Safety Code of Practice 9

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INCIDENT REPORTING AND INVESTIGATION

Summary	This Code of Practice establishes the safety management arrangements for the notification and investigation of incidents that arise from activities under the control of the University of Reading.
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Contents

1 INTRODUCTION

Incident investigation is an important element within the University's overall health and safety system for improving risk management. The University is committed to a positive incident reporting culture that avoids apportioning blame, to better understand what happened, to improve risk control and prevent future reoccurrences of similar or worse events, to prevent unfair accusations, and to comply with the University's legal duties. Every incident therefore provides and an opportunity to learn and make continuous H&S improvement.

For incidents to be investigated properly the University must be notified about H&S incidents. Therefore arrangements must exist for staff, students and others to notify the University of incidents and for them to be allocated to trained investigators for a proportionate investigation. This Code of Practice sets out the safety arrangements Schools/Directorates must be follow to ensure incidents are notified to the University and investigated appropriately.

2 SCOPE

This Code of Practice applies to incidents with health or safety implications or consequences, arising from or involving University of Reading (UoR) work activities, equipment or materials, or on University controlled premises. It applies to road traffic incidents involving staff or students when travelling for work or study activity (i.e. not commuting), when undertaking study trips or fieldwork away from UoR premises and during work-related international travel. In all cases, incidents must be notified to Health and Safety Services (H&S Services) as soon as reasonably possible.

This Code of Practice does not apply to work activities or premises under the control of commercial or private tenants of UoR or within the Reading University Students Union building, unless the incidents involve UoR staff undertaking work activities on behalf of the UoR. It does not apply to construction sites on UoR land which are under the control of a Principal Contractor. University of Reading Malaysia follows the principles of this document but has separate local arrangements in place to reflect domestic legislation.

3 DEFINITIONS

Incidents. Are events where there has been a loss of control to create unsafe acts or conditions. This includes near-miss, accidents, dangerous occurrences, fire, and violence or aggressive behaviour at work.

Near-miss. An event that did not result in injury or damage but had the potential to cause harm if conditions had been different.

Accident. An unplanned event that results in harm: injury, lost time from work or studies by injuries, where first aid is used or an ambulance call-out has been required,

sporting injuries on UoR premises, injury while on fieldwork/fieldtrip or overseas, or occupational diseases/work-related ill health, or non-work-related ill health that requires assistance for the individual completing UoR related activities. These may include RIDDOR-specified incidents.

Dangerous occurrence. This is a loss of material containment, loss of control or other incident with a high potential to cause significant injury, loss of life, or damage to property or the environment. These will likely include RIDDOR-specified incidents.

RIDDOR. The Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013. This includes specified injuries, certain occupational diseases/work-related ill health that is confirmed by a physician, also specified dangerous occurrences. The HSE publishes a list of the current RIDDOR reporting incident types.

Investigation recommendations arise from the investigation process with purpose to reduce the likelihood of incident reoccurrence and the severity of reoccurrence. The actions should be clearly defined to specified individuals and prioritised based on the significance of the risk reduction outcomes.

4 RESPONSIBILITIES

All staff and students are responsible for:

- notifying the University of H&S incidents involving staff/students/visitors using the online notification system
- informing managers/academic supervisors or others as appropriate of all incidents which have occurred during work activities (on or off campus) as soon as reasonably possible.
- **communicating any significant incidents to the Head of School/Directorate and H&S Services immediately (extn. 8888).**

Heads of School/Directorate are responsible for:

- ensuring staff and students understand how to notify the University of a H&S incident using the online notification system
- ensuring that a Health and Safety Coordinator (HSC) is appointed for undertaking incident investigations, and communicate any appointment changes promptly to H&S Services.
- allowing HSCs sufficient time from their duties to complete their investigation training, and to investigate incidents and complete investigation reports.
- ensuring HSCs are able to attend the local H&S committee to discuss incidents.

Following an allocation HSCs are responsible for:

- making initial enquiries to consider if an investigation is appropriate, and then investigate proportionately to the severity and risk of reoccurrence.
- alerting H&S Services if an incident may possibly be a RIDDOR-reportable event.
- communicating their investigation findings and recommendations to those best-placed to action improvements.
- using the University template incident investigation report form, unless a minor incident, in which case an email summary is acceptable.
- communicating their investigation findings to their H&S Services Business Partners (HSBP) or H&S Service Advisor (HSA) within 14 days of receiving the incident allocation.
- managing any sensitive personal information in accordance with the University's rules on data security and protection.

