pedestrians and vehicles?

13 Did the shape or size of any materials involved or difficulty in using any equipment have an influence on the accident/ incident occurring? If so how?

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

Plant and equipment includes all machinery, plant and tools used to organise and carry out the work. All these items should be designed to suit the people who are using them.

14 Was the safety equipment being used sufficient? What equipment was used? If no, why?

You should satisfy yourself that any safety equipment and safety procedures in place are both suitable and applicable for all conditions in which the works take place. For example, Consideration should be given to:

- Extra technical safety equipment at machines
- Power isolation procedures and equipment
- Personal protective equipment
- Building safety systems, e.g. extraction systems.

15 Did other conditions influence the accident/incident? Please describe?

The 'other condition' section can be used to cover anything that has not been reported elsewhere on the form that might have had an influence on the accident / incident. Other conditions may include:

- Disagreements between individuals
- The weather
- Unauthorised interference in the task
- Defective supplies or equipment
- Deliberate acts such as sabotage

Step 3 – Analysing the information

Step 3 is crucial to understanding why the accident / incident happened. The information gathered in Step 2 needs to be sorted to ensure that the immediate and root causes are identified and steps are taken to address these so that they don't happen again.

The simplest way to sort through the information gathered is by asking the question "why?" over and over again until it no longer becomes meaningful. By continually asking "why?" the sequence of events leading to the accident will become clear.

Do not use the accident investigation as an exercise in apportioning blame. Even if it is clear that someone was acting against instruction there are usually reasons why. The purpose of the investigation is to understand all the causes and ensure it doesn't happen again. If people feel that the investigation process is only concerned with blame then they will be less likely to report the accident or provide helpful information.

Work through the questions about the possible immediate causes (the place, the equipment, the people and the processes) to identify which are relevant. Once these immediate causes are identified the necessary risk control measure(s) can be identified and recorded.

For each immediate cause there will be root causes, which will have allowed the immediate cause to exist. These will need to be identified and recorded. Within section 16 of the accident investigation form a list of immediate and root causes are available for your use. These are highlighted below with examples for each description:

Immediate Cause – Unsafe Conditions

- Faulty/ Damaged equipment e.g. frayed electrical cable on electrical hand tool.
- Energised equipment e.g. failure to isolate equipment that was energised by for example, compressed air or electricity.
- Congestion e.g. workplace layout not ensuring enough space for individuals to undertake tasks.
- Hazardous atmosphere e.g. methane gas build up within a confined space.
- Inadequate guards e.g. incorrect or inadequate guarding on equipment.
- Inadequate ventilation e.g. poor air circulation, no local exhaust ventilation where hazardous fumes are produced.
- Poor arrangements e.g. shift handover arrangements not adequate
- Poor equipment design
- Pour housekeeping e.g. clutter caused individual to walk into object and sustain a bruise.
- Poor illumination e.g. lighting levels below recommended levels.
- Slip/ trip Hazard e.g. trailing cables
- Other – please specify other unsafe condition that you feel contributed to the accident.

Immediate Cause – Unsafe Practice

- Changing position suddenly e.g. when lifting an item causing a back strain.
- Failure to lock off e.g. failure to isolate equipment before undertaking work.
- Failure to secure e.g. failure to secure load before being transported.
- Failure to use PPE e.g not wearing required personal protective equipment.
- Failure to warn e.g. failure to inform of safety concern, warn others of danger.
- Hurrying to save time.
- Horseplay e.g. tomfoolery due to completion of an apprenticeship, which leads to an accident.
- Improper equipment service e.g. equipment has not been serviced in line with manufacturer / legal requirements.
- Inappropriate speed e.g. when vehicle is being driven too fast as determined by speed restrictions or road conditions
- Inadequate PPE used e.g. PPE worn however was not suitable for activity such as safety spectacles rather than a face visor.
- Not following method statement
- Not following risk assessment
- Operating without authority e.g. undertaking work that the individual was not authorised to carry out.
- Workload too heavy e.g. where excessive workload contributes to the accident cause.
- Overexertion whilst lifting/moving e.g. where person lifts or moves an object that is beyond their individual capability.
- Position of body e.g. where the position of the individual contributed to the accident.
- Safety device not working e.g. interlock devise overridden or interfered with.
- Using equipment improperly e.g. using equipment not for the use for which it was intended.
- Other – Please specify other unsafe practice that you feel contributed to the accident.

