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### Quality, Health, Safety, Environmental & Energy Manual:

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#### Document No: SM-11 Accident/Incident Reporting & Investigation

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The investigation and analysis of work-related accidents and incidents forms an essential part of managing health and safety. This procedure is to outline how Toyota Material Handling UK Ltd. (TMHUK) report, record and investigate accidents, incidents, diseases and dangerous occurrences arising out of or in connection with the Company's undertaking.

Investigations will help to:

- identify why existing control measures failed and what improvements or additional measures are needed
- plan to prevent the incident from happening again
- point to areas where risk assessments need reviewing
- improve risk control in the future

An investigation is not an end in itself, but the first step in preventing future adverse events, that includes:

- **accident:** an event that results in injury, ill health and damage to product or property
- **incident:**
  - **near miss:** an event not causing harm, but has the potential to cause injury or ill health (in this guidance, the term near miss will include dangerous occurrences)
  - **unsafe circumstance:** a set of conditions or circumstances that have the potential to cause injury or ill health
- **dangerous occurrence:** one of a number of specific, reportable adverse events, as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

TMHUK has a duty to record all accidents involving:

- a TMHUK team member;
- a contractor on TMHUK premises or customer premises;
- a visitor to TMHUK premises;
- any work-related incapacity resulting in absence.

**Failure to comply with this duty is a criminal offence.**

#### **TMHE Reporting of a fatality or serious injury**

TMHE have introduced an instruction of internal reporting in the case of a fatality or serious injury which will ensure that we can act immediately following any event of this kind, supporting our team members and their family and also ensuring that we can prevent re-occurrence.

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## Quality, Health, Safety, Environmental & Energy Manual:

### Document No: SM-11      Accident/Incident Reporting & Investigation

---

This also applies to our contractors when on our site, and also our team members when working from home. Further instructions detailed on page 5.

Please note this process is in addition to TMHUK current process detailed below.

#### **TMHUK Reporting of accidents/incidents**

- 1.0 Anyone involved in an accident/incident must report this as soon as practically possible, ideally within 2 hours of the event. If injuries have been sustained and the injured party is unable to make the report, they must get someone else to report on their behalf if reasonably practical to do so.
- 1.1 Mobile Team members and contractors injured or involved in an accident/incident on customer's premises should report such events to the Site Operator's management, as well as reporting to TMHUK in accordance with the below.
- 1.2 The reporting person is to call the Business Centre Administration Team on 0370 850 1402. Outside of normal business hours these calls will be handled by our 'out of hours' service provider.
- 1.3 Upon receipt of the notification from the reporting person the Business Centre Administrator will record as much detail as possible on the intranet-based accident/incident reporting program. This will initialise a full investigation.
- 1.4 The intranet-based accident/incident reporting program constitutes as the company accident book to enable TMHUK to comply with legal requirements under social security and health and safety legislation.
- 1.5 In addition, certain accidents and dangerous occurrences (see below) must be reported to the relevant enforcing authority under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Failure to comply with these requirements is a criminal offence.
- 1.6 **Accidents on Customers sites, involving any equipment maintained by TMHUK, resulting in injury to Customers personnel or damage to their property, must NOT be entered into our "Company" accident books. For accidents of this nature, see "Customer Accidents" SM-13.**

#### **Investigation**

- 2.0 For an investigation to be worthwhile, it is essential that the management and the workforce are fully involved. Therefore, the intranet-based accident/incident reporting program consists of a minimum of 6 sections as below:
  - Initial Information – Initial Contact. To be completed by Business Centre Administration
  - Accident/Incident Detail – to be completed by Team leader
  - Accident/Incident Investigation – to be completed by Departmental Leader
  - Manager Sign off – Departmental Leader, Functional Leader
    - additional sign of required for after sales team - Service Operations Manager
  - QHSE Sign off - QHSE Team Member