Chairs of local H&S committees are responsible for:

- including an incident section when setting their committee agenda (Safety Note 79), and ensure incident information and discussions are anonymised
- reviewing the incident notifications and monitor the completion of implementing the investigation recommendations. This can be assisted by using the local Committees action tracker tool available on the H&SS website.
- resolving any disagreements on investigation recommendations, and ensure the decision is clearly recorded in the committee minutes.
- escalating to the University Health & Safety Committee (UH&SC) secretary any recommendations that cannot be locally resolved by working in partnerships with other University Schools/Directorates (e.g. Estates, Technical Services).

H&S Services are responsible for:

- developing and maintaining the online incident notification system
- updating and publishing the incident allocation procedure, and then allocate incidents according to the allocation procedure (allocating only to trained HSCs and H&SS staff).
- providing advice to HSCs during investigations through the HSBP or HSA
- deciding which incidents the University is legally required to report and will submit the University's RIDDOR or other reports to relevant enforcement agencies.
- providing information to support Legal Services, Procurement and the University's insurers in responding to legal claims.

- liaising with the Major Incident Team (MIT) on progressing any H&S investigations, and assisting the Serious Incident Review (SIR) process.
- ensuring HSCs have access to incident investigation training as soon as reasonably possible following their appointment.

Human Resources are responsible for:

- liaising with Trade Union Safety Representatives carrying out inspections following a RIDDOR-reportable incident.