Root Cause

- Avoiding discomfort e.g. incorrect body position whilst lifting due to knee problem
- Avoiding effort e.g. taking short cuts from normal working practice to reduce physical effort needed
- Inadequate communication e.g. individuals not aware of what they should be doing, procedures to be followed, language issues etc
- Influence of Emotions e.g. stress
- Influence of fatigue. e.g. excessive working hours, or personal issues leading to tiredness.
- Influence of illness.
- Insufficient planning e.g. where the task was not planned properly and this contributed to the accident.
- Influence of drugs or alcohol.
- Lack of Enforcement e.g. no enforcement when individuals do not follow risk assessments/ safe working procedures.
- Lack of skill e.g. individual not possessing required skills to undertake task.
- Lack of Supervision e.g. supervisor should have noticed unsafe practice or condition.
- Lack of Training e.g. individual has not received required manual handling training as required in training needs analysis.
- Physically impaired e.g. an individual unable to hear warning alarms.
- Procedure/Risk Assessment not established
- Procedure/ Risk Assessment not followed
- Procedure/Risk Assessment not known
- Other root cause.

Step 4 – Identification of Risk Control Measures

Using a methodical approach enables failings and possible solutions to be identified. If several risk controls are identified they should be carefully prioritised as a risk control action plan, which sets out what needs to be done and by whom. (see section 4 of the accident/ incident investigation form)

Step 5 - Action Plan

Once it is clear how and why the accident / incident occurred and what needs to be done to remedy the situation, an action plan should be drawn up to ensure that the measures are actioned.

Finally, when considering the risk control measures and the action plan the risk assessment and the safe working procedures will need to be reviewed and amended to reflect the outcome of the investigation.

Step 6 - Auditing

It is important to periodically review the action plan to ensure that the measures required have been actioned. The area manager should undertake this, and periodic representative checks will be undertaken by the Directorate and Corporate Health and Safety Officers.

Example accident investigation.

Accident details:
Norman Brown was trying to fix a problem on the glue-edging machine when the machine operated. Norman cut his had quite badly. He was given first aid treatment and taken to hospital.

The fuses had been taken out of the machine and a sign hung over it.

Name of investigator: Peter Jones
Position: Line Manager.
Date of investigation: 9th June 2006

Documents included:

- Witness statement included from Colin Pearce, Norman Brown's work colleague.
- Photos of accident area.
- Information gained during discussion with Norman's supervisor Robert Price.

Example of completed investigation form:

Accident / Incident investigation form.

The investigation team should complete parts A and B. Depending on the accident type and severity the investigation team will change. A manager who has the authority to ensure that the actions identified are implemented must countersign part B. When completing this form please refer to the investigation guidance. Completed forms must be sent to Directorate H&S Officer and a copy to the Corporate H&S Unit within 5 days. (N.B. The names of these individuals are fictional)

PART A – INVESTIGATION – Information gathering and analysis.
(supplementary Information to be included on additional sheets if necessary)

Injured Person's Name:	Accident / Incident Date:	iCass Reference number:
Norman Brown	9th June 2006	1234

Members of the Investigation Team	
Name	Job Title
Peter Jones	Line Manager

1. Exactly where did the accident/ incident happen?
   Wood machine Shop – Woodfield Side
   7th June 2006 at 11:15 am

2. Who was injured etc or otherwise involved in the event? (Include witness details)
   Injured Person – Norman Brown
   Witness - Colin Pearce

3. How did the accident / incident happen? (Note any equipment involved)
Norman discovered a defect in the edge-gluing machine. He opened the interlocked lid where the skirting boards are sawn off and planed down. Norman inserted his pen into the interlock so he could operate the machine with the guard in the open position. Thus enabling him to see what was going wrong. The cross cut saw operated and cut Norman's hand. The machine was the Wilmatron 440 edge gluing machine series 1234/56 2001. This uses a Sharp cut Mk1 200mm diameter circular saw blade.

4. What activities were being carried out at the time?
Norman was working on the edge-gluing machine on a batch of aluminium skirting.

5. Was there anything unusual or different about the working conditions? If so, what?
Yes. This machine is normally used with MDF skirting boards and not aluminium.

