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For latest information from DCYP please visit:

<https://www.gov.uk/government/groups/directorate-children-and-young-people>.

For latest information from SCE please visit:

<https://www.gov.uk/government/collections/service-childrens-education>.

ANEX B TO LEAFLET 20 OF PART 3 TO SHEF MANUAL

GUIDANCE NOTES

An accident/incident for Health and Safety purposes is any unplanned event where:

1. Someone suffers an injury or ill health;
2. Someone could have suffered an injury or ill health or there could have been damage or loss to property if the circumstances had been slightly different (often called a 'near miss' or 'near hit' or dangerous occurrence).

The primary aim of an investigation is to establish the cause of the accident/incident. Knowing the cause of an accident/incident will identify the appropriate action to prevent a recurrence. An investigation is not undertaken to apportion blame for the accident/incident. This approach is unlikely to succeed in determining the cause of the accident/incident since vital information may not be forthcoming. As much information as possible into the cause of the accident/incident should be gathered for the following reasons:

1. **To prevent a similar accident happening;**
2. **To report to the Enforcing Authority (usually the Health and Safety Executive) and to the Insurers.**

Immediate action may be required to prevent further accidents before starting the investigation, eg stop an activity or withdraw equipment. Following a serious accident/incident the area where the event occurred should be secured, and no-one allowed to enter or interfere with it. The Police, Health and Safety Executive and other staff may have to examine the area.

Consider the severity or potential severity of the accident/incident when deciding upon the depth of the investigation. A full and detailed investigation is required for serious accidents: a less detailed one for minor accidents. The investigation must gather sufficient information to identify causes and measures to help prevent a recurrence. Only when this is achieved will the investigation be completed. Use the following checklist list as a guide to structuring investigations and reports:

1. **Obtain basic facts**

- Has anything been altered since the accident/incident
- Names of injured/ill employees/witnesses/people first on the scene
- Extent of injury/ill health/damage/disruption
- The task that was being undertaken at the time of the accident/incident
- The time, place and layout of area (building, room)
- The environmental conditions (lighting, ventilation, slippery, obstructions, weather conditions if outside)
- Record conditions eg take photographs or make sketches

2. **Obtain witness statements**

- Name, contact details and occupation of witness

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What did they observe and what did they do

3. **Establish circumstances**

What was being done at the time and what happened

What was the accepted method for carrying out the task. Was it being followed.

Was it adequate

Was the individual competent to carry out the task (qualifications, experience)

What instruction and training was given (records available)

Were they aware of risk assessment for task (how they could be harmed and the measures they should take to prevent harm)

Had the individuals been told to carry out the task, or were they acting on their own initiative

Has something similar happened previously

4. **Immediate response to accident/incident**

Was prompt and appropriate action taken (eg fire fighting, first aid, spillage procedure, make area safe, restrict access, isolate electricity, warning notices, referral to Occupational Health)

5. **Identify preventative measures**

Review the risk assessment for the task (copy available)

What safety precautions were in place and what safety precautions should have been in place

What instruction and training was given and what instruction and training should have been given

6. **Identify underlying causes**

Was supervision and training adequate

Was equipment suitable for task

Was equipment maintained and tested adequately

What pressures/constraints, if any, were being applied?

Was communication adequate between relevant parties

7. **Actions to prevent a recurrence**

Could the outcome have been more serious

What needs to be done to prevent similar accident/incident

Were the safety precautions adequate but not implemented; why not

Actions to prevent recurrence include:

- Better guarding or barriers
- Better test and maintenance schedules
- Revised work method
- Provision and use of personal protective equipment
- Improved supervision, training, inspection, instruction and information
- Better communication
- Review similar activities elsewhere