First Aid Procedure

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First Aid Procedure

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1. PROCEDURE PURPOSE

This procedure supports the First Aid Policy by setting out the operational arrangements campuses must follow for first aid provision, illness and accident response, first aid equipment, emergency medication, off-site activities, medical condition response, head injury management, incident reporting, investigation and review. It should be read alongside the First Aid Policy, Health and Safety Policy, Allergy Safety Policy, Administration of Medicines Policy, Supporting Students with Medical Needs Policy, Educational Visits Procedure, Incident Reporting and Investigation Procedure, and Emergency, Lockdown and Evacuation Procedure.

This procedure gives effect to the First Aid Policy by translating policy requirements into the operational controls campuses must apply. Where this procedure, local arrangements or supporting appendices appear to conflict, the First Aid Policy and the applicable legal or regulatory requirement take precedence, and the matter must be escalated to the Regional Support Office for clarification before local variation is adopted.

1.1 Local first aid implementation record

1.1.1 Each campus must maintain an up-to-date local implementation record confirming named first aiders and training expiry dates; first aid kit locations; AED location; emergency medication locations; trip and vehicle arrangements; medical room or treatment area arrangements; and how first aid arrangements are communicated.

The local implementation record must be reviewed at least annually, following any significant incident, after any change to campus layout or operating model, and whenever the First Aid Policy or related OSG standard is updated. The review must confirm that local arrangements remain

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aligned to the First Aid Policy, Health and Safety Standards, emergency medication arrangements, educational visits requirements and incident reporting requirements.

2. SCOPE

This procedure applies to all staff, students, volunteers, contractors and visitors at OSG UK campuses. It applies on campus, during school transport, educational visits, sports events, lettings, contractor activities, community use and any off-site activity where the campus has responsibility for first aid arrangements.

The procedure must be implemented in accordance with the applicable jurisdictional legal requirements for England, Wales, Scotland and Northern Ireland. Where requirements overlap, the more specific OSG UK procedure and the applicable jurisdictional legal requirement must be followed.

For Welsh campuses, first aid arrangements must also reflect the Independent School Standards (Wales) Regulations 2024, including the requirement to promote and safeguard pupils' health, safety and well-being through appropriate first aid arrangements. Local implementation records must confirm whether any jurisdiction-specific requirements apply and how they are met.

2.1 Roles and responsibilities

Role	Procedure responsibility
Campus Principal	Ensure suitable first aid arrangements, resources, local implementation records and review arrangements are in place.
Campus Premises Manager/Health and Safety Officer	Coordinate the first aid needs assessment, premises-related provision, equipment checks, AED checks, spillage kits and DoneSafe assurance records.
First Aid Coordinator	Maintain first aider competence records, first aid information, emergency medication checks, registers and day-to-day readiness.
Regional Facilities Manager/competent adviser	Support legal interpretation, RIDDOR assessment, investigation, regional assurance and escalation.
All staff	Know how to summon first aid assistance, follow local procedures, report incidents and hazards promptly, and support student welfare within competence.

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3. PROCEDURE

3.1 Where a student feels unwell, they should be taken to the main office. For minor concerns another student may accompany them. For more serious concerns, staff must contact the school office to summon a First Aider. Emergency first aid must not be delayed while consent is sought.

3.2 If an accident occurs, the member of staff in charge must assess the situation, summon a First Aider where require, and decide whether emergency services are needed. Where the First Aider cannot adequately deal with the presenting condition through first aid, appropriate medical treatment must be arranged without delay.

3.3 Where a pupil is transferred to hospital, authorised staff must provide ambulance or hospital personnel with the minimum relevant medical and emergency information needed for treatment. Information must be shared securely from the approved pupil record, emergency summary, Individual Healthcare Plan or Action Plan.

3.4 Students who sustain a head injury must be assessed by a competent First Aider using the Head Injury Checklist. The First Aider must monitor the person, escalate immediately if red flags develop, notify parents or carers, and ensure suspected concussion results in removal from activity, no same-day return to PE or sport, appropriate medical advice, and a gradual return to learning before sport.

3.5 If blood or other bodily fluids are present, a First Aider must arrange containment, clean-up and cleansing of the area. Staff must wear suitable disposable gloves, cover cuts or grazes, use eye protection and disposable aprons where splashing may occur, wash hands after every procedure, and dispose of contaminated material in accordance with campus arrangements.

3.6 Trip leaders must ensure first aid provision is appropriate to the activity, location, group size, participants' ages and needs, known medical conditions, travel arrangements and access to emergency services. The trip risk assessment must confirm competent cover, emergency medication, an accessible first aid kit, emergency contacts, communications and contingency arrangements.

3.7 All accidents, injuries, illnesses, medication uses, exposure events, near misses, treatment delays and first aid equipment failures must be recorded in DoneSafe immediately or as soon as practicable and in any event within 24 hours. Records requiring urgent escalation must be notified promptly to the Campus Principal, Campus Premises Manager or Health and Safety Officer and the Regional Support Office. The record must include the person affected, date, time, location, nature of the incident, first aid provided, medication or AED use where applicable, witnesses, parent or carer notification, escalation decisions, follow-up actions and any RIDDOR assessment requirement.

3.8 First aiders and first aid cover

3.8.1 The campus must display a current list of qualified First Aiders in the staff room and key locations. First aid cover must be determined by the campus first aid needs assessment and must include suitable absence cover for all activities, locations, operating hours, holidays, visits, transport, events and higher-risk curriculum areas.

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3.8.2 The campus must display a current list of qualified First Aiders in the staff room, reception and other key locations. First aid cover must be determined by a documented campus first aid needs assessment approved by the Campus Principal and reviewed with the Campus Premises Manager, Health and Safety Officer or competent adviser. The assessment must account for absence cover, operating hours, holidays, visits, transport, events, lettings, higher-risk curriculum areas, early years provision where applicable, and emergency medication needs.

3.8.3 First Aiders must hold current recognised training appropriate to their role. Certificates and expiry dates must be recorded locally. An appointed person may coordinate first aid arrangements but is not a substitute for a trained First Aider where the needs assessment identifies that trained provision is required.

3.8.4 Training records must be held for all First Aiders, appointed persons and staff with responsibilities for emergency medication or medical condition response. Records must confirm qualification type, provider, completion date, expiry date, refresher requirements and any role-specific training, including anaphylaxis, asthma, diabetes, epilepsy, AED use, infection control, head injury and concussion response where relevant.

3.9 First aid equipment and kit checks

3.9.1 First aid kits must be clearly marked with a white cross on a green background and located at suitable points around the campus, including reception or office areas, staff areas, higher-risk curriculum areas, vehicles and trip arrangements where required. Kits must be checked regularly by the Campus Premises Manager, Health and Safety Officer or designated personnel. Checks, replenishment and expiry dates must be recorded in DoneSafe or the approved local assurance record.