6. Were there adequate risk assessments and safe working procedures? Were they being followed? Please attach copies. Safe working procedures for working on machine and undertaking repairs in place. This was not followed, as the machine should have been isolated before repairs were undertaken.

7. What injuries or ill health effects were caused? How did the injury occur and what caused it? Severe laceration to the top of the right hand at the knuckles resulting in severing of tendons. This was caused by the rotating blade of the cross cut saw.

Did the person become unconscious? ☐ Need resuscitation? ☐ Remain in hospital for more than 24 hrs ☐ or was taken directly to hospital from scene? ☐

8. Was the risk known? If so, why wasn't it controlled? If not, why not? Did controls fail? If so why?
The risk was known, but Norman thought that he would be O.K. as he was only having a look inside the guard. Therefore the interlock device was overridden by a pen.

9. Did the organisation and arrangement of the work influence the accident / incident? How? E.g. was insufficient time / resources allocated.
No, Norman had been experiencing problems all morning and decided to have a look himself before calling an engineer.

10. Was maintenance and cleaning sufficient? If not why not?
Yes, Maintenance and cleaning activities were up to date for the machine.

11. Were the people involved competent and suitable? Please detail competencies.
Norman is a qualified wood machinist with 9 years experience. He had worked on the edge-gluing machine for 3 years.

12. Did the workplace layout influence the accident / incident? Explain how?
Yes – access to the machine is difficult. Access to the viewing window in the guard is also difficult.

13. Did the shape or size of any materials involved or difficulty in using any equipment have an influence on the accident / incident occurring? If so, how? e.g item that is bulky or awkward to lift.

Yes – the machine was being used with aluminium rather than the normal MDF skirting's and the machine was malfunctioning.

14. Was the safety equipment used sufficient? If yes, what equipment? If not, why? E.g PPE, guards.

No – although there is an interlock devise fitted to the machine, it is of the design that means it can be easily overridden.

15. Did other conditions influence the accident / incident? Please describe? E.g adverse weather

No

16. What were the immediate, underlying and root causes? (More than one may apply)

Immediate Causes – Unsafe Conditions		**Immediate Cause – Unsafe Practice**		**Root Causes**	
Faulty / Damaged Equipment	X	Changing Position Suddenly	☐	Avoiding Discomfort	☐
Energised Equipment	X	Failure to Lock Off	X	Avoiding Effort	☐
Congestion	☐	Failure to Secure	☐	Inadequate Communication	☐
Hazardous Atmosphere	☐	Failure to Use PPE	☐	Influence of Emotions	☐
Inadequate Guards	☐	Failure to Warn/ inform	☐	Influence of Fatigue	☐
Inadequate Ventilation	☐	Hurrying to save time	☐	Influence of Illness	☐
Poor Arrangements	☐	Horseplay	☐	Insufficient Planning	☐
Poor Equipment design	X	Improper Equipment Service	☐	Influence of drugs or alcohol	☐
Poor Housekeeping	☐	Inappropriate Speed	☐	Lack of Enforcement	☐
Poor Illumination	☐	Inadequate PPE Used	☐	Lack of Knowledge	☐
Slip/Trip Hazard	☐	Not following method statement	☐	Lack of Skill	x
Other immediate cause – unsafe condition	☐	Not following Risk Assessment	X	Lack of Supervision	X
		Operating without Authority	☐	Lack of Training	X
		Workload too heavy	☐	Physically Impaired	☐
		Overexertion whilst lifting / moving	☐	Procedure/ risk assessment not established	x
		Using Equipment Improperly	X	Procedure/ risk assessment not followed	X
		Safety device not working	☐	Procedure/ risk assessment not known	☐
		Position of body	☐	Other root cause	☐
		Other Immediate Cause – Unsafe practices	☐		

17. What Risk Control Measures are needed / Recommended?

Replace interlock switch with more suitable design
Reposition machine to allow access to the window
Ensure Procedures for isolation of machine are written and available for staff to follow (training)
Ensure procedures for reporting / repairing defects are reiterated to staff
Ensure Clear Allocation of duties
Review Risk Assessment

18. Have similar events happened before? Give details: No

19.Is Incident RIDDOR Reportable	Yes	X	No	☐
Date reported to HSE: 13 June 2006	RIDDOR reference number: 1234			

PART B – THE RISK CONTROL ACTION PLAN

Action plan for recommendations:

20. Recommendation	Person Responsible	Target Completion Date	Actual Completion Date
Risk assessment to be reviewed	Peter Jones (Manager)	20th June 2006	
Replace interlock switch with more suitable design	John Other (Foreman) & H&S Officer	Before re-use of machine	
Reposition machine to allow access to the window	John Other (Foreman)	Before re-use of machine	
Prepare Risk Assessments and safe working procedures for isolation and reporting /repairing defects. Ensure communication to applicable employees.	John Other (Foreman)	1 December 2006	
Assess competence and training needs & Deliver training	John Other (Foreman) & H&S Officer	1 December 2006 1 March 2007	

21. Signed on Behalf of the Investigation team.	
Name: Peter Jones	Signature

22. Management Signature – I agree with the outcome of the investigation.

Signed: Bob Jones Date: 11 June 2006

23. Copies of this accident investigation form have been sent to:

Directorate H&S Officer x Date 12 June 2006 Corporate H&S Unit x Date 12 June 2006

Other Persons
Name: Date:

Notes section –

Office use only

Entered / updated on icass by:	Accident (icass) Ref Number:

Information

Analysis – Supporting notes

How/ Why:

- Edge gluer was used for aluminium without adjusting to suit
- The saw blade was tearing the end sections
- The Operator had decided to investigate the cause
- The Operator decided that to find cause he had to run the machine
- The Operator is unable to see through the viewing window
- The Operator opens the guards and defects the interlock
- The machine makes a cutting stroke
- The Operators hand is cut by the machine

Immediate Causes:

- Not enough room around the machine to do the job
- The saw set up was not suitable for use on aluminium
- The interlocks fitted were of a type easily defeated
- There were no safe working procedures for the job
- The Operative not fully competent

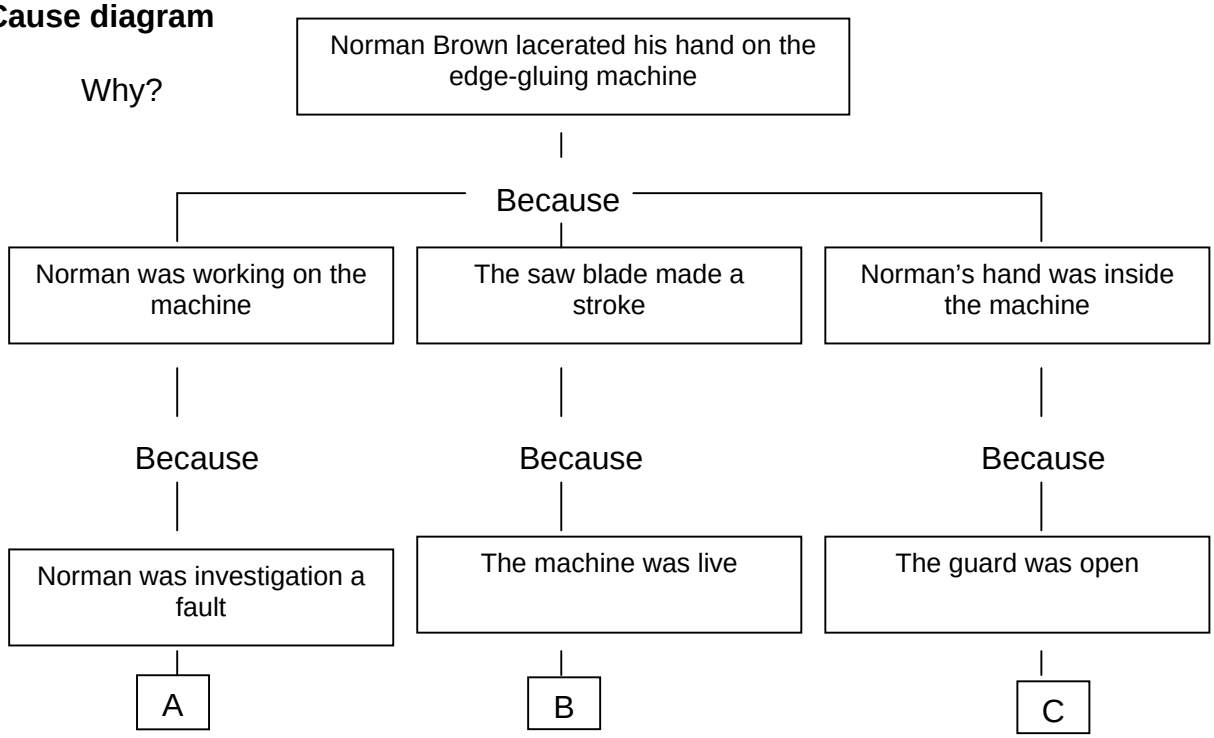
Root Causes:

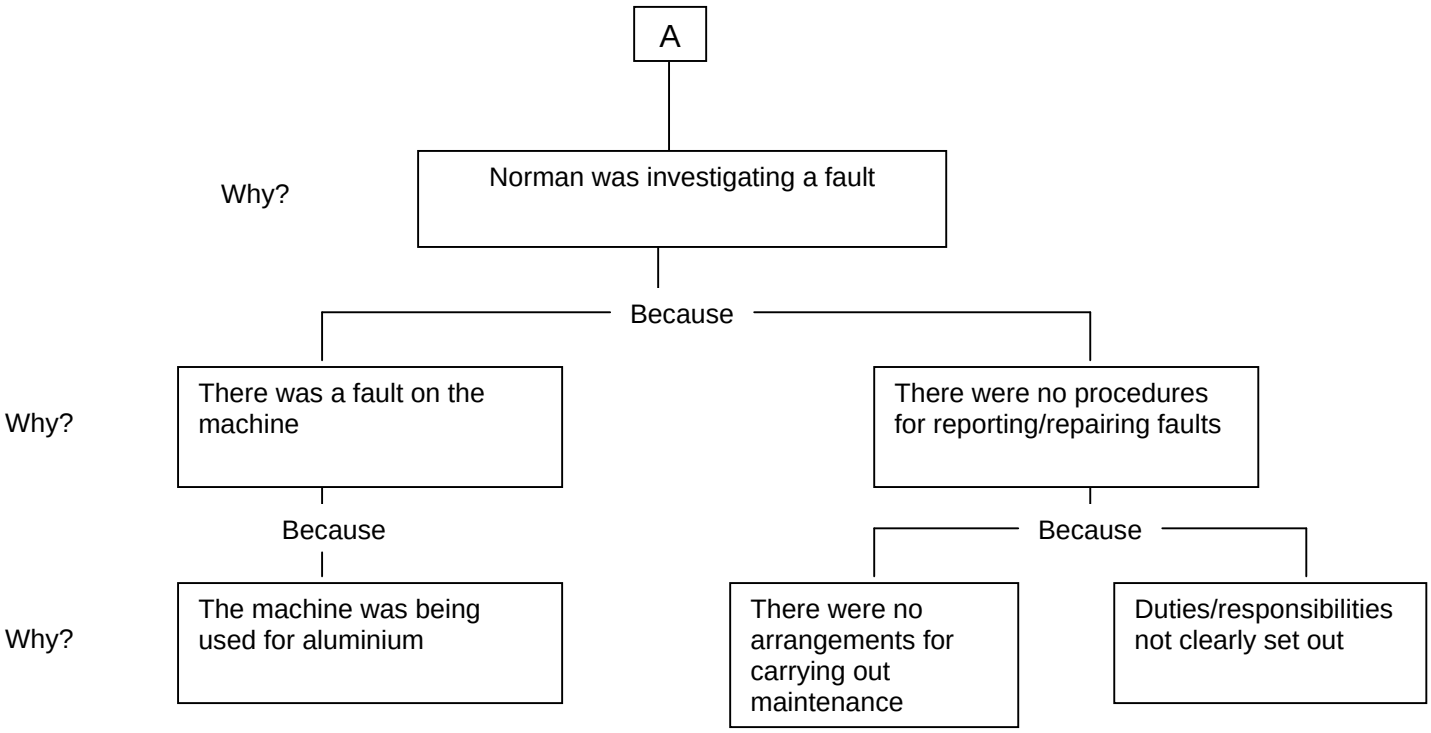
- Poor Workplace layout
- No risk assessments for Maintenance of the machine
- Risk assessments for operation of the machine not followed
- Risk assessments did not address possible interference with the interlock device
- Safe working procedures were not prepared following the risk assessments
- Operators were not suitable trained on machine maintenance and safety devices
- Level of supervision not adequate
- All staff to be reminded of their duties and essential health and safety measures.

