



University of  
St Andrews

# Incident, Accident and Near Miss Reporting and Investigation Policy and Guidance

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## Index

1. Introduction
2. Policy Statement
3. Arrangements
  - 3.1. Health and Safety Assurance Group
  - 3.2. Health and Safety Consultative Group
  - 3.3. Director of EHSS
  - 3.4. Head of School/Unit
  - 3.5. Staff and Students
  - 3.6. Intended Audience
  - 3.7. Where these regulations apply
4. Legislative and Regulatory Framework
  - 4.1. Relationship with existing University Policy, Procedures and Regulation

### 1.0 Introduction

The nature of the activities at the University means there is always a chance of an accident or a near miss or other type of incident (eg a fire) happening. It is vital that all but the most trivial of these incidents are reported so that the University can identify the cause and make appropriate changes to the work activities to ensure that a similar accident does not happen again

### 2.0 Policy Statement

1. The overarching commitments set out in the University's general Health and Safety Policy apply. The general policy can be found here: URL: <https://www.st-andrews.ac.uk/media/environmental-health-and-safety-services/H&S-Policy-2017.pdf>
2. The University will comply with all relevant legislation about the reporting of accidents and dangerous occurrences to the relevant enforcement authority
3. All but the most trivial incidents or near misses to staff or students or members or the public must be report to the Director of Environmental, Health as soon as is reasonably practicable.
4. All fire related incidents including false alarms must be reported to the Director of EHSS.
5. All incidents to staff or students or members of the public which may have an effect on business continuity or crisis management should also be reported to the Director of Environmental, Health and Safety Services.
6. The Director of Environmental, Health and Safety Services will report any accidents/incidents to enforcement authorities which are required to be reported under relevant legislation (eg Reporting Injuries, Diseases, Dangerous Occurrences Regulations 2013 - RIDDOR).
7. A proportionate incident investigation will be undertaken for all but the most trivial accidents, near misses or other incidents.
8. All accidents or near miss or other types of incidents which are reportable to an enforcement authority will be investigated by the Director of Environmental Health and Safety Services.
9. The Director of Environmental, Health and Safety Services will present details of all accidents and the results of investigations to the Health and Safety Assurance Group as a standing item on the agenda.
10. The Director of Environmental, Health and Safety Services will produce a statistical breakdown of all accidents to Schools/Units on an annual basis

### **3.0 Arrangements**

The roles and responsibilities set out in the University's general Health and Safety Policy apply.

#### **3.1 Health and Safety Assurance Group**

The Health and Safety Assurance Group will review all accidents and any relevant investigations on behalf of the University Court.

Where necessary, the Health and Safety Assurance Group will require the Director of EHSS to undertake more detailed accident investigations

#### **3.2 Health and Safety Consultative Group**

The Director of EHSS will present all accident reports and associated proportional investigations to the Health and Safety Consultative Group which consists of the University Union Safety Representatives. The Union Safety Representatives can ask to view the accident report and any published incident investigation.

#### **3.3 Director of EHSS**

All but the most trivial accidents, near misses and other incidents (eg floods, fire alarm activations etc) should be reported to the Director of EHSS.

The Director of EHSS will ensure that an appropriate and proportionate accident investigation is undertaken for such incident reports.

The Director of EHSS will investigate all incidents which have to be reported to an enforcement agency.

Then Director of EHSS will also investigate situations where a potentially serious incident is repeatedly occurring.

The Director of EHSS will provide the Health and Safety Assurance Group with a report on the accidents, near misses and other incidents which have occurred. This will include a brief report on any investigation undertaken.

The Director of EHSS will provide each School or Unit with an annual report of the incidents which have taken place during the year. The Director of EHSS will also ensure each School/Unit has undertaken appropriate investigations for minor incidents.

#### **3.4 Head of School / Unit**

The Head of School/Unit will ensure that all minor incidents are investigated in a proportionate manner by a nominated member of their staff (eg Safety Co-ordinator).

Where recommendations for remedial action are identified in an accident investigation by the Director of EHSS or by local staff, the Head of School/Unit will ensure these are implemented on a prioritised timescale.

