Use the following checklist to structure investigations and written reports. It is intended as a guide. It is not comprehensive and it will not always be necessary to consider all the points in the checklist.

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

1 **OBTAIN BASIC FACTS**

   - Names of injured/ill employees/witnesses/people early on the scene
   - Condition of any equipment
   - Any chemicals / substances in use or present
   - Layout of area
   - Place, time, conditions
   - Extent of any injury / ill health / damage / disruption
   - Make use of camera, sketches, measurement to record the undisturbed scene
   - Take statements from those who were witnesses – statements should be signed by witnesses below the declaration “I believe that the facts stated in this witness statement are true”
   - It is good practice also to take signed statements from those who were present in the area at the time but who did not see anything of note.

2 **ESTABLISH CIRCUMSTANCES**

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

3 HOW SHOULD THE ACTIVITY HAVE BEEN CARRIED OUT; HOW WAS IT ACTUALLY CARRIED OUT?
• How should the job have been done?
• How was it actually done?
• Review any risk assessments and procedures for the activity.
• What precautions should have been in force? What training should those carrying out the activity have received?
• What precautions were actually taken? Compare them with those which should have been taken. What training was actually given? Compare it with training which should have been given.

4 ESTABLISH WHETHER THE INITIAL RESPONSE TO THE ACCIDENT WAS ADEQUATE
• Was prompt and appropriate action taken (such as making safe and dealing with any continuing risks, electrical isolation, suitable fire fighting, effective first-aid response and correct spillage procedures)?

5 IDENTIFY THE UNDERLYING CAUSES
These might include:
• Management or supervision failure
• Lack of competence
• Inadequate training
• Shortcomings in original design of equipment of facilities
• Absence of a system for maintenance

6 DETERMINE ACTIONS NEEDED TO PREVENT A RECURRENCE
In deciding on the right course of action, think whether the outcome could have been more serious and what prevented this from happening.

Reappraise the precautions derived from the risk assessment - do they satisfy the intentions of the School/Support Service’s health and safety policy and do they meet the recommendations of any authoritative guidance?

If the intended precautions appear adequate but they were not fully implemented, why was this? What needs to be done to ensure necessary precautions are taken in the future? Actions to prevent a recurrence might include:
• improve physical safeguards
• introduce better test and maintenance arrangements
• improve work methods
• provide and use personal protective equipment
• make changes to supervision and training arrangements
• review similar dangers elsewhere in the School/Support Service
• review procedures involving outside contractors
• improve inspection systems