5 REQUIREMENTS

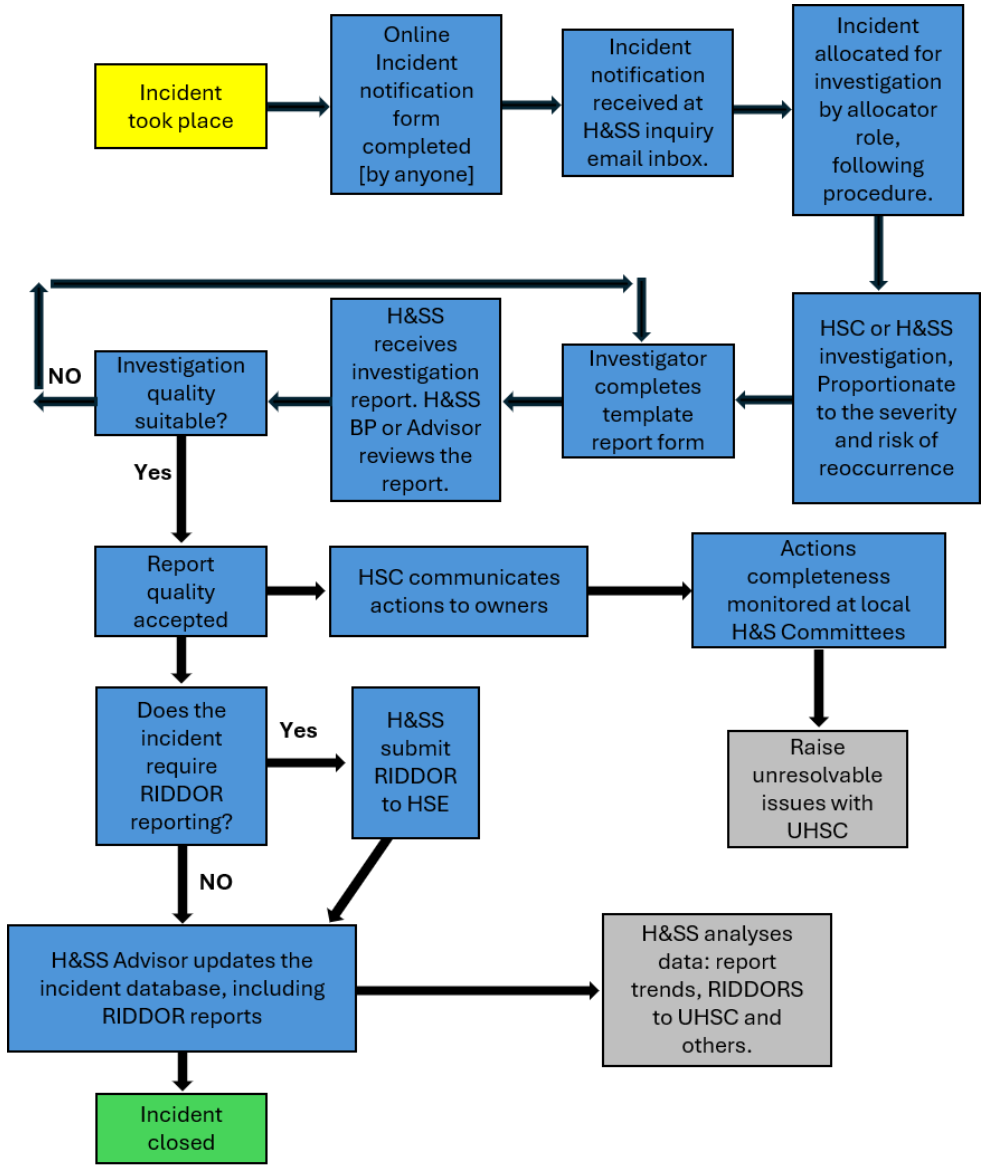

Figure 1. The overall requirements of the incident management process. Further details in sections 5.1-5.2.

5.1 Reporting

5.1.1 Reporting in General

All H&S incidents can be reported by anyone using the online notification system as soon as reasonably possible. Individuals directly involved are strongly encouraged to notify with good detail to initiate an appropriate response. When individuals are unable to complete a notification (e.g. sustained loss of time from work), notification must be completed by their manager/academic supervisor or next of kin. If the online system cannot be used, a template word document form can be made available from safety@reading.ac.uk.

Incidents may additionally be communicated locally to HSCs for prompt information sharing to ensure the immediate situation is safe and to gather any time sensitive information for subsequent investigation purposes (for example spillages, damaged equipment).

5.1.2 Reporting for Peripatetic Workers

Incidents involving peripatetic staff who routinely work in many different areas of the University (maintenance staff, cleaners, porters, delivery drivers, etc) should be notified to H&S Services but also reported to their managers. Managers of peripatetic staff should communicate directly with other staff or managers if there are any uncontrolled hazards that need immediate remedial action to make the situation safe.

5.1.3 Reporting for Events

Any incidents during organised events must be notified to H&S Services by the event organiser or the event safety coordinator. This should include any injuries, serious near-misses or dangerous occurrences, or where significant H&S complaints have been made by attendees, contractors, or local residents. Any remedial action taken should be recorded and reported to the relevant University departments. This includes H&S Services via the incident investigation report, but may also include directly with Estates, Campus Commerce/Events Team/Venue Reading, External Relations, Security (especially for out-of-hours events).

5.1.4 Reporting for International Travel

Incidents during overseas travel must be assessed by the travel group leader (or individual travelling) for when to stop activities or to leave a location, following the latest FCDO guidance. **In an emergency the leader should contact the University's current travel insurance provider**. Full details of emergency repatriation, medical assistance and funds are found in section 5 of the Overseas Travel COP-38. When safe to do so contact the University Security service (+44 (0)118 378 6300) who will contact the of Head of School/Directorate to update them of the situation. Heads should then arrange for a colleague to notify the incident to H&S Services as soon as possible.

5.1.5 Reporting for Agency, Contractor or Self-Employed Workers

Incidents involving agency staff, contractors, delivery drivers, salespersons, etc, working on University premises, should still be notified to H&S Services using the online notification process, even though formal responsibility for RIDDOR-reporting may in some cases rest with the employer of the person concerned. H&S Services will RIDDOR-report applicable incidents involving agency staff, where that has been agreed as part of the agency placing.

5.1.6 Fatalities and Serious Incident Review

In the event of a fatality involving anyone on UoR-controlled premises, Security must be contacted immediately on 0118 378 6300 who will assist in coordinating the emergency service response. This is an addition to any direct contact made with the emergency services. The incident scene must not be disturbed, unless essential to rescue or provide first aid to other casualties. In the event of a student fatality, Security must follow the deceased student policy. In all fatalities, Security must also inform H&S Services .

