**Accident Investigation Form**

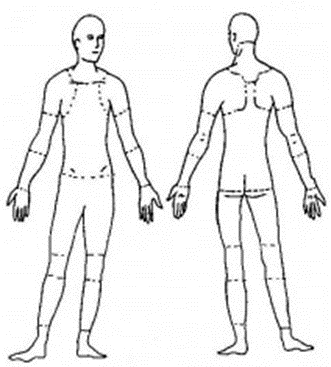
|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of organisation | |  | | Department | |  | |
| **PARTICULARS OF THE ACCIDENT** | | | | | | | |
| Date: |  | Time: |  | Location: |  | Date reported: |  |
| **DETAILS OF INJURED PERSON:** | | | | | | | |
| Name: |  | Age: |  | Accident date: |  | Contact number: |  |
| Job Title: |  | Address: | |  | | Length of employment: |  |
| Type of injury | |  | | | | | |
| Part of body injured  (Please indicate which part of the body has been injured on the diagram below) | |  | | | | | |

|  |  |
| --- | --- |
| **DAMAGED PROPERTY** | |
| Property damaged |  |
| Nature of damage |  |

|  |
| --- |
| **THE ACCIDENT** |
| Describe what happened |
|  |
|  |
|  |
|  |

**PART OF BODY EFFECTED**

**(Please shade all areas that apply)**

**NATURE OF INJURY** **(Please tick all that apply)**

|  |  |
| --- | --- |
| **Abrasions/Scrapes** |  |
| **Amputation** |  |
| **Broken bone** |  |
| **Bruise** |  |
| **Burn (Heat)** |  |
| **Burn (Chemical)** |  |
| **Concussion to the head** |  |
| **Crushing injury** |  |
| **Cut** |  |
| **Laceration** |  |
| **Puncture wound** |  |
| **Hernia** |  |
| **Illness** |  |
| **Sprain/strain** |  |
| **Damage to a body system** |  |
| **Eye injury** |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TREATMENT** | | | | | | | | |
| Type of treatment given: |  | | | | Name of first aider: |  | Doctor/Hospital Seen:  **(Please detail name of doctor or hospital)** |  |
| RIDDOR Reportable? | Yes |  | No |  | Date reported: |  | Reported by: |  |
| Accident investigated by: |  | | | | | Date: |  | |
| Signed: |  | | | | | Department:  **(Please state which department you work in)** |  | |

**PLEASE ANSWER THE FOLLOWING QUESTIONS AS FULLY AS POSSIBLE**

|  |  |
| --- | --- |
| **1.** | Explain in detail, how the adverse event happened? (Please note any equipment involved) |
|  | |
| **2.** | What activities, was the employee completing at the time? |
|  | |
| **3.** | Was there anything unusual, or different about the working conditions? |
|  | |
| **4.** | Were adequate and safe working procedures in place at the time and were they being followed? |
|  | |
| **5.** | Was the risk known?  If so, why wasn’t it controlled? If not, why not? |
|  | |
| **6.** | Did the organisation and/or the arrangement of the work influence the adverse event? |
|  | |
| **7.** | Was maintenance and cleaning sufficient? If not, explain why not. |
|  | |
| **8.** | Were the people involved competent and suitable? |
|  | |
| **9.** | Did the workplace layout influence the adverse event? |
|  | |
| **10.** | Did the nature or shape of the materials influence the adverse event? |
|  | |
| **11.** | Did difficulties using the plant and equipment influence the adverse event? |
|  | |
| **12.** | Was the safety equipment sufficient? |
|  | |

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| **HOW BAD COULD IT HAVE BEEN?** | | | | | |
| Very serious |  | Serious |  | Minor |  |
| **WHAT IS THE CHANCE OF IT HAPPENING AGAIN?** | | | | | |
| Frequent |  | Occasional |  | Rare |  |

|  |
| --- |
| Record here, what has been done to prevent it happening again in the future? |
|  |

|  |  |
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| **WHAT WERE THE**  **IMMEDIATE,**  **UNDERLYING AND ROOT CAUSES?** | |
| **Immediate Cause**  These are aspects of the incident/accident that directly influenced the outcome (damage or injury) and are often referred to as “direct causes”. They are the features of an incident/accident which immediately contributed to harm or damage being caused.  **Example -** if an employee is injured by items falling off shelving, the items falling and striking the employee is an immediate cause. |  |
| **Underlying Causes**  These aspects of the incident/accident are effectively contributory breaches which in themselves did not cause harm but made a significant contribution to the incident/accident. They are often referred to as “in-direct causes”  **Example** - poor maintenance of the shelving could be an underlying cause.  you may discover more than one reason why a problem exists. In the example above, this could be a faulty shelf or incorrect stacking of materials. This means you now have 2 lines of enquiry or another branch to your “Event” or “Fault” tree. |  |
| **Root Causes**  Generally, these are aspects of our safety management performance, which have, in some way failed.  **Example –** the failure to supervise the shelving/racking maintenance programme is a root cause  By addressing root cause, you effectively remove the key reason why the events were allowed to develop for the incident/accident to occur. By only addressing Immediate and Underlying causes, you allow the fundamental management deficiencies to remain and therefore make recurrence more likely. |  |

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| **INVESTIGATION OF ACCIDENT** | | | | | | |
| **Accident investigated by:** |  | | | | **Date:** |  |
| **Signed** |  | | | | **Department**  **(please state which department you work in)** |  |
| **Director informed** | **Yes** |  | **No** |  | **Directors Name**  **(Please print)** |  |