#### **3.5 Staff and Students**

It is the responsibility of all staff and students to report all but the most trivial accident or near miss or a significant incident (eg flood) to their School/Unit representative and also to the Director of EHSS.

#### **3.6 Intended Audience**

This document and attached guidance is intended for all members of staff, students and members of the public who use University facilities.

#### **3.7 Where these regulations apply**

These regulations apply to all sites at the University and also to any work undertaken off the main sites of the University (eg during fieldwork)

### **4.0 Legislative and regulatory framework**

This policy and guidance document has been produced to ensure compliance with the following legislation:

- Health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations 1999
- Reporting Injuries, Diseases and Dangerous Occurrences Regulations 2013

Many other pieces of legislation have a requirement to report specific incidents for example the Genetically Modified Organisms (Contained Use) Regulations 2014 has a requirement to notify the HSE if there has been a release of genetically modified organisms. You should always be aware of the legislation which applies to your particular activity and whether there are specified incidents which require to be reported to an enforcement agency. For example such legislation is required for:

- Genetically Modified Organisms (Contained Use) Regulations 2014 (report to HSE)
- Environmental Authorisations (Scotland) Regulations 2018 (reporting incidents where there is a release of radioactivity - Report to Scottish Environment Protection Agency – SEPA)
- Specified Animal Pathogens (Scotland) Order 2009

#### ***4.1 Relationship with existing University Policy, Procedures and Regulation***

As noted throughout this Policy, compliance with the conditions set out here will on occasion also require observance of other University Policy and Regulations referred to herein.

# Guidance

## 5.0 What is an accident or incident?

There are many definitions of an incident but they are all very similar to:

**Incident:** An *unplanned, undesired* event that hinders completion of a task and may cause injury, illness, or property damage or some combination of all three in varying degrees from minor to catastrophic. Unplanned and undesired do not mean *unable to prevent*.

The Health and Safety Executive (HSE) definition of an incident is:

“any unplanned event that resulted in injury or ill health of people, or damage or loss to property, plant, materials or the environment or a loss of business opportunity”.

An accident is an incident whereby somebody has been injured to some degree

A ‘Near Miss’ is any situation where an incident may have caused injury but did not for whatever reason eg tripped on carpet edge but caused no injury

An ‘Incident’ could be any situation which which may have damaged property but without any potential for personal injury eg Flood.

## 6.0 What should be reported to the Director of EHSS

All accidents, near misses or other relevant incidents should be reported unless they are trivial incidents (eg a paper cut). The aim of such reports is to highlight a situation which can be dealt with to stop others having the same accident. The reporting of near misses also allows the University to expedite remedial actions to ensure that an accident does not occur

The following are examples of the things that should be reported:

### *Accidents*

- Fatality – Must be reported to the Director of EHSS immediately
- Serious injury – eg broken bones, severe loss of blood from a cut – Must be report to the Director of EHSS as soon as practicable
- Serious ill health due to a work activity (eg those working with a category 3 pathogen becoming ill with systems like that produced by the pathogen);
- Unconsciousness
- Receiving an electric shock
- Having a hazardous chemical spilt on the person
- Contaminated by a known human carcinogen
- Pain from a work activity (eg poor ergonomic use of Display Screen Equipment)
- Any diseases which would be due a work activity
- Any injury due to a work activity eg tripping over a paving stone

### *Near Misses*

- Any situation which could have lead a person to have an accident which should be reported to the Director of EHSS – For example tripping on a corner of carpet which could have lead to the person falling over and hurting themselves

### *Other Types of Incident which need to be notified to the Director of EHSS*

- Flood
- Fire alarm activation (False alarm or defective alarm detection equipment)
- Fire (even a small fire)

The only incidents which need not be reported to the Director of EHSS are the most trivial of incidents eg a paper cut.

If you are not sure whether you should report an incident to the Director of EHSS, you should report the incident anyway.

## 7.0 How should I report an incident (accident, near miss or other type of incident)

Where there has been a very serious accident or a fatality, the Director of EHSS should be informed immediately by telephone (01334 462751 or through the office at 01334 462750). Once the Director has been called a formal written accident report should be produced and sent to the Director of EHSS (e-mail: [dir\\_ehss@st-andrews.ac.uk](mailto:dir_ehss@st-andrews.ac.uk)).

