

Adverse event report and investigation form

Part 1 Overview

Ref no

The purpose of this form is to record all adverse events. The term **accident** is used where injury or ill health occurs. The term **incident** includes **near-misses** and **undesired circumstances**, where there is the potential for injury. Part 1 should be filled out immediately by the manager or supervisor for the work activity involved. Part 2 should be completed by the person responsible for health and safety. Part 3 should be completed, where appropriate, by the investigation team. Part 4 should be completed by the investigating team, together with managers who have the authority to take decisions. When completing Parts 2, 3 and 4 refer to the guidance under 'A step by step guide to health and safety investigations'.

Part 1 Overview

Reported by: R Osmund			Date/time of adverse event 23.06.03 10.00am	
Incident	Ill health	Minor injury	Serious injury X	Major injury
Brief details (What, where, when, who and emergency measures taken) Norman Brown was trying to fix a problem on the edge gluer when the machine operated. Norman cut his right hand quite badly. He was given first aid and taken to hospital. The fuses have been taken out of the edge gluer and a sign hung on it.				

Forwarded to: Richard Wills	Date 23.06.03 Time 11.00am
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Part 2 Initial assessment (to be carried out by the person responsible for health and safety)

Type of event

Accident	X
Ill health	
Near-miss	
Undesired circumstance	

Actual/potential for harm

Fatal or major	
Serious	X
Minor	
Damage only	

RIDDOR reportable?	Y/N Y	Date/time reported 15.03.03
Entry in accident book	Y/N Y	Date entered/reference 15.03.03 123/03

Investigation level

High level		Low level	
Medium level	X	Basic	

Initial assessment carried out by: Richard Wills	Date 23.06.03
Further investigation required? Yes	Priority Immediate
For investigation by: Peter Peterson (fitter), John Evans (foreman) and Richard Wills	

Part 3 Investigation information gathering

1 Where and when did the adverse event happen?

Woodmachine shop
Monday 23rd July 2003 at 11.00 am

2 Who was injured/suffered ill health or was otherwise involved with the adverse event?

Norman Brown – Injured person woodmachinist
No witnesses

3 How did the adverse event 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 put his pencil into the interlock switch, so he could operate the machine with the guard open, so he could see what was wrong. The cross cut saw operated and cut Norman's hand.
Wilmatron 440 edge gluing machine series No 1234/23 1998.
Sharpcut 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 skirtings.

5 Was there anything unusual or different about the working conditions?

Yes. This machine normally is used with mdf skirtings, not aluminium.

6 Were there adequate safe working procedures and were they followed?

No. Machines should be isolated before carrying out repairs.

Part 3 Investigation information gathering

7 What injuries or ill health effects, if any, were caused?

Severe laceration to the top of the right hand at the knuckles resulting in severing of tendons.

8 If there was an injury, how did it occur and what caused it?

The rotating blade of the cross cut saw.

9 Was the risk known? If so, why wasn't it controlled? If not, why not?

Yes, but Norman thought he would be OK having a look inside the guard.

10 Did the organisation and arrangement of the work influence the adverse event?

No, but Norman had been having trouble with the machine all morning. After the coffee break, he decided to get it fixed.

11 Was maintenance and cleaning sufficient? If not, explain why not.

Yes

Part 3 Investigation information gathering

12 Were the people involved competent and suitable?

Norman was a qualified wood machinist with 9 years' experience. He had worked on the edge gluing machine for 3 years.

13 Did the workplace layout influence the adverse event?

Yes – access to the edger is difficult. Access to the viewing window in the guard is difficult.

14 Did the nature or shape of the materials influence the adverse event?

Yes – the machine was being used with aluminium rather than the normal mdf skirtings.

15 Did difficulties using the plant and equipment influence the adverse event?

Yes, in that the edge gluer was malfunctioning.

16 Was the safety equipment sufficient?

No – the interlock switch was of a type easily defeated.