In accordance with the Major Incident Plan (MIP), Security may brief a Strategic Lead to consider activating the MIP and initiating a Major Incident Team (MIT). H&SS will assist the MIT and the SIR according to the SIR procedure (restricted access document). H&S Services will investigate if the death was UoR work-related and will report the fatality to the relevant enforcing agencies (HSE for RIDDOR) if applicable, parallel to any other police or MIT activity. For all deceased persons incidents, H&S Services may attend (but not speak) at related Coroner's Court hearings. All other attendance at such hearings should be agreed through Legal Service.

5.2 Incident Investigation

The primary purpose of incident investigation is to reduce the likelihood or severity of future reoccurrence by identifying and communicating improvement recommendations.

The investigation should:

- provide reassurance that notified incidents will be investigated
- promote a positive H&S culture of continuous H&S improvement
- be proportionate to the severity of the incident and likelihood of reoccurrence
- establish the facts about what happened
- determine the immediate and underlying/root causes.
- specify the improvement recommendations, who is best placed to achieve them, and at a timescale proportionate to the risk (e.g. immediately, next month, etc).
- satisfy legal compliance and to provide information for any futures claims.

To achieve these outcomes, the University requires that the investigator (HSCs or H&SS staff) will make initial inquires to establish what caused the incident, and as appropriate to the incident, confirm that the situation has been made safe. Further

investigation may be required to assess if risks were suitably controlled (underlying causes) and to establish the suitability of the managerial arrangements (root causes).

The investigation may require:

- a visit to the scene, taking photographs and measurements, request documents
- to sensitively conduct interviews with the injured person(s) and any witnesses
- to review the suitability and implementation of existing risk controls (e.g. PPE available and used, the frequence of equipment maintenance)
- to identify if any job role factors have contributed to the incident (e.g. timing of activities, familiarity of the location/equipment)
- to identify if any human factors have contributed to the incident (e.g. workload, fatigue, changes in health, equipment and workplace design, communication)
- to establish if enhanced control measures are required
- to establish if further training is required

The investigator (HSCs or H&SS staff) should then record their investigation findings, including the improvement recommendations, and then communicate the recommendation those identified in the report. A copy of the report must be communicate to H&SS for completing the incident management process. The HSBP or HSA may advise or assist HSCs during the investigation, or may resume responsibility or appoint an external specialist to complete the investigation.

6 COMPETENCE

The training requirements for HSC role and their ongoing competence are published on the H&SS HSC website. HSBPs and HSAs will also provide investigation feedback to HSCs to support their on-going learning.

7 REVIEW & AUDIT

HSBPs or HSAs will review incidents for investigation completion and to identify possible themes or trends. H&S Services will provide a regular summary of notable incidents and themes or trends to the UH&SC and for inclusion in the University's Annual H&S Assurance Report.

8 RECORDS & RETENTION REQUIREMENTS

H&S Services is responsible for maintaining records of incidents notified to them for at least 5 years. Records of RIDDOR-reported incidents will be retained by H&S Services. Reports of occupational ill health or personal exposure to harmful substance should be retained for 40 years after the last incident in line with regulation 10 of COSHH 2002 (ACOPs L5 6th edition 2013).

9 RELEVANT LEGISLATION

Health and Safety at Work etc. Act 1974
Management of Health and Safety at Work Regulations 1999
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
Control of Substances Hazardous to Health Regulations 2002 (as amended)
Safety Representatives and Safety Committees Regulations 1977 (as amended)

10 REFERENCES

1). H&S Services online incident notification webpage

2). HSE RIDDOR webpages

APPENDICES A – INVESTIGATION DETAILS

Obtain the facts

- Date and time of incident.
- Name(s) and contact details of injured/affected person(s), age, gender, occupation/course of study.
- The nature of the injury (size, position, location, e.g. 2cm cut to right thumb) / ill health / assault / property damage sustained, details of treatment received (also if by/not by trained first aider), hospital attended, length of stay, length of absence from work/study, if normal duties could not be undertaken on return to work,
- Location details (building, room number) and layout of the area in which the incident occurred or photographs and room diagrams, the use of any access controls.
- Details of witnesses / people first on the scene of the incident / first aiders who attended.
- Condition and description of plant or equipment involved (before and after the incident) - including make, model, serial number, safety devices provided etc.
- If appropriate, take photographs, draw sketches and take measurements to record the scene of the incident before things are moved, repaired and cleaned up. The University may need this evidence later.
- If investigating a report of ill-health or exposure to hazardous substances, obtain Safety Data Sheets if they are not already available and request copies of risk assessments, record the type and availability of PPE at the scene, if applicable RPE face-fit testing records and the maintenance records of LEV systems, waste procedures and work/shift pattern records.
- Names, contact details of any contractors involved, you may need to contact them later.