Kit/location	Required contents/procedure
General first aid kit	Leaflet giving general first aid advice; 20 sterile adhesive dressings or plasters; 2 sterile eye patches; 4 triangular bandages; 6 safety pins; 6 medium sterile wound dressings; 2 large sterile wound dressings; 3 pairs disposable gloves; microporous tape; resuscitation device with valve; blunt-ended scissors.
Science, Design and Technology, Food Technology or Cooking	Additional items should include eyewash, finger dressing and burn or soothe relief dressing where risk assessment identifies the need.
Burns kit	General first aid leaflet; sterile adhesive dressings; eyewash phials; sterile eye patches; triangular bandages; safety pins; medium and large sterile wound dressings; finger bandage; disposable gloves; moist cleansing wipes; adhesive tape; resuscitation device; foil blanket; small and medium burns dressings; blunt-ended scissors; burn relief dressing.

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Bodily fluid spillage kit	Super absorbent powder, biohazard disposal bags, disinfectant spray, alcohol-free wipes, scoop, scraper, gloves and aprons. Use must align with COSHH arrangements for microbiological hazards.
OneBus/school vehicle kit	10 antiseptic wipes; disposable bandage; 2 triangular bandages; 24 sterile adhesive dressings; 3 large sterile ambulance dressings; 2 sterile eye patches with attachments; 12 safety pins; blunt-ended scissors; disposable gloves.
Travelling kit for trips and visits	First aid leaflet; 6 sterile adhesive dressings; 2 triangular bandages; 2 safety pins; 1 large sterile wound dressing; 1 pair disposable gloves; 10 moist cleaning wipes.
PE and sports kit	First aid leaflet; adhesive dressings; eye patches; triangular bandages; safety pins; medium and large wound dressings; disposable gloves; microporous tape; resuscitation device; blunt-ended scissors; foil blankets; ice packs; wound wash or moist wipes; deep freeze spray and deep heat spray where locally approved.

3.10 Emergency medication and student information

3.10.1 Parents and carers must provide current medical and emergency contact information at the start of every term. Essential medical information, including allergies, recent accidents or illnesses and other relevant medical conditions, must be shared with authorised staff on a need-to-know basis. Emergency medication and devices must be clearly labelled, safely stored, readily accessible and never locked away where access depends on one person being present.

3.10.2 Local arrangements must cover self-carry where appropriate, backup medication, classrooms, dining areas, sports facilities, transport, visits, evacuations, lockdowns, IT outages, expiry checks, replacement after use and secure information-sharing on a need-to-know basis.

3.10.3 Emergency medication checks must be completed at a defined local frequency and recorded. Checks must confirm availability, correct labelling, storage, accessibility, expiry dates, consent, Individual Healthcare Plan or Action Plan status, spare device availability where permitted, and replacement arrangements after use or expiry.

3.11 Specific medical condition response

Condition	Signs / symptoms	Action
Anaphylaxis	Flushing, hives, swelling of throat or mouth, difficulty swallowing or speaking, severe asthma, abdominal pain,	Send for the nearest adrenaline device and call for assistance. Do not make the person walk to medication. Lay flat with legs raised unless breathing difficulties require supported sitting. Give adrenaline

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	nausea, vomiting, weakness, collapse or unconsciousness.	without delay in line with the Action Plan, call 999 stating “anaphylaxis”, give a second dose after five minutes if no improvement and a second device is available, commence CPR and use an AED if there are no signs of life, hand used devices and relevant information to ambulance staff, inform parents or carers and record in DoneSafe.
Asthma	Frequent coughing, wheezing, shortness of breath, chest tightness, difficulty speaking, obvious effort to breathe or widened nostrils.	Use the student’s reliever inhaler or the school emergency salbutamol inhaler only where the required diagnosis or prescription, written parental consent and register entry are in place, and the student’s own inhaler is unavailable, empty or not working. Keep the emergency inhaler kit with a compatible spacer, current register and consent details. Check availability, condition, cleaning and expiry; replace after use or before expiry; record every use; notify parents or carers promptly; never use another pupil’s prescribed inhaler for a different pupil.
Diabetes – low blood sugar	Pale appearance, glazed eyes, blurred vision, confusion, shaking, headache, behaviour change, agitation, drowsiness, tingling lips, sweating, hunger, dizziness or unconsciousness.	Administer fast-acting glucose from the student’s emergency supply. After 5–10 minutes, provide further snacks as advised by parents. Do not leave the student unaccompanied. Inform parents. If unconscious, place in the recovery position, do not give glucose by mouth, call 999, inform parents and accompany the student to hospital where required.
Diabetes – high blood sugar	Tiredness, weakness, thirst, passing urine more often, nausea, vomiting, drowsiness,	Inform the Campus Administration Officer or nominated staff member. Arrange blood glucose testing where possible. Inform

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	breath smelling of acetone, blurred vision or unconsciousness.	parents as soon as possible. Call 999 where required and ensure the student is accompanied to hospital until parents arrive.
Epilepsy/seizure	Confusion, falling, slow noisy breathing, blue colouring around the mouth, rigid muscle spasms, twitching of limbs or face, possible incontinence.	Help the student to the floor if safe, move hazards away, place something soft under the head, clear the area, call a First Aider, cover the student if needed, stay throughout the seizure, place in recovery position as the seizure subsides, inform parents and call an ambulance if it is the first seizure, lasts more than five minutes or injury occurs.

3.12 Monitoring, review and investigation

3.12.1 Serious incidents, dangerous occurrences, significant treatment delays, systemic control failures and material near misses must be investigated proportionately under the Incident Reporting and Investigation Procedure. Investigations must identify immediate, underlying and organisational causes, preserve relevant evidence, assign corrective actions to named owners with completion dates, verify completion and escalate significant findings or overdue actions through regional governance arrangements.

3.12.2 The Campus Principal must confirm compliance with this procedure through the local assurance process. Evidence should include the current needs assessment, named First Aider list, training records, kit and AED checks, emergency medication checks, first aid notices, trip first aid arrangements, DoneSafe reporting evidence, incident investigation actions and confirmation that local arrangements remain aligned to the First Aid Policy and related OSG standards.

3.12.3 NSO or the appropriate regional function may conduct scheduled or random checks of first aid arrangements, DoneSafe records, equipment checks, training records, emergency medication records and local implementation records. Where issues are identified, improvement actions must be assigned to named owners with completion dates and monitored through regional governance until closed.