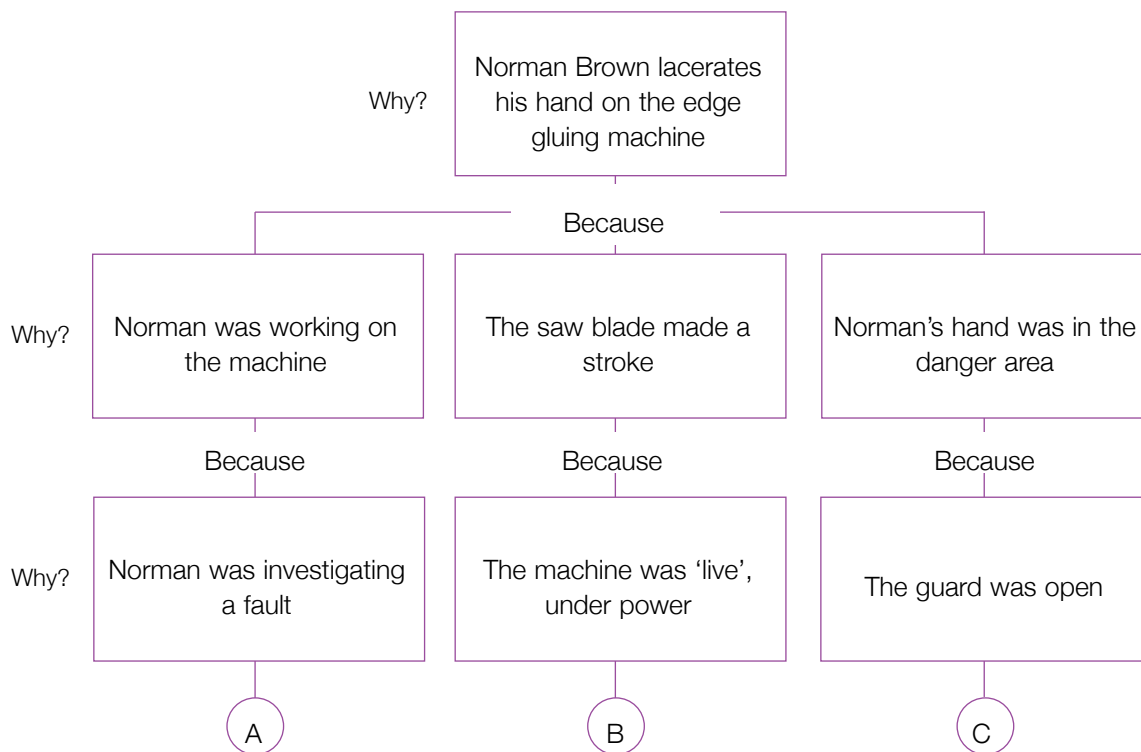
17 Did other conditions influence the adverse event?