If you are away from the University when the incident happens and still within the UK, you should always ensure that any injured person receives the appropriate medical attention first. Then if it is serious injury, you should

- If the injury is very serious or a fatality, you should phone the Director of EHSS (tel: 01334 462742 or the EHSS Office at Tel: 01334 462771).
- You should then e-mail the Director of EHSS (e-mail: [dir\\_ehss@st-andrews.ac.uk](mailto:dir_ehss@st-andrews.ac.uk)) with details of the incident and a completed accident/near miss form which can be obtained at [EHSS Accident Report Website](#) (see Appendix 1)
- or the EHSS office at e-mail: [ehss@st-andrews.ac.uk](mailto:ehss@st-andrews.ac.uk) with this information

If you are abroad or undertaking fieldwork abroad you should always ensure if the person concerned has been injured that they receive appropriate medical attention. You should then:

- e-mail the Director of EHSS (e-mail: [dir\\_ehss@st-andrews.ac.uk](mailto:dir_ehss@st-andrews.ac.uk)) with details of the incident and a completed accident/near miss form which can be obtained at [EHSS Accident Report Website](#) (see Appendix 1)
- or the EHSS office at e-mail: [ehss@st-andrews.ac.uk](mailto:ehss@st-andrews.ac.uk) with this information

Whenever there is an incident you should inform the Director of EHSS using the Accident/Near Miss Report Form (see Appendix 1)

Any fire alarm activation should also be reported to the Director of EHSS using the Form as shown in Appendix 2. This form can be downloaded from the EHSS website at [EHSS Fire Alarm Website](#)

Where there is a concern about a particular workplace health and safety issue/accident/incident and the member of staff are concerned that there is a sub-standard response by their School/Unit, staff should raise the issue in a prioritised way:

- Raise the issue with the Director of EHSS
- Raise the issue with their local Union Safety Representative
- Staff and Students may report any incident to the HSE as a personal issue as defined on the in the HSE Health and Safety Law leaflet (see <http://www.hse.gov.uk/pubns/lawleaflet.pdf>). The address of the local HSE Office in Edinburgh is:

### Edinburgh HSE Office

Belford House

59 Belford Road

Edinburgh

EH4 3UE

**Fax only:** 0131 247 2121

See URL <http://www.hse.gov.uk/contact/concerns.htm> to see the process of reporting a workplace health and safety issue.

## 8.0 Reporting Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

The RIDDOR regulations are designed to inform the Health and Safety Executive of serious incidents so that they can respond if they wish to.

The RIDDOR also provide general background statistics on accidents at work and the types of accidents which occur at work.

RIDDOR incidents are only reportable when they are due to work related activities or the state of the workplace.

The Director of EHSS will determine if any specific incident has to be reported under RIDDOR. Nobody else should report any specific incident to the HSE under RIDDOR.

The following are incidents which would have to be reported under RIDDOR are:

## ***Serious Injuries***

- Fatality due to a work related activity
- a fracture, other than to fingers, thumbs and toes;
- amputation of an arm, hand, finger, thumb, leg, foot or toe;
- permanent loss of sight or reduction of sight;
- crush injuries leading to internal organ damage;
- serious burns (covering more than 10% of the body, or damaging the eyes, respiratory system or other vital organs);
- scalplings (separation of skin from the head) which require hospital treatment;
- unconsciousness caused by head injury or asphyxia;
- any other injury arising from working in an enclosed space, which leads to hypothermia, heat-induced illness or requires resuscitation or admittance to hospital for more than 24 hours.
- An employee who is away from work for more than 7days due to an injury due to a work related activity

## ***Diseases***

- carpal tunnel syndrome;
- severe cramp of the hand or forearm;
- occupational dermatitis;
- hand-arm vibration syndrome;
- occupational asthma;
- tendonitis or tenosynovitis of the hand or forearm;
- any occupational cancer;
- any disease attributed to an occupational exposure to a biological agent.