3.13 RIDDOR and reportability

3.13.1 Reporting to HSE must be coordinated at central/NSO level only. Campus staff must not submit independent RIDDOR reports unless formally instructed. Staff accidents resulting in death, specified injury, reportable disease or qualifying absence from normal work must be escalated for assessment. Student or visitor incidents are reportable only where the accident arises out of or in connection with work and results in death or direct transfer from the scene to hospital for treatment.

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3.13.2 Employee injuries must be assessed against current RIDDOR criteria, including deaths, specified injuries, diagnosed occupational diseases and injuries causing an employee to be unable to perform normal work duties for more than seven consecutive days. Injuries to pupils or visitors are reportable only where they arise out of or in connection with work and result in death or the person being taken directly from the scene to hospital for treatment.

3.13.3 For events, lettings, community use, contractor activities and school transport, the responsible manager must confirm first aid provision through the relevant risk assessment or event plan. The arrangements must identify who will provide first aid, how assistance and emergency services will be summoned, access arrangements, emergency medication availability, incident reporting responsibilities and the information to be communicated to staff, volunteers, drivers, contractors and venue representatives.

3.13.4 Where a campus provides early years provision or otherwise falls within an applicable early year's framework, the campus must identify and maintain the required paediatric first aid cover during operating hours and relevant outings. Qualification type, staffing cover, certificates and expiry dates must be recorded in the local implementation record.

3.13.5 Each campus must provide an AED with clear signage and rapid, unobstructed accessibility. Checks must be completed and recorded at the manufacturer's specified frequency; pads and batteries must be replaced before expiry and after use where required. Manufacturer safety and software updates must be implemented, the AED must be registered on The Circuit where appropriate, and every use must be followed by documented review, replenishment and incident learning.

3.13.6 First aid arrangements for organised trips, sports events and other off-site activities must be confirmed before departure along with supporting risk assessments. First aid kits must be carried by the First Aider or nominated responsible adult, prescribed and spare emergency medication must be readily accessible, and treatment, medication use, incidents and near misses must be recorded promptly in DoneSafe.

3.13.7 Accident and incident records must be retained in accordance with the controlled OSG UK records-retention schedule. Retention decisions must account for applicable limitation periods, child claims, safeguarding requirements, employment matters, insurance requirements and any legal or regulatory hold. Records must be access-controlled, kept securely, preserved while a hold applies and disposed of securely when authorised under the schedule.

3.13.8 Where a person is contaminated with blood or other bodily fluids, affected skin must be washed with soap and running water, eyes irrigated with tap water or eyewash, and nose or mouth splashes rinsed with tap water without swallowing. Details of the contamination must be recorded, the incident reported to the Campus Principal, and medical advice sought where appropriate.

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4. VERSION CONTROL

Document Code	Date	Version No.	Nature of change
PRO_UK_WHS_First Aid Procedure_V8	09/2026	1.0	Created First Aid Procedure by cross-referencing and transferring procedural content from POL_UK_WHS_First Aid Policy.docx, including main procedure sections, appendices, reporting requirements and document control alignment. Final approval-readiness updates: strengthened first aid needs-assessment governance, added appendix hierarchy and local-placeholder controls, added jurisdictional/Wales compliance note, confirmed alignment to the First Aid Policy, and completed final formatting and consistency clean-up.

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APPENDIX 1 – FIRST AID NOTICE



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APPENDIX 2 - GUIDANCE AND PROTOCOLS FOR SPECIFIC MEDICAL CONDITIONS

ANAPHYLAXIS

Signs and symptoms of Anaphylaxis (severe allergic reaction)

What can cause anaphylaxis?

- Common causes include foods such as peanuts, tree nuts (e.g. almonds, walnuts, cashews, and Brazil nuts), sesame, fish, shellfish, dairy products and eggs.
- Non-food causes include wasp or bee stings, natural latex (rubber), penicillin or any other drug or injection.
- In some people, exercise can trigger a severe reaction — either on its own or in combination with other factors such as food or drugs (e.g. aspirin).

What are the symptoms of a severe allergic reaction?

- generalised flushing of the skin
- nettle rash (hives) anywhere on the body
- sense of impending doom
- swelling of throat and mouth
- difficulty in swallowing or speaking
- alterations in heart rate
- severe asthma
- abdominal pain, nausea and vomiting
- sudden feeling of weakness (drop in blood pressure)
- collapse and unconsciousness

Adrenaline auto-injectors

- Delays in administering AAIs have been associated with fatal outcomes. AAIs MUST be administered without delay to students if there are ANY signs of anaphylaxis present to those students who are known to be at risk of anaphylaxis, for whom both medical authorisation and consent for the use of AAIs have been provided.
- School staff must always call 999 and request an ambulance if an AAI is used and keep a detailed record including, where the reaction took place and how much medication was given. Relevant parents or guardian(s) should be informed as soon as practicable.
- The First Aid coordinator and the Campus Principal are responsible for ensuring that the Guidance on the use of adrenaline auto-injectors in schools (the AAI Guidance) is properly implemented and followed.
- AAIs are to be stored, cared for and disposed of in accordance with Part 3 of the AAI Guidance. The requirements of this procedure and the First Aid Policy apply to AAIs, including but not limited to appropriate training, use and record keeping.
- The First Aid coordinator will have overall responsibility for re-stocking at least 1 AAI (which may be bought without prescription). The First Aid coordinator will check the stock on a monthly basis to ensure that the AAIs are present and in date and that replacement AAIs are obtained in good time.

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- Spare AAIs should only be used on students who are known to be at risk of anaphylaxis, for whom both medical authorisation and consent for the use of AAIs have been provided.
- The First Aid coordinator will maintain an up-to-date register of students at risk of anaphylaxis this includes students who have been prescribed an AAI and those who have been provided with a medical plan confirming this, but who have not been prescribed AAI and in respect of whom parental consent to the use of the spare AAI has been obtained.
- The register should be reviewed at least annually) to take into account students' changing needs. A copy of the register is to be stored with the spare AAIs.
- Parents are to notify the school as soon as practicable that a particular student is at risk of anaphylaxis and in that case provide their consent to use the spare AAIs. Completed consent forms should be stored on the student's file and, where appropriate, the ICHP updated accordingly.
- Further guidance and general information on how to recognise and respond to an anaphylaxis can be found at: http://www.nhs.uk/conditions/Anaphylaxis/Pages/Introduction.aspx

ASTHMA

Signs and symptoms of an Asthma attack

In childhood asthma, the lungs and airways become easily inflamed when exposed to certain triggers, such as inhaling pollen or catching a cold or other respiratory infection. Childhood asthma can cause bothersome daily symptoms that interfere with play, sports, school and sleep. In some children, unmanaged asthma can cause dangerous asthma attacks. Symptoms include:

- Frequent coughing
- A whistling or wheezing sound when breathing out
- Shortness of breath
- Chest congestion or tightness
-

In severe cases, you might see the child's chest and sides pulling inward as he or she struggles to breathe. The child might have an increased heartbeat, sweating and chest pain. Seek emergency care if the child:

> Is trying so hard to breathe that the abdomen is sucked under the ribs when he or she breathes in

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Asthma register, and emergency inhalers

- The requirements of this procedure and the First Aid Policy apply to emergency inhalers, including but not limited to appropriate training, use, supply, storage, care, disposal and record keeping.
- The First Aid coordinator and the Campus Principal are responsible for ensuring that Guidance on the use of emergency salbutamol inhalers in schools (Inhalers Guidance) is properly implemented and followed.
- Only students who have been diagnosed with asthma and/or prescribed a reliever inhaler may use the school emergency salbutamol inhaler where written parental consent and register entry are in place, and where the student's own inhaler is unavailable, empty or not working. The emergency inhaler must be a school-held device and must not be another pupil's prescribed inhaler. The First Aid Coordinator will maintain an up-to-date register of eligible students, review it at least annually and store a copy with the emergency inhaler kit.
- Parents are to notify the school as soon as practicable that a particular student has been diagnosed with asthma and / or has been prescribed a reliever inhaler.
- If an emergency inhaler is used by a student, the First Aid coordinator or school secretary will notify the relevant parents or guardian(s) as soon as practicable.
- Emergency inhalers are also to be stored, cared, and disposed of in accordance with Part 3 of the Inhalers Guidance.
- Further guidance and general information on how to recognise and respond to an asthma attack can be found at: http://www.nhs.uk/Conditions/Asthma/Pages/Treatment.aspx

DIABETES

Signs and symptoms of low blood sugar level (hypoglycemia)

- Onset can be quite quick and may be due to a missed/late meal, missing snacks, infection, more exercise, warm weather, too much insulin and stress. Individuals should test their own blood sugar levels if testing equipment available. Symptoms include:
  - Pale
  - glazed eyes
  - blurred vision
  - confusion/incoherent
  - shaking
  - headache
  - change in normal behaviour-weepy/aggressive/quiet
  - agitated/drowsy/anxious
  - tingling lips
  - sweating
  - hunger
  - dizzy
  - leading to unconsciousness

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Action

- The student should be administered with fast acting glucose ('Lucozade' drink or glucose tablets) - the student should have their own emergency supply in the school medical room. This will raise the blood sugar level quickly.
- After 5 - 10 minutes the student should be given further snacks as advised by the Parents. Do not leave the student unaccompanied at any time.
- The student should be allowed access to regular snacks and check blood sugar level again and as necessary.
- The student's Parents should be informed about the incident as soon as possible.

Action to be taken if the student becomes unconscious

- The student must be placed in the recovery position. Glucose must not be administered by mouth as this may cause choking.
- Telephone 999
- Inform Parents as soon as possible
- Accompany the student to hospital and await arrival of Parent

Signs and symptoms of high blood sugar level (hyperglycemia)

- This develops much more slowly over time but can be much more serious if untreated. Caused by too little insulin, eating more carbohydrate, infection, stress, and less exercise than normal.
- Symptoms may include:
  - feeling tired and weak
  - feeling thirsty
  - passing urine more often
  - nausea and vomiting
  - drowsy
  - breath smelling of acetone
  - blurred vision
  - unconsciousness

Action

- The Campus Administration Officer must be informed. Arrangements will be made for blood glucose testing, if possible. The student's Parents should be informed about the incident as soon as possible. 999 should be called and the student must be accompanied to casualty, where they will await the arrival of the student's Parents.
- For further information and guidance: http://www.nhs.uk/Conditions/Diabetes/Pages/Diabetes.aspx

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EPILEPSY ETC

How to recognise a seizure

- There are several types of epilepsy, but seizures are usually recognisable by the following symptoms:
  - the student may appear confused and fall to the ground
  - slow noisy breathing
  - possible blue colouring around the mouth, returning to normal as breathing returns to normal
  - rigid muscle spasms
  - twitching of one or more limbs and/or face
  - possible incontinence

Action

- The following actions should be taken to assist the student:
  - try to help the student to the floor if possible but do not put yourself at risk of injury
  - move furniture etc. away from the student in order to prevent further injury
  - place a cushion or something soft under the student's head
  - clear the area of students
  - call one of the First Aid trained staff
  - cover the student with a blanket as soon as possible in order to hide any incontinence
  - stay with the student throughout duration of the seizure
  - as the seizure subsides place the student into recovery position
  - inform Parents as soon as possible
  - send for ambulance if this is the student's first seizure or, if a student, known to have epilepsy has a seizure lasting for more than 5 minutes, or if an injury occurs as a result of the seizure. The student must be accompanied until their Parents arrive
  - allow the student to rest for as long as necessary
  - reassure the other students and staff

For further information and guidance:
http://www.nhs.uk/Conditions/epilepsy/Pages/treatment.aspx

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APPENDIX 3 – HELPFUL GUIDANCE WHEN TO CALL AN AMBULANCE

NHS Guidance - Urgent and emergency care services

WHEN TO CALL 999

At some point, most people will either witness or be involved in an accident or experience a medical or mental health emergency.

Knowing what to do next and who to call can potentially save lives.

LIFE-THREATENING EMERGENCIES

Call 999 in a medical or mental health emergency. This is when someone is seriously ill or injured and their life is at risk.

These emergencies can include:

- loss of consciousness
- a sudden confused state
- fits that are not stopping
- chest pain
- breathing difficulties
- severe bleeding that cannot be stopped
- severe allergic reactions (anaphylaxis)
- severe burns or scalds
- someone has seriously injured themselves or taken an overdose

Call 999 immediately if you think you or someone else is having a heart attack or stroke. Every second counts with these conditions.

Also call 999 if you think someone has had a major trauma, such as after a serious road traffic accident, a stabbing, a shooting, a fall from height, or a serious head injury.

Find out more about urgent and emergency care services or how to get urgent help for mental health.

If you're not sure what to do

NHS 111 can help if you need urgent medical help or you're not sure what to do.

They will ask questions about your symptoms, so you get the help you need.

If you need to go to A&E, NHS 111 will book an arrival time. This might mean you spend less time in A&E. This also helps with social distancing.

You can get help from NHS 111 online or call 111. It's available 24 hours a day, 7 days a week.

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WHAT HAPPENS WHEN I CALL 999?

If it's a genuine emergency, where someone is seriously ill or injured and their life is at risk, call 999 and don't panic.