Establish the circumstances of the incident

- Events leading up to the incident.
- What was being done at the time, was this unusual or different from normal?
- What were the immediate causes of the incident – how did it happen?

- If investigating a case of disease or ill health, is there any evidence linking this to work activities? Request a list of workplace duties and the associated risk assessments.
- What established methods or operating procedures were given to those involved before the incident?
- Did those involved carry out the received training/instructions prior to the incident?
- What was the behaviour and actions of individuals before, during and after the incident?
- What was the role of supervisors and managers in the activities concerned?

Identify the underlying causes of the incident

There is often far more to accidents than simply unsafe acts by individuals or unsafe conditions, you need to consider why the circumstances leading to the incident occurring and went unnoticed and unchecked. How did things get this far? Consider the following:

- If there was human error dig deeper to understand what human factors may have contributed to this error – e.g. lighting, distraction, contradictory instructions, bullying, poor ergonomics, poor design of the human/machine interface, etc
- Has anything similar happened before? Ask H&S Services to check the incident records, ask colleagues in the incident area.
- Has the problem been mentioned before, when, by whom, what action was taken?
- Was this risk known and had a risk assessment been completed for this activity / substance / these premises, is it suitable and sufficient? When was it last reviewed?
- Were University or local guidelines, policies or rules being followed?
- What control measures and safety equipment were identified by the risk assessment – are they still in place and effective (were the individuals doing the work aware of these)?
- Are any management or supervision failures evident?
- Was communication between the relevant parties adequate and effective?
- What was the level of competence of those involved – including the nature of any training, instruction or information provided, was it adequate?
- Are there any shortcomings in the original installation or design, if relevant?
- Were adequate performance standards set and monitored by management?
- Was there an adequate system for maintenance and cleaning of premises or equipment?
- Were systems of work that individuals were expected to follow actually being followed in practice? were these systems workable and realistic (if not, why not?)
- Was suitable PPE provided, was it effective (if not, why not?)
- Is record keeping adequate?

Establish whether the initial emergency and management response was adequate

- Was the initial response to the incident by the University prompt and effective? Consider the actions taken to make the situation safe, or to deal with any continuing risks.
- Was the response to the incident by the Emergency Services or other external agencies, prompt and effective?
- Was the fire fighting and first aid response suitable, were correct spillage procedures known and followed?
- Was the incident promptly reported to the relevant parties (if not, why not)?
- How was the injured person treated and supported –was this adequate?
- Were the needs of witnesses adequately addressed (de-briefing, counselling etc)?

Identify and record any further action needed to prevent a recurrence or improve future emergency preparedness or response

You should assess or reassess the risks of this particular activity / equipment / area. When doing this you should question the adequacy of existing control measures and work methods and any discrepancy between these and what was intended. You will need to establish if the existing controls meet current standards and are adequate to effectively control risks.

In particular, you may need to:

- Improve physical safeguards or safety features or modify design or workplace layout.
- Improve existing work methods or introduce new safe working procedures.
- Provide additional safety equipment e.g. lifting aids, personal protective equipment.
- Produce or review risk assessments.
- Update written health & safety rules, standards or policies, communicate these to employees / students, as appropriate.
- Improve communications systems.
- Make changes to or provide extra training, supervision or information sources.
- Introduce better testing, maintenance or cleaning arrangements.
- Introduce or improve inspection, monitoring and audit systems.
- Review similar risks in other sections.

Once you have identified what is required to prevent a recurrence of the incident in question, the investigator should communicate recommendations to those best-placed to effect improvement, making it clear what is required and by when. Those persons should formulate an action plan.

Lessons learnt should be shared with other groups carrying out similar activities within the School/Directorate, or more widely across campus.

Remember:

- Always try to talk to the injured person and witnesses to get their account of events
- Verify the facts – do not make assumptions about what happened

- Try not to apportion blame, but to learn from mistakes, so as to continually improve health and safety standards