## ***Dangerous Occurrences***

Detailed information on the types of Dangerous Occurrences which need to be reported under RIDDOR can be found at URL: <http://www.hse.gov.uk/riddor/dangerous-occurences.htm> Examples of such occurrences are:

- The collapse, overturning or failure of any load-bearing part of any lifting equipment, other than an accessory for lifting.
- Radiation generators and radiography
  - (1) The malfunction of:
    - a radiation generator or its ancillary equipment used in fixed or mobile industrial radiography, the irradiation of food or the processing of products by irradiation, which causes it to fail to de-energise at the end of the intended exposure period; or
    - equipment used in fixed or mobile industrial radiography or gamma irradiation, which causes a radioactive source to fail to return to its safe position by the normal means at the end of the intended exposure period.
- Collapse of scaffolding
- Explosion or fire - Any unintentional explosion or fire in any plant or premises which results in the stoppage of that plant, or the suspension of normal work in those premises, for more than 24 hours.
- Hazardous escapes of substances - The unintentional release or escape of any substance which could cause personal injury to any person other than through the combustion of flammable liquids or gases.

These are just a few examples of Dangerous Occurrences which need to be reported to the HSE under RIDDOR. The full list of such Dangerous Occurrences can be viewed at URL: <http://www.hse.gov.uk/riddor/dangerous-occurences.htm>

## 9.0 Accident Investigations

### 9.1 *Introduction*

The University has a duty to investigate the immediate, underlying and root causes of incidents (accidents, near misses other incidents which may have an effect on the running of the University) to determine how they happened and what can be done to prevent the accident happening again. The nature of the investigation should always be to identify the underlying causes of the incident and not to blame any specific individual.

All accident investigations should be proportionate to the scale of the incident, thus major incidents will require a significant amount of resource in the investigation while minor incidents will require much less resource.

[The Management of Health and Safety at Work Regulations 1999](#) requires that risk assessments should be reviewed if there is reason to suspect they are no longer valid. A specific incident like an accident would suggest the risk assessment is no longer valid thus there is a legal requirement to review the incident and revise the risk assessments for the work activity.

### 9.2 *Definition of an Incident*

One of the definitions of an incident is:

‘An unplanned or uncontrolled event(s) that could result in physical harm, damage or loss to people, equipment, buildings, materials or the environment’

Thus an accident is an incident which causes physical harm to an individual.

### 9.3 *Who undertakes an incident/accident/near miss investigation*

All serious accidents or near miss incidents (for example all RIDDOR Reportable incidents, serious fires etc) will be investigated by the Director of EHSS or a nominated depute from EHSS.

For minor incidents, it is expected that the Head of School / Unit is responsible for ensuring that the minor accident is investigated in a proportionate manner locally.

Training will be provided by EHSS to local staff to undertake such investigations. EHSS staff will also provide help and guidance in undertaking such investigations.

If it is unclear whether an incident is a serious or minor incident, you should contact the Director of EHSS who will determine who will carry out the investigation.

It should be noted that any accident report and then published investigation report can be viewed by the local Union Safety Representative. You may also wish to invite the relevant local Union Safety Representative to be part of the investigation team.

### 9.4 *When to investigate*

All incidents which cause harm to a person, cause significant damage (though no injury), may cause a significant injury or cause damage to the building fabric should be investigated at a proportional level. Thus minor accidents may require a limited report but more serious accidents will require more detailed reports.



The Accident Report Form in Appendix 1 does have a small section for minor remedial action for such very minor incidents.

## 10.0 *Incident Investigation Process*

Detailed guidance can be found in the HSE publication entitled '[Investigating Accidents and Incidents](#)' (HSG245). This document includes several very good examples of the accident investigation process.

When you undertake an accident investigation you should:

- Take photographs of the incident as soon as it is reported to you;
- Take statements from the individuals who were involved in the incident or were witnesses to the incident as soon as practicable after the incident
- Establish the facts (try to avoid third/fourth party beliefs on what happened);
- Use the facts to determine the causes
- Make recommendations to ensure the incident does not happen again.

It is important to keep a written record of any investigation. It is vital that the investigation report is linked to the accident report.