You can contact emergency services via SMS if you're deaf, hearing impaired or have a speech impediment.

Visit the emergency SMS website for more information or to register your phone.

1. Answer the questions

Once you're connected to a call handler, you'll have to answer a series of questions to establish what's wrong, such as:

- where are you (including the area or postcode)?
- what phone number are you calling from?
- what has happened?

This will allow the operator to determine the most appropriate response as quickly as possible.

Dialling 999 does not necessarily mean an ambulance will be dispatched. The call handler will decide what's appropriate.

It may be safe enough for you to be seen elsewhere, or you can be given telephone advice by a medically trained clinical adviser.

An ambulance will be sent if it's a life-threatening emergency.

Response units that could be dispatched include:

- an emergency ambulance
- a rapid response vehicle or motorbike
- a cycle response unit
- a community first responder
- a combination of the above

2. Do not hang up yet

Wait for a response from the ambulance control room. They might have further questions for you, such as:

- what's the age, gender and medical history of the patient?
- is the person awake or conscious and breathing?
- is there any serious bleeding or chest pain?
- what is the injury and how did it happen?

The person handling your call will let you know when they have all the information they need.

You might also be given instructions about how to give first aid until the ambulance arrives.

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3. How you can assist the ambulance crew

There are a number of things you can do to assist the ambulance service.

For example, stay calm and:

- if you're in the street, stay with the patient until help arrives
- if you're in a dark house, turn on lights and open curtains
- if you're in a car, turn on hazard lights
- call the ambulance service back if the patient's condition changes
- call the ambulance service back if your location changes
- if you're calling from home or work, ask someone to open the door and direct the paramedics to where they're needed
- lock away family pets
- if you can, write down the patient's GP details and collect any medicine they're taking
- if you can, tell the paramedics about any allergies the patient has

If appropriate, you may want to call the patient's GP. The GP may meet you at the A&E department or call with important information about the patient.

HOW TO GIVE FIRST AID

If someone is injured in an incident, first check that you and the casualty are not in any danger. If you are, make the situation safe.

When it's safe to do so, assess the casualty and, if necessary, dial 999 for an ambulance. You can then carry out basic first aid.

It's important to stay calm and try to get an overview of the situation.

See if you can identify what the most serious problem is. The most obvious problem is not always the most serious.

Treat the most life-threatening problems first, such as:

- lack of breathing
- bleeding
- shock

If a person is not breathing normally after an accident, call an ambulance and start CPR straight away if you can.

If a person is unconscious but is breathing and has no other life-threatening conditions, they should be placed in the recovery position.

Check for broken bones and other injuries afterwards.

More info in Urgent and emergency care services.

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APPENDIX 4 – HEAD INJURY PARENT LETTER & NHS GUIDANCE

[Insert date]

Dear Parent,

Your child has received medical attention today due to an injury to their head. He/she has received first aid and was well enough to remain in school after 15 minutes observations/your child has been sent home due to the severity of their injury

If they experience any of the following symptoms, please take them straight to your nearest GP surgery, A&E department or call 999. (Please refer to the NHS Head Injury Advice Sheet, printed copy attached)

- Swelling to the eye/s
- Blurred vision
- Severe headache
- Continuous pain
- Confusion
- Vomiting
- Slurred speech
- Unusually drowsy
- Disturbed sleep pattern

Concussion can build up gradually and may not be apparent immediately. Please be aware that it may take up to 36 hours for concussion to manifest itself after a head injury

Useful contact numbers:

- Royal Surrey Hospital, Guildford (A&E) – 01483 571 122
- Haslemere Community Hospital (UTC) - 01483 956 500
- Walk in Centre - call 111

If you would like to contact the first aider, please dial 01428 601800

Kind regards,

Maxine Baker

First Aider

NHS Head Injury Advice Sheet
https://what0-18.nhs.uk/application/files/8815/8643/3598/CS45385_NHS_Head_Injury_advice_sheet_April_20.pdf

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APPENDIX 5 – HEAD INJURY PROCEDURE AND CHECKLIST

This procedure must be used by First Aiders when assessing and treating all head injuries in school. This procedure will be used to determine the appropriate course of action based on the circumstances and symptoms displayed.

Bump To Head	A bump to the head is common in children. If a child is asymptomatic ***i.e.,*** there is no bruising, swelling, abrasion, mark of any kind, dizziness, headache, confusion, nausea or vomiting and the child appears well then, the incident will be treated as a 'bump' rather than a 'head injury'.

Bump to Head protocol:

Anyone who has suffered a Head injury must be assessed by a competent First aider, who will be using the Head Injury Checklist.

The First Aider must observe the injured person for a minimum of 15 minutes. If the person begins to display head injury symptoms, they will be referred to the emergency services for further assessment and medical support. If there are no changes / symptoms during observation period, then student / staff can return to normal lessons.

First Aider must inform the teacher / colleague, who will continue to monitor the injured person, and notify the First Aider if notices any changes in their conditions / have any concerns.

- Campus must record the incident on the OSG UK Online Safety Portal (DoneSafe).

Minor Head Injury	**A minor head injury often just causes lumps or bruises on the exterior of the head. Other symptoms Include:** • Nausea • Mild headache • Tender bruising or mild swelling of the scalp • Mild dizziness

Minor Head Injury Protocol

Anyone who has suffered a Head injury must be assessed by a competent First aider, who will be using the Head Injury Checklist.

Contact parent to notify of head injury and communicate plan of action.

- **Rest**
- **Observation** – Complete observation checklist and repeat every 15 minutes until the child feels better or is collected by a parent/carer
- If the injured person's symptoms subside, they may return to class / work.
- Parent should be initially informed of their child injury by phone, requesting they read the Head Injury Advice letter sent to their attention by email and letter though student on their way home (appendix 4).

First Aider must inform the teacher / colleague, who will continue to monitor the injured person, and notify the First Aider if notices any changes in their conditions / have any concerns.