- Director Sign off - Director

- 2.1 Adverse events have many causes. What may appear to be bad luck (being in the wrong place at the wrong time) can, on analysis, be seen as a chain of failures and errors that lead almost inevitably to the adverse event. (This is often known as the Domino effect) These causes can be classified as:
1. immediate causes: the agent of injury or ill health (the blade, the substance, the dust etc);
  2. underlying causes: unsafe acts and unsafe conditions (the guard removed, the ventilation switched off etc);
  3. root causes: the failure from which all other failings grow, often remote in time and space from the adverse event (eg failure to identify training needs and assess competence, low priority given to risk assessment etc).
- 2.2 To determine the root cause of the adverse event the 5 why's technique is to be used.
- 2.3 All corrective/preventative actions which address the immediate, underlying and root causes must be identified, implemented and recorded.

#### **Near Miss/Unsafe Circumstances Reporting**

- 3.0 The company requires that all such events are recorded, reviewed and investigated.
- 3.1 All Near Miss/Unsafe Circumstance events are to be recorded on form Q008 or via Microsoft Forms and sent directly to the QHSE Team. It is also possible to report by calling the QHSE Team direct and a form will be completed remotely.
- 3.2 All personal details will be treated confidentially; however near miss/unsafe circumstance reports may be submitted anonymously if preferred. The latter may have an effect on the actions/options available to the reviewer.
- 3.3 To determine the root cause of the adverse event the 5 why's technique is to be used.
- 3.4 All corrective/preventative actions which address the immediate, underlying and root causes must be identified, implemented and recorded.
- 3.5 The company considers near miss/unsafe circumstance reporting an important management tool for identifying hazards, identifying trends and improving general workplace safety.

#### **RIDDOR Reportable Events**

- 4.0 For the purposes of RIDDOR, an accident is a separate, identifiable, unintended incident that causes physical injury. This specifically includes acts of non-consensual violence to people at work.
- 4.1 Not all accidents need to be reported, a RIDDOR report is required only when:
1. the accident is work-related; and
  2. it results in an injury of a type which is reportable (as listed under 'Types of reportable injuries').

<b>Date of Issue: March 2026</b>	<b>Page 3 of 9</b>	<b>Revision 7</b>
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- 4.2 When deciding if the accident that led to the death or injury is work-related, the key issues to consider are whether the accident was related to:
1. the way the work was organised, carried out or supervised;
  2. any machinery, plant, substances or equipment used for work; and
  3. the condition of the site or premises where the accident happened.

If none of these factors are relevant to the incident, it is likely that a report will not be required.

- 4.3 If an accident/incident falls into one of the categories listed in the table on page 7 then the team leader is to inform the QHSE Team **IMMEDIATELY**, in order for the relevant enforcing authority be notified.
- 4.4 There is no obligation to report Road Traffic Accident/Injuries under RIDDOR to the authorities and it is the company's policy not to do so.

# Quality, Health, Safety, Environmental & Energy Manual:

## Document No: SM-11      Accident/Incident Reporting & Investigation

### IN THE EVENT OF A FATALITY – TMHUK Individual areas of responsibility

No.	Timeline	Action Required (in the event of FATALITY)	TMHUK Responsibility
1	Immediate	Immediate notification to Functional Director via phone call. Should the Functional Director be unavailable, direct contact should be made with the Managing Director or HR & QHSE Director.	Functional Leader
2	Immediate	Immediate notification to Managing Director via phone call.	Functional Director
3	Immediate	Fast alert to TMHUK Chairman, and/or TMHE CEO via phone call.	Managing Director
4	< 3 Hours	Fatality report (partial) to be completed with as much detail as possible and e-mailed to Managing Director, HR & QHSE Director and Functional Director.	Functional Leader
5	< 4 Hours	Fatality report (partial) to be e-mailed to TMHUK Chairman, TMHE CEO & VP HR.	Managing Director
6	< 22 Hours	Fully completed fatality report to be e-mailed to Managing Director, HR & QHSE Director and Functional Director. Please note this report needs to be fully completed with all known facts and any supporting information.	Functional Leader
7	< 24 Hours	Fatality report to be shared with TMHUK Chairman, TMHE CEO & VP HR.	Managing Director

