University of Worcester

Safety Code of Practice **SCoP 09**

INCIDENT REVIEW

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1. BACKGROUND

1.1 Why Investigate?

SCoP 06 Reporting Incidents, Diseases and Near Misses describes the procedures to be followed when reporting certain incidents. The University of Worcester recognises the importance of fostering a culture of incident reporting as this has a significant impact on safety management. Once reported, there is then a need to investigate incidents for the following reasons:

- Make safe any unsafe activities/situations and to prevent any recurrence
- Identify the immediate and underlying causes
- Consider the circumstances causing the incident to enable management to identify any improvements or necessary changes to the existing safety management system relating to:
    a. Safe systems of work
    b. Risk assessments and other documentation
    c. Training
    d. Communication
    e. Provision of safety equipment and clothing
- Enable a decision to be made as to whether the incident needs to be reported to HSE
- Refer any significant incidents to the University of Worcester insurers
- Share lessons learnt with colleagues
- Ensure compliance with any legal requirements
- Identify higher risk activities, or those causing the greatest number of incidents
- Maintain the high standards as set out in the University of Worcester Health and Safety Policy and to protect the reputation of the University

1.2 Which Incidents Should be Reviewed?

As a general rule, all incidents, injuries, near misses and dangerous occurrences should be investigated to address some, if not all of the points in 1.1 above. The more complex or serious the issue, the more detailed the investigation/review should be. In any event, the line manager locally (or equivalent) should always review the incident to ensure safety. For the more serious incidents (see 1.3), Safety Services will direct that certain incidents are reviewed more formally with findings and an Action Plan set out in the form IRF1 (see Appendix 1)

1.3 Who Should Review the Event?

Conducting an incident review does not need to be a complex and onerous exercise. A lot of the time, it is a case of applying simple common sense and the following will provide guidance and pointers towards the issues that need to be considered. On that basis, any person will be perfectly capable of conducting a review and this SCoP will provide guidance. However, for the more complex issues a review will need to be more detailed but there will always be support provided by Safety Services. In some cases, Safety Services will conduct the review from the outset. In any event, once a notification has been received a decision will be made by Safety Services as to firstly, is a formal review needed and if so, who will carry it out. For further guidance see Appendix 2.

2. PRACTICAL INCIDENT REVIEW

2.1 Establish the Basics

When carrying out a review of an incident, dangerous occurrence or near miss, the following will help to guide the reviewer through this process. Initially, the following basic facts should be clarified

- Date, time and exact location of the incident
- Detailed account of exactly what happened. As a rule of thumb, the author should assume the reader knows nothing about the location/activity/individuals etc. and so provide as much detail as possible
- If the incident relates to a University employee, were they at work at the time? Were they performing a work related role? Were line managers aware of the activity and agree it was part of their regular job. Do they have any concerns about the incident?
- Details of the injured person (IP) where relevant to include name and contact details
- Details of any injury to include any first aid treatment given or visit to hospital (at this point it does not matter whether treatment was received at hospital – just whether they attended)
- For the more serious incidents, a list of witnesses should be compiled and the details of any other people first on the scene for example first aiders, staff, security etc. This should not be limited to University of Worcester staff but can include details of contractors and visitors where appropriate

2.2 Immediate vs Underlying Causes

Most incidents can be attributed to a failure of some kind and usually involve a failure to follow instructions, training and /or procedures etc. It is important to break down the components of failure into manageable parts and we do this by identifying the immediate case and underlying causes. Once we have done this, it is much easier to identify what action if any, needs to be taken to make safe any unsafe activities or scenarios.

The **immediate cause** is something that has obviously caused the incident/near miss or injury. For example, injury using a circular saw due to a missing guard. A person falling over an extended cable would be a trip, a person falling from a ladder would be a fall from height

Underlying causes, (there are normally more than one) are usually a combination of a number of factors that together result in the incident. For example, take the unguarded circular saw below, immediate cause could be a lack of guarding and underlying causes could include poor maintenance, poor training, a lack of risk assessment or no supervision. A review of an incident will identify the immediate and underlying causes and using these, a broader picture of the incident can be produced. Here is an example.

Member of staff was injured using a circular saw with a missing guard presenting a risk of injury. The guard had broken 2 days before and staff were instructed to use it, but told to be careful until it was repaired 'in house'. The IP had received training and a risk assessment was in place but did not include guarding and maintenance, just training. The immediate cause was contact with dangerous machinery due to the guard being missing. The incident review identified the following underlying causes, poor training provided to staff, poor maintenance arrangements and use of the circular saw was not subject to a suitable and sufficient risk assessment.

2.3 Additional Detail

Where appropriate the review should also include reference to the following.

- Details of any previous similar event to include outcomes and any action taken
- Any relevant history to the incident involving previous warnings being given or concerns being raised etc.
- What should the IP have been doing compared to what actually happened. This should be supported by documented evidence of a safe system of work. For example, looking at the circular saw incident, the IP may not have been following a documented procedure covering safe use of the equipment. It would not be enough to say that, the report would need to include a copy of the procedure to evidence it. Likewise, if the review concludes that training was not being followed, this also needs to be evidenced with a copy of the training that was provided and proof that the staff member attended
- Copies of all relevant documentation to include training records, documented assessments (risk, COSHH, noise etc.), safe systems of work, maintenance records and method statements
- If equipment was involved in the incident, you should include details e.g. serial number, model, make and photographs where possible. A description of the equipment post incident for example were guards in place, was it damaged etc.
- If chemicals have been involved in the incident, include copies of the Data Sheets and an explanation of how they were involved in the incident and copies of the COSHH assessment relating to the incident
- Where relevant to the incident, was PPE necessary, used and in good condition?