If, at any point, the student's condition deteriorates and shows any of the symptoms of a severe head injury, follow the protocol in the **severe head injury section below.**

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Severe **Head Injury**	**A severe head injury will usually be indicated by one or more of the following symptoms:** • Unconsciousness briefly or longer • Difficulty in staying awake • Seizure • Slurred speech • Visual problems including blurred or double vision • Difficulty in understanding what people are saying/disoriented • Confusion (Rule out signs of confusion by asking them the date, where they are, what year group they are in, etc.) • Balance problems • Loss of power in arms/legs/feet • Pins & needles • Amnesia • Leakage of clear fluid from nose or ears • Bruising around eyes/behind ears • Vomiting repeatedly • Neck pain **These are signs of a severe head injury – follow the Severe head injury protocol.** **Also, if the student has either of these conditions, follow the severe head injury protocol:** • If the Student has had brain surgery in the past • If the student has a blood clotting disorder
Severe Head Injury Protocol	

- If unconscious, you should suspect a neck injury and do not move the student
- CALL 999 FOR AMBULANCE
- Notify parent asap (call all telephone numbers and leave a message). Repeat every hour
- If the ambulance service assesses the pupil over the phone and determine that no ambulance is required, student is to be sent home.
- Parent informed by phone, requesting they read the Head Injury Advice letter sent to their attention by email and though student on their way home (appendix 4).
- Head Injury advice sheet (appendix 4) to be given to pupil
- Campus must record the Accident on the OSG UK Online Safety Portal (DoneSafe).

.....

- On return to school, the Campus Principal or delegated member of staff must liaise with parent to determine the nature of PE activities to be allowed.
- Campus Principal or delegated member of staff must then liaise with PE teacher and inform of arrangements/agreement made with parents. It is ultimately the parent's responsibility to sign-off the child's return to PE/sports activities.

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Concussion (Post-Concussion Syndrome)	**Concussion is the sudden but short-lived loss of mental function that occurs after a blow or other injury to the head. It is the most common but least serious type of brain injury and can occur up to 3-days after the initial injury.** **The cumulative effects of having more than one concussion can be permanently damaging. Concussion must be taken extremely seriously to safeguard the long-term welfare of the person.** **Symptoms include:** • Headache • Dizziness • Feeling in a fog • May or may not have lost consciousness • Vacant expression • Vomiting • Unsteady on legs • Slow reactions • Inappropriate or abnormal emotions – irritability/nervous/anxious • Confused/disorientated • Loss of memory of events leading up to and after the concussion

Concussion (Post-Concussion Syndrome) **Protocol :**

If you notice any of these symptoms in a student who has previously sustained a head injury, they may be suffering from post-concussion syndrome and should be referred to the First Aider immediately.

If any of the above symptoms occur, the student must be seen by a medical professional in A&E, minor injuries, or the GP surgery. If a parent is not able to collect the child, call 999 and inform parent.

Guidance to be followed from World Rugby on Return to Play after Concussion (Appendix

6) - For all severe head injuries, not limited to rugby injuries.

This gives clear guidance on students returning to academic studies and sport following a Concussion.

- On return to school, the Campus Principal or delegated member of staff must liaise with parent to determine the nature of PE activities to be allowed.
- Campus Principal or delegated member of staff must then liaise with PE teacher and inform of arrangements/agreement made with parents. It is ultimately the parent's responsibility to sign-off the child's return to PE/sports activities.
- Campus must record the Accident on the OSG UK Online Safety Portal (DoneSafe).

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APPENDIX 5B – HEAD INJURY CHECKLIST FOR FIRST AIDERS

Minor head injury symptoms - assess the child for signs of the following:

- Nausea
- Mild headache
- Tender bruising or mild swelling of the scalp
- Mild dizziness

These are signs of a minor head injury – follow the Minor head injury protocol
If no symptoms – follow Bump to Head protocol

Severe Head Injury symptoms – assess the child for signs of the following:

- Unconsciousness briefly or longer
- Difficulty in staying awake
- Seizure
- Slurred speech
- Visual problems including blurred or double vision
- Difficulty in understanding what people are saying/disoriented
- Confusion (Rule out signs of confusion by asking them the date, where they are, what year group they are in)
- Balance problems or loss of power in arms/legs/feet
- Pins & needles
- Amnesia
- Leakage of clear fluid from nose or ears
- Bruising around eyes/behind ears
- Vomiting repeatedly
- Neck pain

These are signs of a severe head injury – follow the Severe head injury protocol
If the Student has either of the following, treat the injury with the Severe Head Injury Protocol and call 999 immediately:

- If the Student has had brain surgery in the past
- If the Student has a blood clotting disorder

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APPENDIX 6 – UK CONCUSSION GUIDANCE AND AFPE CONCUSSION RECOGNITION MATERIAL

Health & Safety Update – March 2021

Concussion is the topic for the March Health & Safety Update. Why? There has been a number of media items during the first part of 2021 on this subject area, and we thought it would be worth focusing on a PESSPA context.

Repetitive minor trauma to the head, where the brain is shaken against the inside of the skull, is known to have potential dangers at the time of injury and in later life. Concussion is a form of minor brain trauma that is now receiving more serious attention and consideration than before.

In sports where there is a known risk of concussion the degree and quality of guidance provided by governing bodies of sport and the medical profession has improved significantly. The diagnosis and treatment for concussion at the elite level of sport now has a high profile with frequent reports of elite performers in a broad range of sports having been concussed. Concern does remain about the possible misdiagnosis or inadequate treatment of concussion at school, college and out of school hours learning.

afPE is working closely with a number of National Governing Bodies to ensure Physical Education and School Sport is part of the discussion and members concerns are shared.

We know from queries that there are members who are in the process of reviewing policy documentation on concussion and have asked for support. If you need to update your policy, select from the list below and add/ amend where appropriate for your establishment.

We hope the following is of use.

If schools already have protocols and procedures for head injuries as part of their whole-school first aid and emergency treatment procedure, including guidance regarding concussion, a separate procedure is not required. However, subject leaders should check that this procedure covers specific guidelines about concussion in PESSPA contexts.

As a staff team are you aware of the signs, symptoms, treatment and policy development that is so important for safe participation in a wide range of activities including non- contact sports?

Where this is not the case, the following information and the suggestions listed below may be of use when updating local PESSPA procedures:

- understand that symptoms can be delayed for up to 48 hours, and recognise the need for monitoring anyone with possible concussion over that period
- know how to recognise, assess and treat possible concussion injuries - a copy of the pocket concussion recognition tool for all staff would be helpful https://bjsm.bmj.com/content/bjsports/47/5/267.full.pdf
- understand what second impact syndrome (SIS) is and how critical it is that such situations are avoided
- ensure staff knowledge and understanding about concussion is current through regular updates as part of ongoing health and safety training for all staff.
- risk assess where injuries likely to cause concussion symptoms may arise within their individual teaching, supervision or management contexts
- record any and all possible concussion occurrences within a whole school register of incidents
- ensure parents are made aware of any such situation their child has experienced through a robust whole school reporting system