### IN THE EVENT OF A SERIOUS INJURY\* – TMHUK individual areas of responsibility

No.	Timeline	Action Required (in the event of SERIOUS INJURY*)	TMHUK Responsibility
1	Immediate	Immediate notification to functional Director via phone call. Should the functional Director be unavailable, direct contact should be made with the Managing Director or HR & QHSE Director.	Functional Leader
2	Immediate	Immediate notification to Managing Director.	Functional Director
3	< 22 Hours	Fully completed serious injury report to be e-mailed to Managing Director, HR & QHSE Director and Functional Director. Please note this report needs to be fully completed with all known facts and any supporting information.	Functional Leader
4	< 24 Hours	Serious injury report to be shared with TMHUK Chairman, TMHE CEO & VP HR.	Managing Director

\* Serious Injury – any injury leading to hospitalisation (i.e. night following injury spent in hospital)

Date of Issue: March 2026	Page 5 of 9	Revision 7
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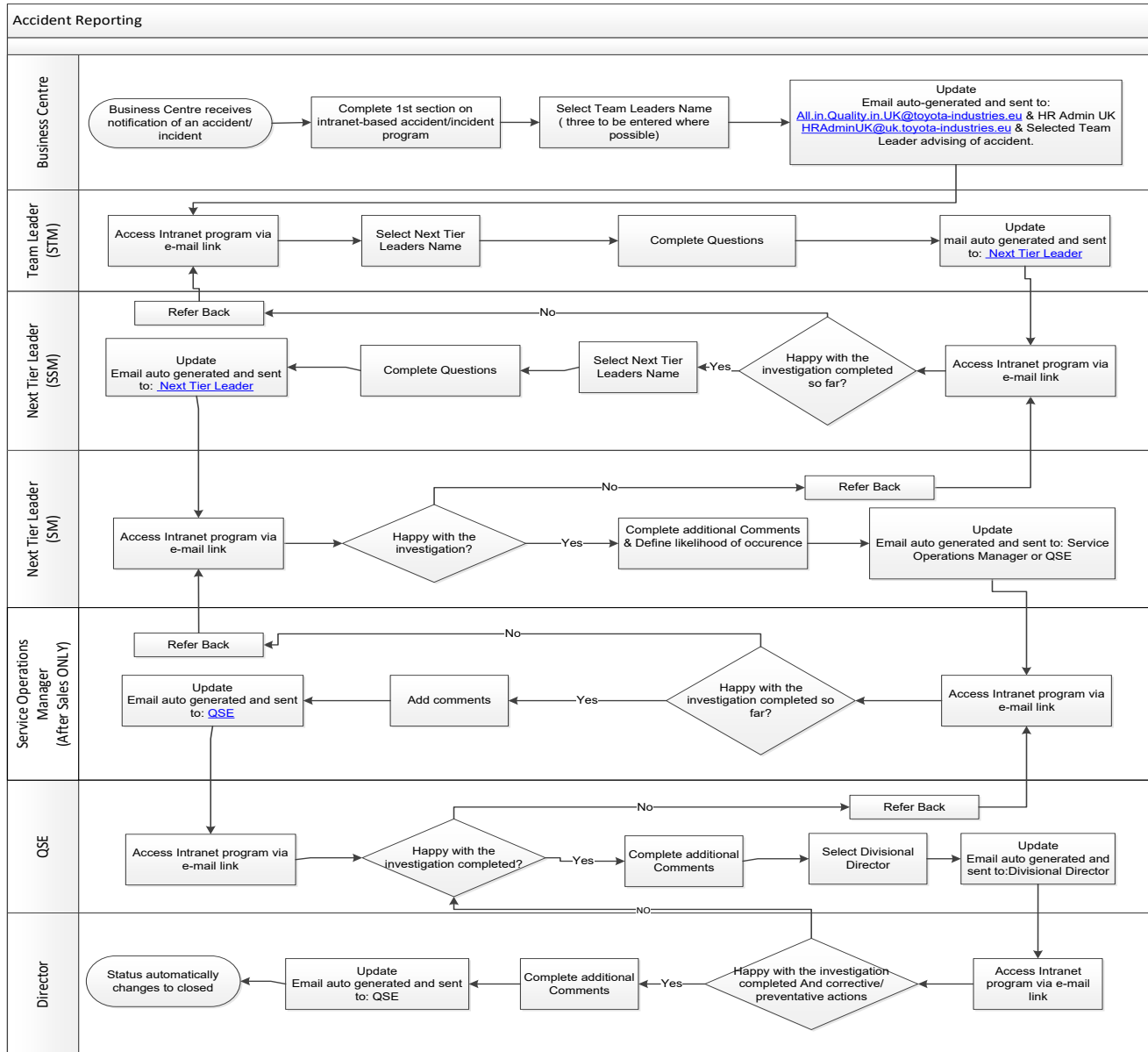
Authorisation: HR-QHSE Director  
Approval: QHSE Manager