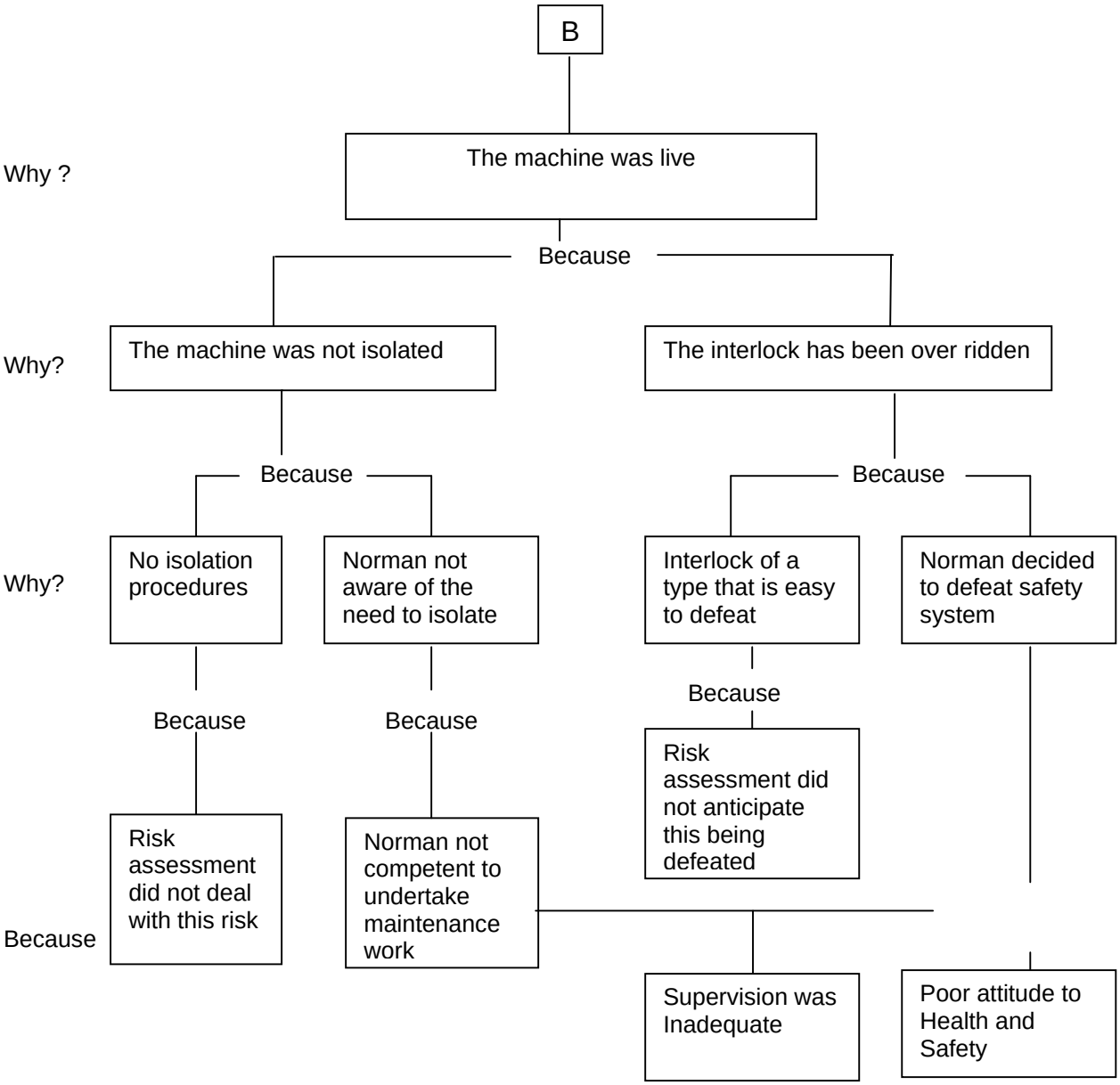
Others:

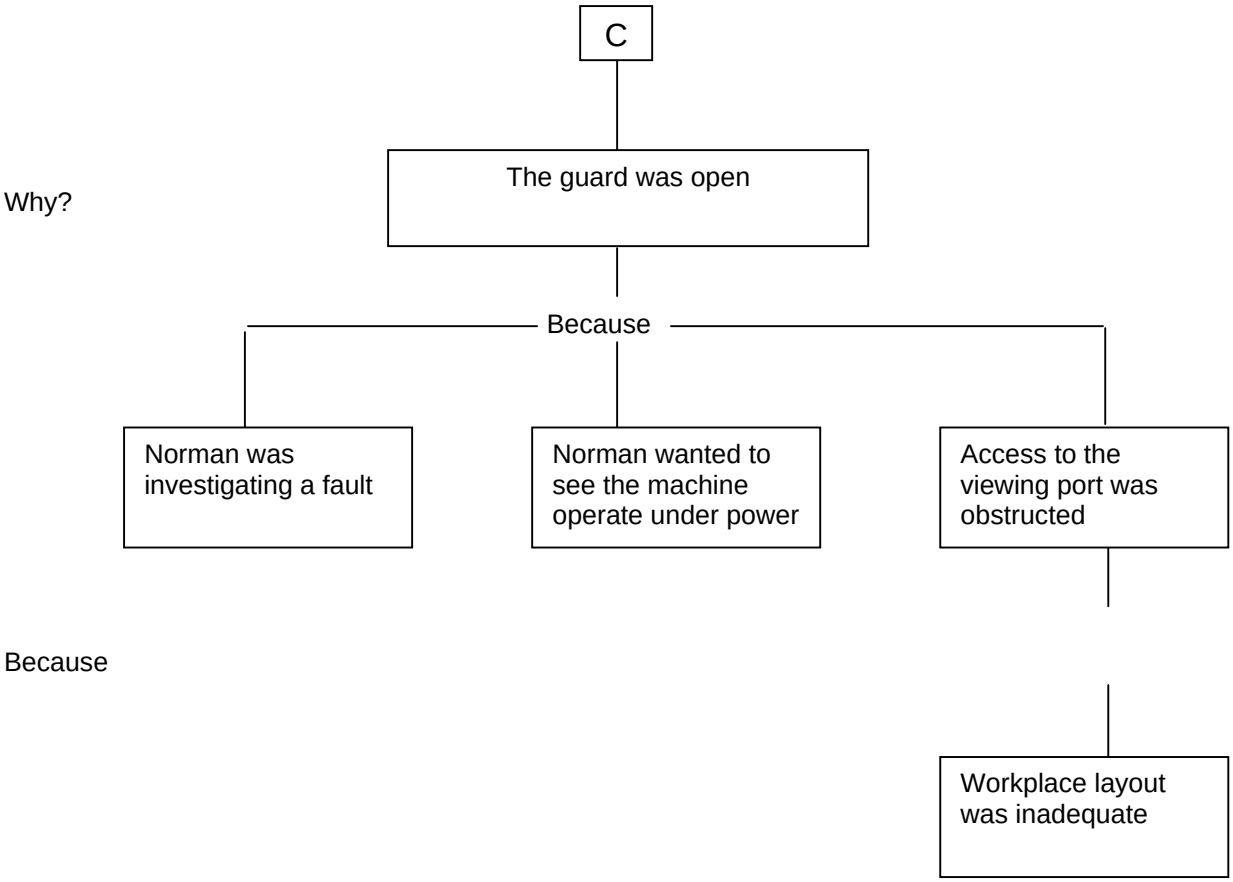
- Management commitment to Health and Safety not communicated to employees.
- Unclear lines of communication and responsibilities

Cause diagram




A
Why?
Norman was investigating a fault
Because
Why?
There was a fault on the machine
There were no procedures for reporting/repairing faults
Because
Because
Why?
The machine was being used for aluminium
There were no arrangements for carrying out maintenance
Duties/responsibilities not clearly set out


B
Why ?
The machine was live
Because
Why?
The machine was not isolated
The interlock has been over ridden
Because
Because
Why?
No isolation procedures
Norman not aware of the need to isolate
Interlock of a type that is easy to defeat
Norman decided to defeat safety system
Because
Because
Because
Risk assessment did not anticipate this being defeated
Because
Risk assessment did not deal with this risk
Norman not competent to undertake maintenance work
Supervision was Inadequate
Poor attitude to Health and Safety


C
The guard was open
Why?
Because
Norman was investigating a fault
Norman wanted to see the machine operate under power
Access to the viewing port was obstructed
Because
Workplace layout was inadequate