**9.6.1 Immediate Cause** - There are many layers to an accident investigation. The immediate cause of the accident should be determined by asking the following questions:

- **Who?** – Who was involved in the incident (this would not only include any person who was injured but also others who may have been involved in causing the accident or who had a near miss). If this was an accident, then it is vital that any injuries are clearly identified in specific detail (eg injury to the left hand – not injury to hand);
- **When** – When did the incident happen. A clear timeline for the incident is valuable to try and identify the causes of the incident
- **What?** – What happened and also what were the surrounding conditions like (eg weather, light, tripping hazards, slippery surfaces). It is vital that as much detail as possible about the incident is recorded. If possible it is vital that as many photographs of the incident are taken at the time of the incident as a clear record of the situation.
- **Where?** – Where did the incident take place. Again it is vital that as much precise detail is kept. To say the incident happened in the Bute building is not helpful to further investigations. Please state which room or outside which room the incident occurred
- **How?** - How did the incident happen and again it is important to provide specific details about what happened.
- **Why?** - Why did the incident happen.

It is vital that you keep a clear and open mind about the incident. It is very easy to dismiss an incident because there were no injuries or any injuries were very superficial. It is vital that you understand the causes.

When investigating the immediate cause it is vital to visit the scene as soon as possible after the incident has happened and record the scene as you found it. This may be a written record or it may be a photographic record or a mixture of both.

It is important at this stage to try and speak to the people involved in the incident and to any witnesses of the incident. The aim of this is to collate as much information about:

- The incident itself
- The events leading up to the incident
- The events after the incident (this can often give a picture of what exactly happened).

It is vital that you try to speak to any witnesses as soon after the event as is practicable. Witness statements are much less reliable if there is a long delay after the incident. People have a tendency to think what the cause may be and then unconsciously start telling the story to support that thought.

### 9.6.2 Underlying Causes

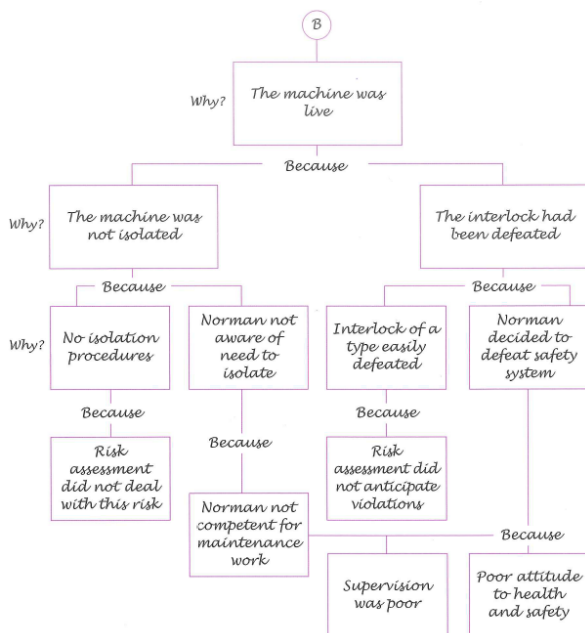
The cause of an incident is often due to multiple layers of failures within the system. These are the underlying causes. Examples of such failures are:

- Lack of a risk assessment and suitable control measures;
- Lack of a detailed and precise ‘Safe System of Work’
- Poor management of the activity;
- Poorly designed processes
- Poor maintenance
- Lack of proper training
- Lack of competence
- Poor communication between workers/Units
- Lack of suitable and sufficient personal protective equipment

The sort of questions that need to be asked when you are trying to determine the underlying causes of an incident are shown in Appendix 3.

### 9.6.3 Root Cause

It is recommended that for more serious incidents, you should attempt to ask as many 'Why Did' questions with regard to the underlying cause. This will help identify the 'Root Cause' of the incident. It is suggested that you look for at least 5 underlying root causes. Once you have a significant number of underlying causes, then you will reach the ‘Root Cause’. This will show the major failing(s) which have been the cause of the accident. For example:



In this example the ‘Root Causes’ of the incident were:

- The risk assessment did not have adequate control measures for this particular risk;
- The person was not competent to do the work activity
- Poor supervision of the worker
- Poor attitude to health and safety

## 9.7 Accident Investigation Report

A copy of the [University Accident/Incident Investigation Report Form](#) is given in Appendix 4.