2.4 Notification

- Was the incident reported in accordance with SCoP 06, if not provide details?
- What was the immediate response at the time? Was it effective, timely and proportionate?
- Were emergency services called and if so, were there any issues with access etc? Was the information provided to emergency services adequate, were the correct procedures in place at the time and followed?

2.5 Action Plan

Following the review of the incident, consideration should be given to identifying any remedial action or improvements for the future. A simple way to look at it is to consider what should have happened compared to what actually happened. The Action Plan relates to narrowing the gap between the two.

In particular, it is important to prevent a recurrence and to ensure that any lessons learned are implemented in a timely manner. This may include:

- Reviewing competence issues and providing additional training
- Improving existing procedures and safe systems of work
- Reviewing and updating documented assessments relating to risk, COSHH, noise, legionella, manual handling, asbestos, working at height etc.
- Improve communication and coordination between departments/organisations/staff/contractors
- Recommend improvements in maintenance checks
- Implement a system of auditing procedures, or workplace inspections

For example, looking at the circular saw incident, there is clearly a reason why the guard was missing. The Action Plan for this incident may include:

a. Implement a system of user checks on a daily basis

b. Provide update training for all users using this incident as a basis to highlight the importance of inspection and safe use
c. Update the risk assessment relating to use of the circular saw
d. Review and update the safe system of work for all users
e. Engage the services of a competent external contractor to carry out regular maintenance checks of the circular saw – frequency to be determined

It is important to be clear about who takes ownership of implementing the Action Plan with specific dates set out for completion. The Action Plan will be considered by Safety Services and guidance provided where additional measures are required or where the deadline needs adjusting.

2.6 **Sign Off**

The person conducting the review should sign and date it, this should then be referred to their line manager to add comments, sign and date. The Head of Department should then review the document making any necessary comments before referring to Safety Services. The purpose of this is so that each Department can take ownership of any health and safety related issues and ensure that they are addressed locally.

The Head of Safety Services will then review the document ensuring that the issue has been thoroughly reviewed, the findings are reasonable and the Action Plan addresses the findings and is achievable. There may be occasions when Safety Services direct that additional measures are needed and this will be in discussion with all relevant parties.

To ensure that the notification can be processed in good time, it is important that where possible, the review is conducted and the completed form returned to Safety Services within **3 days**.

As always, Safety Services will provide support and assistance where requested.

3. APPENDIX 1 INCIDENT REVIEW FORM IRF 1

This form should be used if you have been asked to conduct a review of an incident, accident or near miss and should be completed within **3 days** of the request. It is important that you provide as much detail as possible so that the incident can be processed and the appropriate action taken.

Please note the ACTION PLAN needs to be completed for all proposed actions following the review and this will be used to monitor post incident actions.

For further information please contact Safety Services (safety@worc.ac.uk).

<table>
<tr><td>Notification Reference
From notification</td><td colspan="2"></td><td>Incident Date</td><td></td><td>Time</td><td></td></tr>
<tr><td>Completed by</td><td colspan="2"></td><td>Signed</td><td></td><td>Dated</td><td></td></tr>
<tr><td>Description
Provide as much info as possible to describe what happened</td><td colspan="6"></td></tr>
<tr><td>Findings
To include immediate and underlying causes. Set out any proposals in the Action Plan</td><td colspan="6"></td></tr>
<tr><td>Learning Points
Are there any issues that are relevant to the University and may need further investigation?</td><td colspan="6"></td></tr>
<tr><td rowspan="2">Management Comments
Agree the findings and Action Plan and comment on how the Action Plan will be implemented.</td><td colspan="6"></td></tr>
<tr><td>Signed</td><td colspan="3"></td><td>Dated</td><td></td></tr>
<tr><td>Head of Safety Services Comments</td><td colspan="6"></td></tr>
<tr><td rowspan="2">Head of Department Comments</td><td colspan="6"></td></tr>
<tr><td>Signed</td><td></td><td colspan="2">Dated</td><td colspan="2"></td></tr>
</table>

ACTION PLAN

Action Plan to include description, who is responsible and completion date	ACTION TO INCLUDE A COMPLETION DATE (continued)	BY WHO	COMPLETION DATE
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
	7.		
	8.		
	9.		
	10.		

4. APPENDIX 2 Who Should Conduct an Incident Review

Although not a prescriptive list, the following guidance should be followed.

SCENARIO	WHO SHOULD INVESTIGATE
All incidents immediately recognisable as being reportable under RIDDOR	Head of Safety Services assisted by local management
Incidents likely to be reportable under RIDDOR (refer to SCoP 06). The Head of Safety Services will make a determination as to who should conduct the immediate review depending on severity and significance of the incident.	Local management unless referred to the Head of Safety Services.
Near misses unless significant	Local management
Any incidents of a sensitive nature or leading to a significant insurance claim. Head of Safety Services will determine whether to take the lead.	Local management unless referred to the Head of Safety Services.