Information classification: Internal

# Quality, Health, Safety, Environmental & Energy Manual:

## Document No: SM-11      Accident/Incident Reporting & Investigation

### TMHUK Reporting of accidents/incidents



**RIDDOR Reportable Events**

<b>Types of reportable injury</b> Lists are not definitive and are for guidance only, for more detailed information contact a member of the QHSE Team.	
<b>Deaths</b> <i>Requires Immediate Notification</i>	All deaths to workers and non-workers must be reported if they arise from a work-related accident, including an act of physical violence to a worker. Suicides are not reportable, as the death does not result from a work-related accident.
<b>Specified injuries to workers</b> <i>Requires Immediate Notification</i>	<ul style="list-style-type: none"> <li>• <b>A fracture</b>, other than to fingers, thumbs and toes;</li> <li>• <b>Amputation</b> of an arm, hand, finger, thumb, leg, foot or toe;</li> <li>• <b>Sight</b> Permanent loss of sight or reduction of sight;</li> <li>• <b>Crush</b> injuries leading to internal organ damage;</li> <li>• <b>Serious burns</b> (covering more than 10% of the body, or damaging the eyes, respiratory system or other vital organs);</li> <li>• <b>Scalpings</b> (separation of skin from the head) which require hospital treatment;</li> <li>• <b>Unconsciousness</b> caused by head injury or asphyxia;</li> <li>• 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.</li> </ul>
<b>Over-seven-day injuries to workers</b> <i>Report within 15 days.</i>	This is where an <b>employee, or self-employed person, is away from work or unable to perform their normal work duties for more than seven consecutive days</b> (not counting the day of the accident)
<b>Injuries to non-workers</b>	Work-related accidents involving members of the public or people who are not at work must be reported if a person is injured and is taken from the scene of the accident to hospital for treatment to that injury. There is no requirement to establish what hospital treatment was actually provided, and no need to report incidents where people are taken to hospital purely as a precaution when no injury is apparent.
<b>Reportable occupational diseases</b>	Employers and self-employed people must report diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work. These diseases include (regulations 8 and 9): <ul style="list-style-type: none"> <li>• carpal tunnel syndrome;</li> <li>• severe cramp of the hand or forearm;</li> <li>• occupational dermatitis;</li> <li>• hand-arm vibration syndrome;</li> <li>• occupational asthma;</li> <li>• tendonitis or tenosynovitis of the hand or forearm;</li> <li>• any occupational cancer;</li> <li>• any disease attributed to an occupational exposure to a biological agent.</li> </ul>
<b>Reportable dangerous occurrences</b>	Dangerous occurrences are certain, specified 'near-miss' events (incidents with the potential to cause harm.) Not all such events require reporting. There are 27 categories of dangerous occurrences that are relevant to most workplaces. For example: <ul style="list-style-type: none"> <li>• the collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;</li> <li>• plant or equipment coming into contact with overhead power lines;</li> <li>• explosions or fires causing work to be stopped for more than 24 hours.</li> </ul> For a full, detailed list, refer to the online guidance at: <a href="http://www.hse.gov.uk/riddor">www.hse.gov.uk/riddor</a>