The investigation report must clearly identify what happened to cause the incident and give details of the potential underlying causes. There should be a clear 'Root Cause(s)' for the incident which will highlight the failings which caused the incident concerned.

Once the investigation has identified the immediate cause and the underlying causes, it is vital that there are clear recommendations with regard to remedial action which will ensure the same incident does not happen again. The recommendations must clearly state who is responsible for implementing the remedial actions and by when. The date when the redial actions have been implemented in full should be recorded in the remedial actions table

University of St. Andrews

Report of an Accident, Dangerous Occurrence or Near Miss



Details of the Person Injured or Involved in the Accident, Dangerous Occurrence or Near Miss

Full Name of Person involved in incident, Address plus Post Code And Telephone Number

Age

Sex (M or F)

School / Unit

Occupation of Injured Person or Status if not an Employee (e.g. Resident, Visitor)

Date of Incident  Time of Incident

Nature of Injury or incident (e.g. Broken arm, bruising or fire)

Management (Please tick appropriate boxes)

No Action taken	<input type="checkbox"/>	First Aid Only	<input type="checkbox"/>	Advised to see Doctor	<input type="checkbox"/>
Ambulance Called	<input type="checkbox"/>	Casualty Taken to Hospital	<input type="checkbox"/>	Admitted to Hospital for more than 24 Hours	<input type="checkbox"/>
Other (please state actions) <input type="text"/>					

Account of Accident, Dangerous Occurrence or Near Miss  
Describe what happened, where and how. In the case of an accident, state what the injured person was doing at the time.

Witnesses (Please give names, address and occupation)

In the event of the casualty being absent from normal duties, please fill in the date of the first absence and date of return to work

Date off work  Date of Return to Work

Not yet returned from Work  Returned to work on full duties  Returned to work on modified duties (if YES, attach details on separate page)

Remedial Action Taken (to be completed by the School / Unit)  
(Note: All incidents, other than minor incidents, will require a full accident investigation form to be completed),

Name of person making report ..... Signature ..... Date .....

Name of Safety Co-ordinator (or Depute) ..... Signature ..... Date .....

**Name of Safety Co-ordinator (or Depute) for at workplace if different from above**

Name of Safety Co-ordinator ..... Signature ..... Date .....

To Be Completed by EHSS

Accident Investigation required YES  NO  Date Action Completed



# University of St. Andrews

## Environmental, Health and Safety Services

Bute Building, St Andrews, Fife KY16 9TS

Tel: (01334)462750 Fax: (01334) 462747

### FIRE INCIDENT REPORT FORM

**From:** [redacted]

**Date:** [redacted]

**To:** Angus Clark, Director, Environmental, Health and Safety Services

Fife Fire and Rescue Service were called out on [redacted] at [redacted]

when a [redacted]

was activated in [redacted]

at [redacted]

The cause of the activation was deemed to be:

Fire  Faulty Detector  False Alarm  Malicious Alarm Activation

Other  (Give details) [redacted]

If actual fire, give account of incident [redacted]

Any other comments [redacted]

Signed: [redacted]

#### **FOLLOW-UP ACTION (to be completed by the Director, Environmental, Health & Safety Services)**

.....  
.....  
.....  
.....

Director Mr Angus J Clark Tel: (01334) 462751 E-mail: <a href="mailto:ajc@st-andrews.ac.uk">ajc@st-andrews.ac.uk</a>	Deputy Director Dr Paul W S Szawlowski Tel: (01334) 462753 E-mail: <a href="mailto:pwss@st-andrews.ac.uk">pwss@st-andrews.ac.uk</a>	Fire Safety Adviser Mr Steven McKenzie Tel: (01334) 462749 E-mail: <a href="mailto:sm341@st-andrews.ac.uk">sm341@st-andrews.ac.uk</a>	Fire and Training Adviser Dr Christine H M Linton Tel: (01334) 462789 E-mail: <a href="mailto:chlml@st-andrews.ac.uk">chlml@st-andrews.ac.uk</a>
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# Appendix 3

## Underlying and Root Causes of Incidents

### Underlying and Root Causes

If your answers to the Place, Plant, Procedures and People sections identified any immediate cause, consider the relevant 'Underlying and Root Causes' section.