No

Analysis and further action

18 What were the immediate, underlying and root causes?

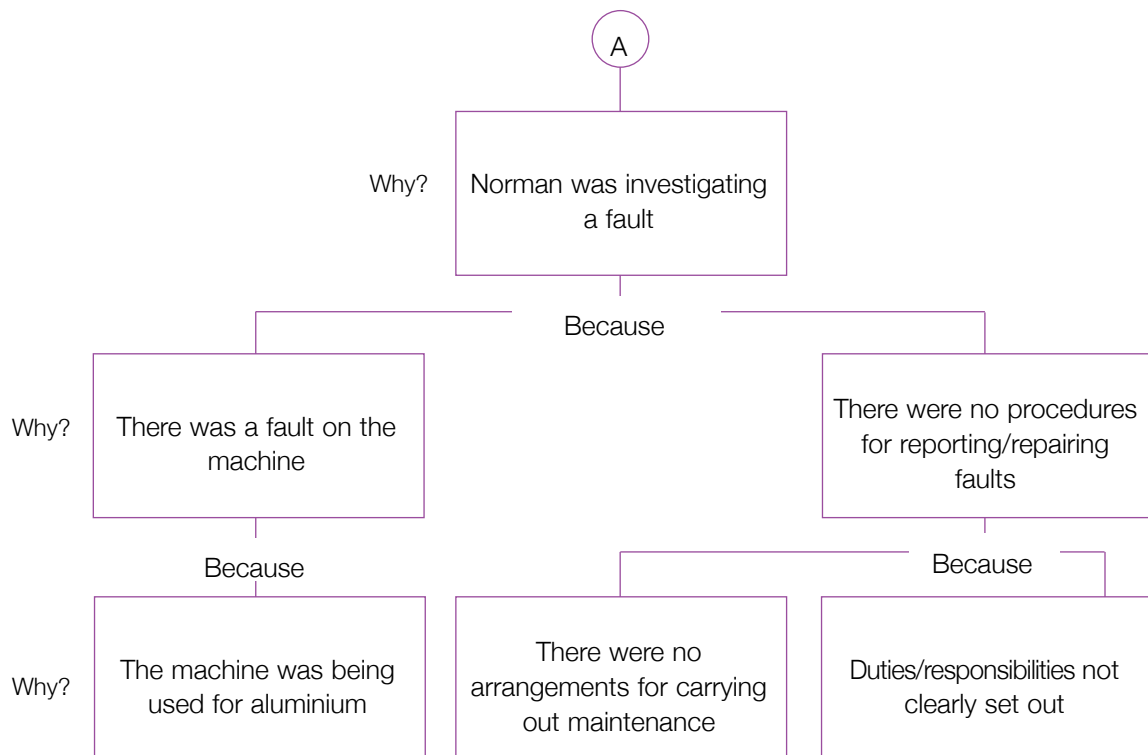
Analysis (see 'Analysis' under 'Step two')



Analysis and further action

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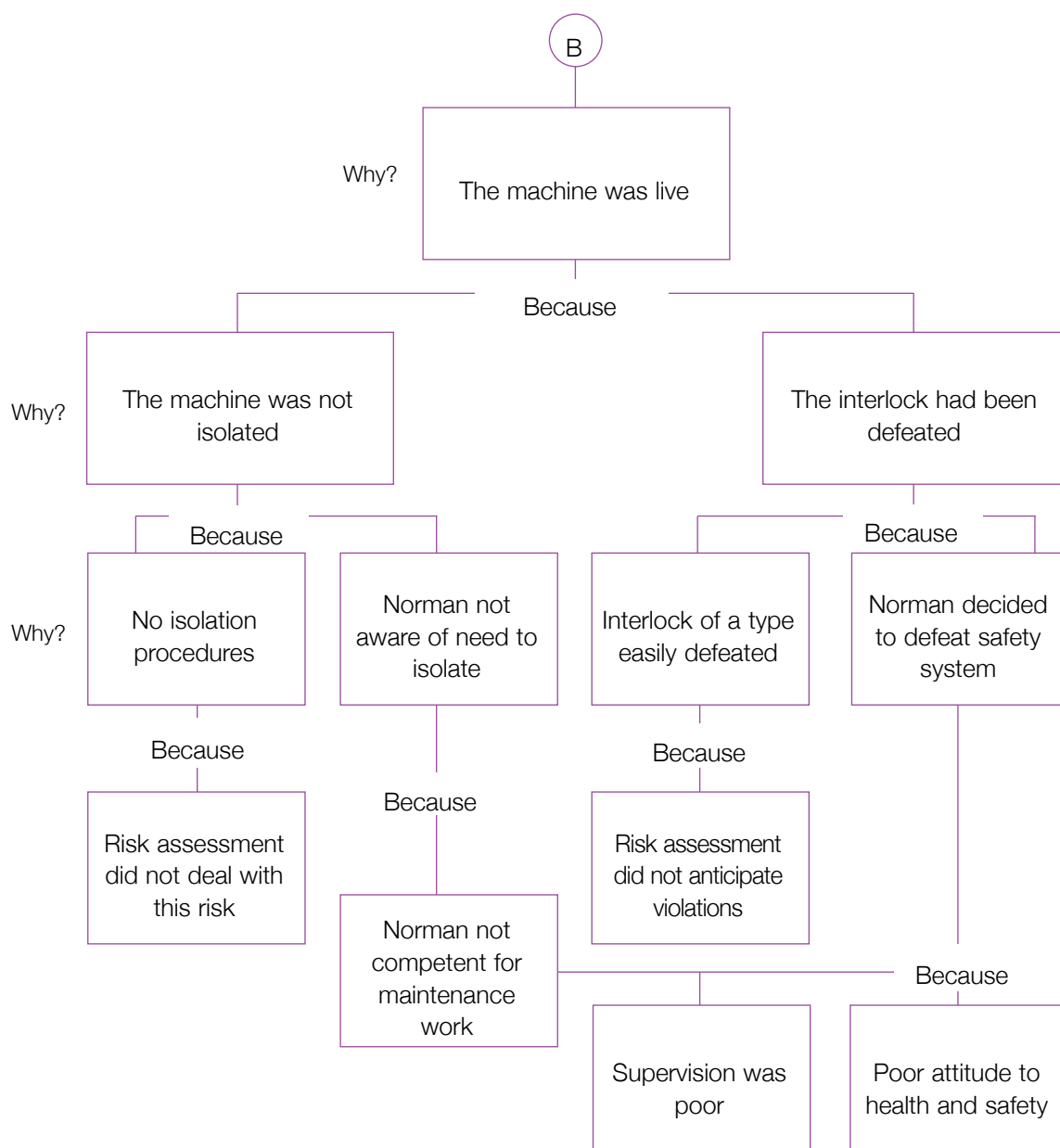
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Analysis and further action

