**MED Incidents 1-1-19 to 3-6-19**

|  |  |  |  |
| --- | --- | --- | --- |
| Ref | Date | Description | Action |
| IN 013897 | 20-5-2019 | RA was working in CAGB 101 with others on a prototype electrical apparatus housed in a metal enclosure. The RA accessed the inside of the enclosure by removing the top cover. The device was turned off by the switch adjacent to the 240v ac socket entry on the enclosure. However, the supply was not disconnected by removing the plug from the mains socket. Inside the enclosure the bare terminals on the back of the entry socket would have remained as a live 240v ac connection. The RA used her index finger to push some cables away to get a clearer view and in doing so touched the live 240v ac pole. A small current then passed up her arm giving her an electric shock.  The RA was very upset by the incident and stated that this was first electric shock she had ever received. She went to the toilets and came back a little while later to CAGB 101. She was still upset and left the lab to return to the fifth floor. Yatish Patel found her at @6:30pm. She was still upset. They went to the coffee room on the level 5. A first aider from security attended and at the request of the RA they were taken by college security to hospital. At the hospital she was examined, her blood pressure checked, and an electrocardiogram test performed. | In an Initial Investigation, the department or section will look into the circumstances of the incident with the support of the FSM / CSM / DSO and try to learn any lessons which will prevent future occurrences.  The incident was the result of a knowledge-based mistake. There was a failure to follow the correct procedures. Work was being carried out by an unsupervised, non-competent person.  Meeting held with the parties concerned. It was agreed that procedures need to be revised to ensure that all prototype electrical apparatus is inspected and tested by the departmental electrician before connection to the mains supply. The electrician is to carry-out modifications or to indicate what is required for others to modify in order for the equipment to conform to standard and be safe to use. It was agreed that electrically non-competent users are to be always supervised by qualified personnel when working on electrical equipment.  The research group will be reviewing their risk assessment amending their documentation, training procedures and safe systems of work accordingly, as well as making design alterations to the devices to improve their intrinsic safety. Any such devices constructed in future will be checked by an electrically qualified competent person before plugging in to the mains supply, in line with Departmental policy. Similarly only a qualified person will be permitted to work on such equipment, unless the mains component is separate and not accessible to users. |
| IN03894 | 20-5-2019 | Male student felt unwell due to viral conjunctivitis | Medical issue, no action |
| IN013852 | 10-5-2019 | A student called to say that one side of her face was not feeling right | Tizard Hall. Medical issue – not our jurisdiction |
| IN013638 | 3-4-2019 | When I was leaving on Wednesday 3rd April at approx. 5:30pm, I saw an arc flash from the corridor that it’s coming from Pit Garage. I investigated and found 3 x UG students performing the welding. One had PPE (mask and overalls) and the other 2 UGs had no PPE and were filming the welding operation on their phones. The identity of the students is not known at the first stage.  After an investigation Andrew Wallace has a cash invoice for the delivery of the gas cylinder for the MIG welder from LONDON Gases (not a College supplier) that was ordered by Owen Heaney – captain of the Motor Club (UG student). As Department we decided to remove the welding equipment from Pit Garage immediately and some days later student contacted with us to take it back because it’s not belong at Mech Eng.  After a second investigation that we had as department we found that the student belongs to aeronautic engineering and they used the area of Pit garage for welding because he is member of the students union and he said us that at the Motor club couldn’t do welding because there are petrol/oil. After that we decide to inform that we don’t permit any welding practise into Pit garage because the area is not suitable for this( not lev, etc…) |  |
| IN013639 | 27-2-2019 | While dissecting a cadaveric knee, my scalpel in my right hand slipped and hit my left first finger. A few seconds later, I realized I had nicked the two pairs of gloves I was wearing, and while removing the gloves to replace them, found a small bit of blood and a ~2 mm long cut on my left first finger. I stopped dissecting, washed my hands with warm water and the soap used to clean your hands after dissections for 1-2 minutes. I then covered the cut with a plaster (even though it had stopped bleeding at that point) and asked around to figure out what I needed to do. It was recommended I talk to Occupational Health. By the time I got back to my office, I had become distracted and forgot to report the incident until today. | The IP was interviewed on 6-3-19.  The IP was working in CAGB 707A on cadaver specimens for use by many researchers. The cadaver parts were all out in bags. He was searching for a particular form of anatomical part in the knee. He used the scalpel that caused the injury on various different specimens. He remembers changing the scalpel blade at some stage. He is of the opinion that the scalpel would have been contaminated by more than one of the cadaver specimens. He recalls that when the injury was caused he was working on a smaller seized knee joint - possible female.  He was advised by coworkers to contact OH on Monday 04 March. There was some delay in contacting OH and the physician who interviewed him expressed concern and stated that he should have attended OH immediately.  When asked of his training for dissection he replied that he had some experience as a UG at the University of Massachusetts, dissecting embalmed primate cadaver parts. Does not consider that the training was of any great quality. Witnessed bad practices by the instructor – who did not use gloves and kept stroking her hair. He said he has picked-up using a scalpel for dissection along-the-way. He remembers a surgeon told him to hold the scalpel like a pencil.  He states that he received a lab induction. He does not think he attended the departmental safety lecture.  He does not recall completing the *cadaver safety induction*.  He does not think he has completed RAFT.  He said he was not familiar with the incident reporting process (SALUS).  Cadaver references have been obtained along with testing information prior to delivery. We are still awaiting information /confirmation from the biomechanics group that cadavers are tested for TB – This is an outstanding audit action.  There still needs to be follow up – can they wear different gloves etc. dissecting gloves? |