**ORGANISATION – how we do things and how we make sure they are done correctly**

#### Control

- 1 Were the workplace and work activities adequately supervised and monitored in order to ensure that risk control measures were effective and implemented as intended?
- 2 Did the supervisors have adequate resources to carry out their duties?
- 3 Were people held accountable for their performance in carrying out their duties with regard to Health and Safety?
- 4 Were there adequate arrangements for overseeing and controlling contractors?

#### Co-operation

- 1 Were trade unions, employees and their representatives involved in determining workplace arrangements, preparing risk assessments and safe working procedures?
- 2 Did the individuals involved in the incident share information?
- 3 Were there arrangements for cooperation with, and co-ordination of, contractors?

#### Communication

- 1 Were responsibilities and duties clearly set out?
- 2 Were they clearly understood by those involved?
- 3 Did everyone involved know who they report to and who reports to them?
- 4 Was there sufficient, up-to-date information to enable good decisions to be made?
- 5 Were there adequate arrangements for passing on information at shift changes?
- 6 Were written instructions, safe working procedures and product information sheets practical and clear?
- 7 Were the instructions and procedures available to all who needed them?
- 8 Was communication between workers and supervisors effective?
- 9 Was the communication between different departments effective?
- 10 Were there effective communications with contractors?

#### Competence: Training and suitability

- 1 Were the people involved assessed as suitable for the work in terms of health and physical ability?
- 2 Were the health and safety training needs of people identified?
  - on recruitment;
  - on changing jobs;
  - when changes in the work are proposed;
  - periodically as part of refresher training?
- 3 Were the training requirements for particular jobs identified?
- 4 Was the training effectively delivered?
  - with adequate resources?
  - effectively?
  - and assessed?
  - were training records kept?
- 5 Was the competence of contractors, employees and agency workers checked?

#### Planning and Implementation: How we prepare to do things effectively and efficiently

##### Design

- 1 Were the workplace and equipment layouts designed considering health and safety?
- 2 Were the controls, displays etc of plant and equipment designed to reduce the risk of, or prevent, human error? For example mis-reading dials or operating the wrong switch

##### Implementation

- 1 Were there arrangements for ensuring that sufficient, and suitable, plant, equipment and materials were available?
- 2 Were there arrangements for ensuring that sufficient and suitable labour was available?
- 3 Was there adequate cover for leave or sickness absence?
- 4 Were suitable contractors appointed?
- 5 Were there adequate arrangements for cleaning?
- 6 Were there adequate arrangements for reporting defects in plant and equipment?
- 7 Were there adequate arrangements for carrying out maintenance work?
- 8 Were there adequate arrangements for reporting health and safety concerns?
- 9 Were there adequate arrangements for reporting near-misses and undesired circumstances?
- 10 Were there adequate arrangements for carrying out health surveillance?
- 11 Were there adequate arrangements for carrying out air monitoring/sampling? (If required)
- 12 Did production targets take account of health and safety?
- 13 Were there adequate arrangements for appointing and controlling contractors?

## Risk assessment

Risk assessments involve identifying the hazards, identifying who may be affected and putting in place suitable arrangements to eliminate or reduce the risks to an acceptable level.

- 1 Were there risk assessments for the work in question?
- 2 Were they adequate?
  - did they correctly identify the risks?
  - were they up-to-date and reviewed as necessary?
  - were correct technical standards used?
  - were adequate risk control measures identified?
  - were safe working procedures developed?
  - were there clear conclusions and recommendations?
  - were employees involved in preparing them?
- 3 Did the risk assessments result in a risk control action plan with SMART (Specific, Measurable, Agreed, Realistic and Timescaled) objectives?
- 4 Were responsibilities for implementing the risk control action plan set out?
- 5 Had the risk control action plan been implemented?
- 6 If there had been similar adverse events in the past, had they been investigated?
- 7 Were adverse events recorded, investigated and the findings fed back into the risk assessments?
- 8 Did the risk assessments include the risks from work carried out by contractors?

A 'no' answer to any of the questions in the underlying or root cause section identifies an underlying or root cause.

These underlying or root causes in turn point to failings in the health and safety management system. Senior management should consider all the questions in the following 'Management' section to identify weaknesses in the overall risk control management of the organisation.