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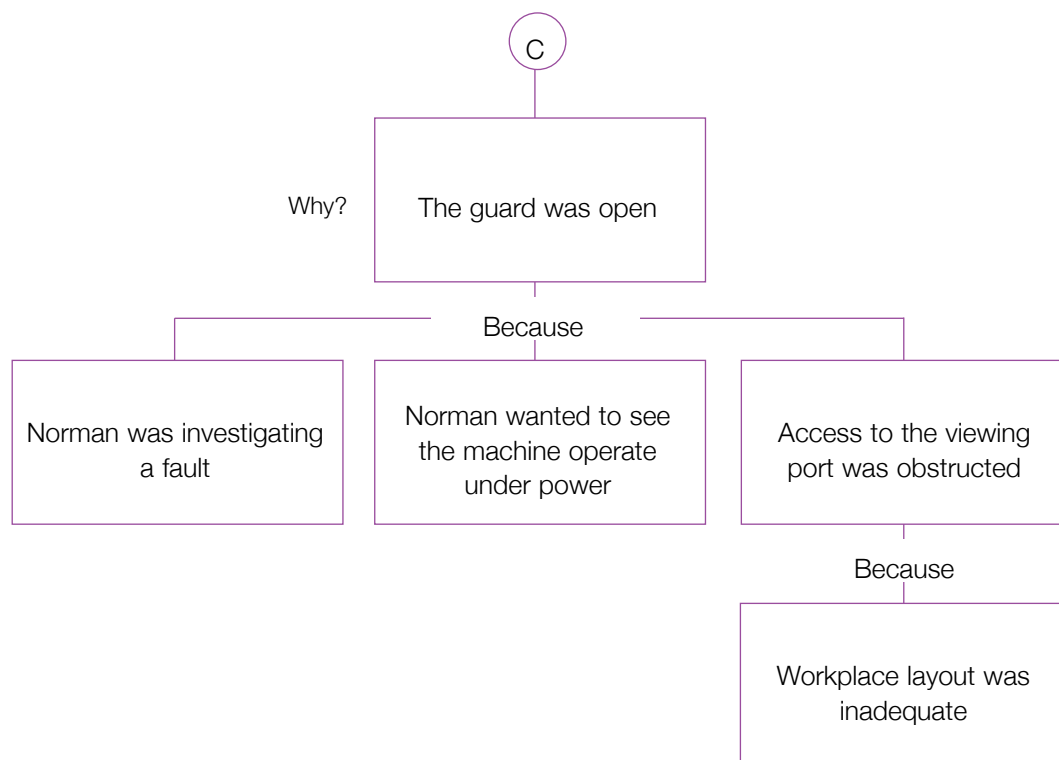
Analysis (see 'Analysis' under 'Step two')



