

SHE Incident – Investigation Report

Remember:

- Set aside sufficient time to do an investigation properly.
- Undertake investigations promptly – ideally within a couple of days of the incident.
- Conduct discussions face to face in a neutral non-confrontational environment.
- Remember the purpose of an investigation is **to determine what happened and how we can prevent other such incidents happening again**, not to determine 'blame'.
- Conduct the investigation in an open, fair and objective manner explaining how you will use the information.

See STFC [SHE Code 5](#) for guidance and requirements on how to conduct an incident investigation.

1. Incident Date and Time:		2. Evotix Ref:	
3. Location of Incident:	Site / Building no. / Room no.		
4. Investigation Allocated to:	Name / Department / Team		

5. Initial Incident Report

Copy text from incident description on Evotix into this box

6. Gather Information (what happened)

Include relevant evidence such as photos, event timeline, witness statements, maps, SDS, certificates etc.

The investigation should as minimum address the following questions:

6.1 Was anyone injured? Choose Yes/No

Only answer the following, if you answered yes to the above;

- a) Were they seen by a first aider? Choose Yes/No
- b) Did they attend minor injuries or hospital? Choose Yes/No
- c) Did the person take any time off work due to the injury? Choose Yes/No
If yes, please specify the amount of lost time.

6.2 Did anyone witness the incident? Choose Yes/No

If yes, please list names of witnesses here

6.3 Were any tools, materials/substances or equipment involved? Choose Yes/No

If yes, please include relevant information for example name, make, model, PPE worn at the time, condition, maintenance history, inspection records

- a) Did the nature or shape of the materials influence the adverse event? Choose Yes/No
- b) Did difficulties using the plant and equipment influence the adverse event? Choose Yes/No
- c) Was the safety equipment sufficient? Choose Yes/No

Please include any additional comments such as was it working as intended, checked by the user, within statutory inspection or calibration period

6.4 Were the people involved competent and capable? Choose Yes/No

Please include any additional comments such as years of experience, relevant training, behaviour. Were they capable to perform the task safely, stressed, overloaded/underloaded and competent to deal with the circumstances?

6.5 Were there documented safe working procedures and were they followed? Choose Yes/No

Please include any additional comments such as were instructions clearly understood? Any deviation? Was a permit to work required and in place?

6.6 Had the task /activity / location been risk assessed prior to the incident? Choose Yes/No

- a) Was the risk known? Choose Yes/No
If so, why wasn't it controlled? If not, why not?
- b) Has the risk assessment been reviewed following this incident? Choose Yes/No

6.7 Was there anything unusual or different about the working environment? Choose Yes/No

- a) Did the workplace layout influence the event? Choose Yes/No

Please include any additional comments to the above if relevant such as weather, noise, lighting, time of day, ergonomics, housekeeping, cleaning

6.8 Did the planning and arrangement of the work influence the incident? Choose Yes/No

Please include any additional comments to the above if relevant such as gaps in the communication/planning/supervision/support/monitoring/time/pressure

6.9 Did any other conditions influence the adverse event? Choose Yes/No

Please include any additional comments such as was it a complex or difficult task? Routine or non-routine task? Distractions e.g. more than one task carried out? Peer pressure? Safety culture issues?

7. Causes & measures to prevent recurrence

Based on the Information above, list the causes that lead to the incident. For each cause, list one or more actions that will prevent recurrence. Consider completing a 'Why-Why' diagram to identify immediate, underlying and root causes. An example is provided in [Appendix 4 of SC05](#).

The immediate cause is the direct reason the incident occurred, usually an unsafe act or condition.

Underlying causes are contributing factors that allowed the immediate cause to happen such as a system weakness or organisational gap e.g. lack of a risk assessment or not completing a pre-use check. Root cause is an initiating event or failing from which all other causes or failings spring and generally management, planning or organisational failings.

Outstanding actions will be setup on Evotix by a SHE Advisor unless they have already been completed.

Make sure an action is SMART. It should be specific, has a realistic deadline, been communicated to and agreed with the action owner. The action owner must have sufficient resources, knowledge and support. SHE Group will communicate actions where they apply to individuals in other departments.

Cause	Action Description	Action Owner	Due by
List each circumstance (think of the immediate / underlying / root causes) that contributed to the incident. one per row. Add as many rows as needed.			

8. Does this incident have any wider learning?

Consider if similar risks could exist elsewhere or if a code update would be beneficial. Highlight any good practices that could be shared more widely.

9. Any suggested change to the incident severity?

Complete this field if the incident severity requires review and should be upgraded or downgraded from the initial rating. The original severity rating can be found on the incident record in Evotix Assure or within the incident notification email. Any proposed change should be justified with reference to the severity categorisation definitions provided in [Appendix 1 of the SC05](#).

10. Report Completed by:

Name:	Name / Job Title	Date:	Click to enter a date.
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Send a copy of the completed report and any attachments such as a 'Why-Why' diagram to the SHE Advisor assigned to the incident within two weeks. If you are not sure who this is you can email it to your local SHE Team ([RAL](#); [DL](#))