## Management: How we create the environment and set the standards under which all other health and safety activities take place

- Was there a written health and safety policy statement?
- Did all employees know and understand the health and safety policy statement?
- Were named partners, directors and senior managers made responsible for health and safety arrangements?
- Was there an adequate commitment to health and safety at a senior level?
- Was this commitment reflected in the actions of directors, partners and managers?
- Were sufficient people appointed to assist with health and safety measures?
- Were the people appointed to assist with health and safety measures adequately trained and competent?
- Did the health and safety assistants have sufficient authority to carry out their duties?
- Were the tasks of carrying out risk assessments and preparing safe working practices given to competent persons?
- Was the carrying out of risk assessments a high priority?
- Were adequate resources allocated to health and safety?
- Was it your policy to learn from adverse event investigations and improve your health and safety performance?
- Were the recommendations and findings of the health and safety team acted on?
- Was the work of the health and safety team (including managers, safety officers, safety assistants, supervisors and safety representatives) monitored?
- Were the health and safety team held to account for their performance?
- Were there clear and integrated lines of communication and control?
- Was there a conflict between production and health and safety?
- Was health and safety performance measured and monitored?
- Did you seek to improve your health and safety performance as a result of your dealings with the regulatory authorities and other health and safety professionals?

(From the HSE Guidance Document 'Investigating Accidents and Incidents' (HSG245) – see URL: [www.hse.gov.uk/pubns/hsg245.pdf](http://www.hse.gov.uk/pubns/hsg245.pdf))



## Appendix 4

# Incident Investigation Report Form

University of St. Andrews

## Accident/Incident Investigation Report

### 1. Details of the Accident/Incident

School/Unit/Residence .....

Date/Time of Accident ..... 20 ..... am/pm .....

Name of Person(s) Involved .....

Place of Accident/Incident .....

Name of Investigator .....

Date of Investigation .....

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### 2. DETAILS OF WHAT HAPPENED

a. **Historical Evidence** (Timing and sequence of events)

b. **Describe the process being undertaken when the incident happened**

c. **Provide copies of the risk assessment for the work activity and the relevant control measures which should have been in place and also any Safe Systems of Work which should have been followed.**  
**Was the risk assessment/Safe System of Work adequate and if not, why not**

**d. Possible causes of the incident**

CAUSITIVE AGENT (Tick more than one option if applicable)					
Live Animal		Falls from height		Hot/cold contact	Violence/Assault
Electricity		Struck or trapped by object		Defective premises	Defective equipment
Explosion		Striking against fixed or stationary object		Exposure to toxic substances or pathogenic material	Work-related vehicle/traffic accidents
Fire					
Falls on level		Sharps (incl. Glass & needles)		Unintentional spillages/releases of harmful substances	Occupational Illness
Falls on stairs		Handling/Lifting			Other

These are just examples of possible causative agents. If the incident did not involve any of these, please add the risk to the table.

- e. Geographical Evidence** (Take measurements of relevant items, objects and equipment involved. If deemed useful, take photographs and make scale drawings).

- f. Other underlying causes which may have been a factor in the incident** (for example; poor management/supervision, poorly designed process, poor maintenance, lack of proper training., poor communication, lack of suitable and sufficient personal protective equipment)

- d. Circumstantial Evidence.** (Where there is no witness to establish a conclusion).

- 3. Conclusion** (From the evidence give reasons for accident/incident and also the underlying causes and 'Root Causes' of the incident e.g. failure of plant or equipment, human error, inadequate training, lack of supervision, lack of a safe system of work etc).



4. **Recommendations** (Measures to prevent recurrence of accident/incident. Counselling - Victim/Witness)

Recommendation number	Underlying causes of the incident	Recommendations for remedial action	Person responsible for implementing remedial actions	Proposed date remedial actions to be completed by	When remedial actions completed

**Send Report to Head for attention/action**

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**Head of School/Unit/Residence - Remarks**

<b>Version number</b>	<b>Purpose / changes</b>	<b>Document status</b>	<b>Author of changes, role and school / unit</b>	<b>Date</b>
v1.0	New Document	Approved	Dr Paul Szawlowski	12/07/2021