Analysis and further action

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Analysis and further action

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Analysis (see 'Analysis' under 'Step two')

How/Why

- 1 Edge gluer was used for aluminium without adjusting to suit
- 2 The saw blade was tearing the end of the sections
- 3 The operator decided to investigate the cause
- 4 The operator decides that to find the cause he has to run the machine
- 5 The operator is unable to see through the viewing port
- 6 The operator opens the guards and defeats the interlock
- 7 The machine makes a cutting stroke
- 8 The operator's hand is cut by the saw blade

Immediate causes

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

Underlying causes

- 6 Poor workplace layout
- 7 No risk assessments for use/maintenance of machine
- 8 Risk assessments didn't address use of other materials
- 9 Risk assessments didn't address violations
- 10 SWPs were not prepared following risk assessments
- 11 Operators not trained on machine maintenance and safety devices
- 12 Level of supervision not adequate – should have detected violations
- 13 All staff to be reminded of their duties and essential health and safety measures

Root causes

Management commitment to H&S not communicated to employees
Health and safety assistants not fully competent and resourced
Unclear lines of communication and responsibilities

Part 3 Investigation information gathering

19 What risk control measures are needed/recommended?

- 1 Replace interlock switch with tongue type switch
- 2 Rearrange machine to allow access to window
- 3 Procedures for isolation of machine
- 4 Procedures for reporting/repairing defects
- 5 Clear allocation of duties
- 6 Review risk assessment

20 Do similar risks exist elsewhere? If so, what and where?

Yes – there are similar interlock switches on the multi-headed moulder/planer

21 Have similar adverse events happened before? Give details.

No

Part 4 The risk control action plan

22 Which risk control measures should be implemented in the long and short term?

Control measure	Completion Date	Person responsible
1 Replace interlocks	Before use	Peter (fitter)
2 Rearrange workshop	Before use	John (foreman) Richard (H&S)
3 Prepare SWPs for isolation and reporting and repair/maintenance	1.12.03	John (foreman) Richard (H&S)
4 Assess competence and training needs & deliver training	1.12.03 1.3.04	John (foreman) Richard (H&S)
5 Prepare/review risk assessments	1.03.03	Richard (H&S)

23 Which risk assessments and safe working procedures need to be reviewed and updated?

Name of risk assessment safe working procedure	Completion Date	Person responsible
1 Risk Assess. For workplace	1st week in July	Richard (H&S)
2 Risk Assess. For machinery	1st week in July	Richard (H&S)
3		
4		

Part 4 The risk control action plan

24 Have the details of the adverse event and the investigation findings been recorded and analysed? Are there any trends or common causes which suggest the need for further investigation? What did the adverse event cost?

Details have been recorded – no trends or common causes – need to check quality of risk assessments.

Estimated cost of accident £3,700

25 Signed on behalf of the investigation team

Name

Signature

26 Members of the investigation team

Name	Position
Richard Wills	H&S Officer
John Evans	Foreman
Peter Peterson	Fitter

Part 4 The risk control action plan

27 The findings of this investigation need to be communicated to the following managers, union and employee safety representatives

Person	Signature	Date
A. Director		
W.K.S Manager		
A. Rep		