<b>Reportable gas incidents</b>	<p>If you are a distributor, filler, importer or supplier of flammable gas and you learn, either directly or indirectly, that someone has died, lost consciousness, or been taken to hospital for treatment to an injury arising in connection with the gas you distributed, filled, imported or supplied, this can be reported online.</p> <p>If you are a gas engineer registered with the Gas Safe Register, you must provide details of any gas appliances or fittings that you consider to be dangerous to the extent that people could die, lose consciousness or require hospital treatment. This may be due to the design, construction, installation, modification or servicing, and could result in:</p> <ul style="list-style-type: none"> <li>• an accidental leakage of gas;</li> <li>• inadequate combustion of gas; or</li> <li>• inadequate removal of products of the combustion of gas.</li> </ul>
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## **Records**

- 5.0 Near Miss/Unsafe Circumstance records and investigations will be held by the Quality, Health, Safety and Environment (QHSE) Department for a minimum of five years.
- 5.1 The QHSE Team is responsible for notifying the enforcing authorities of any RIDDOR events.
- 5.2 The QHSE Department will maintain a "Company Wide" database record of all accident, incident, near miss and unsafe circumstance reports and investigations.
- 5.3 Local copies of investigation reports or records must not be saved
- 5.4 All accident book records, completed F2508 (RIDDOR) forms and investigation reports will be held by the QHSE Department as per Statuary Retention periods below:
- **Accident books, accident records/reports** (See below for accidents involving chemicals or asbestos)
    - a. **Statutory retention period:** minimum 3 years from the date of the last entry (or, if the accident involves a child/ young adult, then until that person reaches the age of 21).
    - b. **Statutory authority:** The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
  - **Health Surveillance documentation**
    - a. A health record must be kept for **all** team members under health surveillance.
    - b. Records are important because they allow links to be made between exposure and any health effects. Health records, or a copy, should be kept in a suitable form for at least 40 years from the date of last entry because often there is a long period between exposure and onset of ill health.
  - **Medical records and details of biological tests under the Control of Lead at Work Regulations**

<b>Date of Issue: March 2026</b>	<b>Page 8 of 9</b>	<b>Revision 7</b>
----------------------------------	--------------------	-------------------



- a. **Statutory retention period:** minimum 40 years from the date of the last entry.
- b. **Statutory authority:** The Control of Lead at Work Regulations.
- **Medical records as specified by the Control of Substances Hazardous to Health Regulations (COSHH)**
  - a. **Statutory retention period:** minimum 40 years from the date of the last entry.
  - b. **Statutory authority:** The Control of Substances Hazardous to Health Regulations.
- **Medical records under the Control of Asbestos at Work Regulations: medical records containing details of employees exposed to asbestos and medical examination certificates**
  - a. **Statutory retention period:** minimum 40 years from the date of the last entry (medical records); 4 years from the date of issue (medical examination certificates).
  - b. **Statutory authority:** The Control of Asbestos at Work Regulations. Also see the Control of Asbestos Regulations and the Control of Asbestos Regulations.
- **Medical records under the Ionising Radiations Regulations.**
  - a. **Statutory retention period:** Until the person reaches 75 years of age, but in any event for at least 50 years.
  - b. **Statutory authority:** The Ionising Radiations Regulations.
- **Records of tests and examinations of control systems and protective equipment under the Control of Substances Hazardous to Health Regulations (COSHH)**
  - a. **Statutory retention period:** minimum 5 years from the date on which the tests were carried out.
  - b. **Statutory authority:** The Control of Substances Hazardous to Health Regulations.