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- be in a position to advise parents that recreational activities such as prolonged reading, television, computers, video games, smartphones, exercise and sport should be avoided until a gradual return to full health is achieved
- follow up post-incident, within established whole school procedures
- ensure that parents are aware that it is a parental responsibility to obtain confirmation from a recognised medical source that their child is fit to participate in a gradual return to full learning and activity sessions
- embed in the curriculum students' understanding about concussion, how it may occur, how it may be recognised, and what safe practice outcomes are essential to mitigate such an injury.
- communicate with other staff who teach a student who has been diagnosed as being concussed so that this is taken into consideration in lessons, with any impact on studies noted and referred if necessary
- be aware that concussion will impact on academic learning and that adjustments need to be made during convalescence and a gradual return to full involvement in school activities, an example may be applying a 'no homework' rule.
- apply the whole-school first aid procedure at all times

- above all else, ensure that the well-being and safety of students is paramount

For further advice including a Summary Table providing guidance on recognising, managing and treating concussion in PESSPA please refer to 2.7.119, page 117 in **Safe Practice in Physical Education, School Sport and Physical Activity (2020).**

Find out more and order a copy of this essential reference and development tool for everyone involved in PESSPA at: http://www.ukcoaching.org/safepractice
afPE Health & Safety Team

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AFPE – POCKET CONCUSSION RECOGNITION TOOL

Pocket CONCUSSION RECOGNITION TOOL™

To help identify concussion in children, youth and adults

RECOGNIZE & REMOVE

Concussion should be suspected **if one or more** of the following visible clues, signs, symptoms or errors in memory questions are present.

1. Visible clues of suspected concussion

Any one or more of the following visual clues can indicate a possible concussion:

Loss of consciousness or responsiveness
Lying motionless on ground/Slow to get up
Unsteady on feet / Balance problems or falling over/Incoordination
Grabbing/Clutching of head
Dazed, blank or vacant look
Confused/Not aware of plays or events

2. Signs and symptoms of suspected concussion

Presence of any one or more of the following signs & symptoms may suggest a concussion:

- Loss of consciousness
- Seizure or convulsion
- Balance problems
- Nausea or vomiting
- Drowsiness
- More emotional
- Irritability
- Sadness
- Fatigue or low energy
- Nervous or anxious
- "Don't feel right"
- Difficulty remembering
- Headache
- Dizziness
- Confusion
- Feeling slowed down
- "Pressure in head"
- Blurred vision
- Sensitivity to light
- Amnesia
- Feeling like "in a fog"
- Neck Pain
- Sensitivity to noise
- Difficulty concentrating

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3. Memory function

Failure to answer any of these questions correctly may suggest a concussion.

"What venue are we at today?"
"Which half is it now?"
"Who scored last in this game?"
"What team did you play last week/game?"
"Did your team win the last game?"

Any athlete with a suspected concussion should be IMMEDIATELY REMOVED FROM PLAY, and should not be returned to activity until they are assessed medically. Athletes with a suspected concussion should not be left alone and should not drive a motor vehicle.

It is recommended that, in all cases of suspected concussion, the player is referred to a medical professional for diagnosis and guidance as well as return to play decisions, even if the symptoms resolve.

RED FLAGS

If ANY of the following are reported then the player should be safely and immediately removed from the field. If no qualified medical professional is available, consider transporting by ambulance for urgent medical assessment:

- Athlete complains of neck pain
- Increasing confusion or irritability
- Repeated vomiting
- Seizure or convulsion
- Weakness or tingling/burning in arms or legs
- Deteriorating conscious state
- Severe or increasing headache
- Unusual behaviour change
- Double vision

Remember:

- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Do not attempt to move the player (other than required for airway support) unless trained to so do
- Do not remove helmet (if present) unless trained to do so.

from McCrory et. al, Consensus Statement on Concussion in Sport. Br J Sports Med 47 (5), 2013

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Br J Sports Med: first published as on 11 March 2013. Downloaded from http://bjsm.bmj.com/ on April 19, 2022 by guest. Protected by copyright.

APPENDIX 7 – DEFINITIONS OF INCIDENT, ACCIDENT AND DANGEROUS OCCURRENCE

Term	Definition
Accident / incident	Any unplanned event that results in injury or ill-health to people involved in activities, or damages equipment, property or materials where there was a risk of harm.
Minor injury	Any minor injury such as a scratch, bruise, minor cut or grazing.
Injury	Any injury or ill-health arising out of, or in connection with, a work activity, excluding minor injury.
Near miss	Any incident that could have resulted in injury, damage or loss but did not on this occasion.
Dangerous occurrence	A specified near-miss event listed in Schedule 2 to RIDDOR 2013, or the corresponding Northern Ireland regulations where applicable.
Verbal and physical assault	Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work.
Road traffic incident	Any incident causing injury or damage to a person, animal, vehicle or property while driving for work. This does not include commuting. It applies when driving for a work activity and covers OSG vehicles, hired vehicles and personal vehicles used for work.
Environmental incident	Any incident that solely impacts the environment, such as discharge to drainage, flora or fauna damage, or spillages.
First Aid	Immediate assistance or treatment given to someone injured or suddenly unwell before professional medical help is available.
First Aider	A member of staff who has completed a recognised first aid course and holds a valid certificate appropriate to their role.
AED	Automated External Defibrillator.
DoneSafe	The OSG UK online safety portal used for recording incidents, accidents, near misses, actions and assurance records.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

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APPENDIX 8 – EMBEDDED FIRST AID VISUALS AND DISPLAY MATERIALS

Appendices and visuals are operational aids and reference materials. They support consistent campus implementation but do not override the controlled First Aid Procedure, the First Aid Policy or any applicable legal or regulatory requirement. Where an appendix, template or visual aid appears to conflict with the controlled procedure or policy, the controlled procedure and policy take precedence.

Visual / display material	Relevant appendix / use
First Aid Notice	Appendix 1 – First Aid Notice 
Head Injury Parent Letter and NHS guidance	Appendix 4 – Head Injury Parent Letter and NHS Guidance

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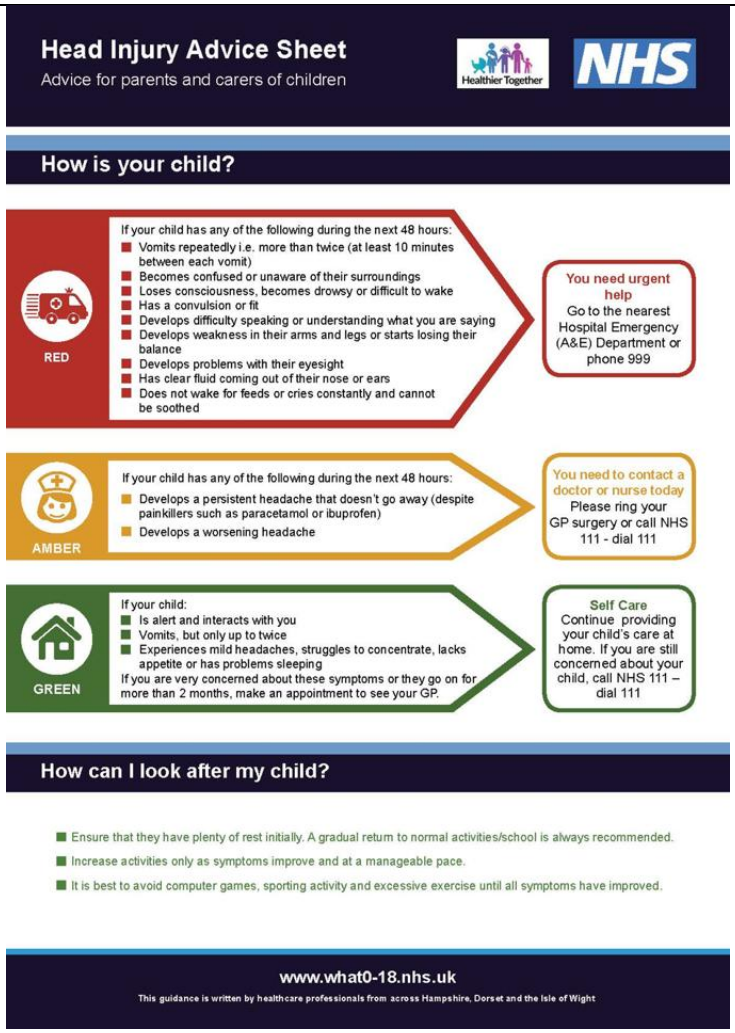
Head Injury Advice Sheet
Advice for parents and carers of children
Healthier Together
NHS
How is your child?
RED
If your child has any of the following during the next 48 hours:
Vomits repeatedly i.e. more than twice (at least 10 minutes between each vomit)
Becomes confused or unaware of their surroundings
Loses consciousness, becomes drowsy or difficult to wake
Has a convulsion or fit
Develops difficulty speaking or understanding what you are saying
Develops weakness in their arms and legs or starts losing their balance
Develops problems with their eyesight
Has clear fluid coming out of their nose or ears
Does not wake for feeds or cries constantly and cannot be soothed
You need urgent help
Go to the nearest Hospital Emergency (A&E) Department or phone 999
AMBER
If your child has any of the following during the next 48 hours:
Develops a persistent headache that doesn't go away (despite painkillers such as paracetamol or ibuprofen)
Develops a worsening headache
You need to contact a doctor or nurse today
Please ring your GP surgery or call NHS 111 - dial 111
GREEN
If your child:
Is alert and interacts with you
Vomits, but only up to twice
Experiences mild headaches, struggles to concentrate, lacks appetite or has problems sleeping
If you are very concerned about these symptoms or they go on for more than 2 months, make an appointment to see your GP.
Self Care
Continue providing your child's care at home. If you are still concerned about your child, call NHS 111 – dial 111
How can I look after my child?
Ensure that they have plenty of rest initially. A gradual return to normal activities/school is always recommended.
Increase activities only as symptoms improve and at a manageable pace.
It is best to avoid computer games, sporting activity and excessive exercise until all symptoms have improved.
www.what0-18.nhs.uk
This guidance is written by healthcare professionals from across Hampshire, Dorset and the Isle of Wight

<table>
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<tr><td>Head Injury Procedure and Checklist</td><td>Appendix 5 and Appendix 5B – Head Injury Procedure and Checklist</td></tr>
<tr><td>UK Concussion Guidance and AFPE material</td><td>Appendix 6 – UK Concussion Guidance and AFPE Concussion Recognition Material</td></tr>
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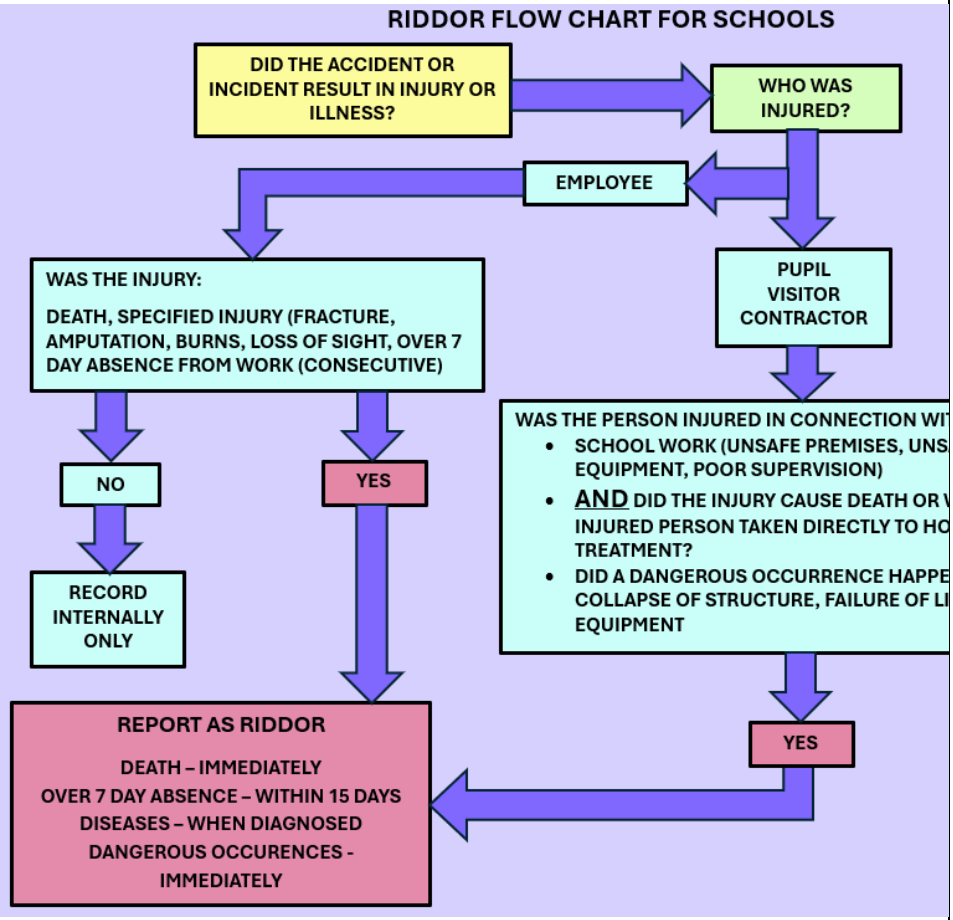
Appendix 7 Reporting of Injuries, Diseases and Dangerous Occurrences Regulation (RIDDOR)



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