Queen Mary University of London

Occupational Health & Safety Directorate

Health and Safety Standard & Guidance

Incident / Accident Management and Reporting

(Ref: QM_OHSD_GA015)

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Contents

1. Executive Summary

This Health and Safety Standard establishes the framework for incident reporting and investigation by Queen Mary University of London (QMUL) staff and students and also for others who may be affected by QMUL activities. The objective of the Standard is to minimise loss, harm or damage, enable legal compliance and promote best practise in incident reporting. By identifying the root causes of incidents and applying the lessons learnt it is more likely that any potential system failures can be averted.

The incident reporting guidance within the Standard gives advice on the operational arrangements to take following an incident including; completing an incident report, what and how to report and carrying out an incident investigation.

Accompanying the Standard is a full appendix of incidents which QMUL has a statutory duty to report under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

2. Introduction

Queen Mary University of London (QMUL) endorses the view that organisations with effective systems for reporting, reviewing and learning from adverse events, are more able to respond to improve the safety of staff, students and visitors. This can only be achieved if the culture of the organisation is open, supportive, non-threatening and just.

QMUL is committed to providing a working environment where risks to employees and others who may be affected by its operations or environment are controlled, so far as is reasonably practicable.

To facilitate the effective control of risk, the organisation must manage all incidents and near misses appropriately. In doing so, we will seek early identification of potential problems and timely intervention to prevent or **minimise** the impact of risk and **maximise** opportunities to learn.

The Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR) 2013 require QMUL to report specified work-related serious accidents, dangerous occurrences and occupational diseases to the Health and Safety Executive (HSE) within specified timescales.

There is also a statutory requirement to notify the HSE of work-related injuries which result in an employee being absent from work for more than seven days (including weekend/rest days) after the day of the accident. Additionally, the HSE expects us to keep an internal record of work-related injuries which result in an employee being absent from work for more than three days after the day of the accident.

The Queen Mary Occupational Health and Safety Directorate (OHSD) is responsible for reporting relevant work related accidents, diseases and dangerous occurrences to the HSE, but compliance with the legislative

requirements depends on the timely reporting of comprehensive incident information.

Types of incidents that require notification to the HSE are listed in **Appendix 1**

This standard provides a framework for incident management across QMUL. It is designed to encourage staff to report incidents and near misses with the assurance that these will be reviewed, analysed and the knowledge gained disseminated. The review analysis of an incident is not conducted to apportion blame but will offer insights into how and why things went wrong and will often reveal that it was not due to a single cause, but to a number of contributory system failures.

3. Standard Statement

See **Appendix 1** for details of RIDDOR reportable incidents/diseases.

4. Scope

This Standard relates to accidents, dangerous occurrences and near misses occurring on QMUL premises and also to incidents involving QMUL staff and students working off Campus.

All accidents causing personal injury, however small, and any incidents (including near misses) that happen either on Queen Mary premises or in connection with its activities, must be reported to the local line manager as well as to the OHSD, using the Incident Report Form (0040). This is to ensure that basic information of the incident is available to Queen Mary in the event of any future enquiry and to enable the incident to be investigated and followed up with a view to preventing further similar occurrences.

This includes accidents to **any person**, including students, contractors and visitors, in **any part** of the Queen Mary (including conference facilities), Student Union bars and premises, Halls of Residence and sports grounds and facilities.

Accidents and near misses involving members of Queen Mary that occur in other locations, such as on field trips and during visits to other laboratories, should also be reported in the same manner, although they should also be reported locally.

Student incidents which have already been reported to the Trust (e.g. dental labs at the Royal London) should be copied to the Queen Mary Occupational Health and Safety Directorate (OHSD).

It is acknowledged that independent contractors have different accountability arrangements from direct employees of QMUL, and therefore this policy should be used in conjunction with the requirements of their own employers. However, any incident involving contractors working in QMUL premises should be reported to the OHSD on a QMUL incident reporting form.

5. Standard Objectives:

By implementing this standard QMUL wishes to:

5.1 Minimise loss, harm or damage to employees/students/others, and the reputation or assets of QMUL.
5.2 Enable compliance with the statutory duty to report certain types of incident and occupational disease
5.3 Define and promote best practice in incident reporting and management
5.4 Promote local ownership of incident management
5.5 Ensure appropriate action is taken following an incident or near miss to reduce risk of recurrence and enable rapid follow up of incidents while recollection of events is still fresh
5.6 Ensure the organisation adopts a consistent and co-ordinated response to significant events /serious incidents
5.7 To identify the root causes of incidents and apply the lessons learned to ensure any potential system failures in any part of QMUL are averted

Whilst the principle aim of this framework is to improve systems, not to apportion blame, it is recognised that there may be situations where disciplinary action must be considered if there is evidence of the following:-

- intentional harm
- deliberate and knowing breach of policy/standard designed to prevent harm
- negligence
- reckless behaviour
- Professional misconduct, e.g. , concealing evidence or relevant information.
- illegal practice, e.g. obstructing HSE/Police
- obstructing QMUL investigating officers

Where this applies, action will be taken in line with the relevant QMUL Human Resources Policies and Procedures.

6. Definitions

Within this document, unless the context requires otherwise:

An **incident** is an unplanned event that did result, or could have resulted, in harm, injury or damage to people, property or equipment

An **accident** is a type of incident that results in physical injury to a person

A **dangerous occurrence** is an incident that does not result in physical injury to a person, but did or could have resulted in damage to property or equipment

A **near miss** is a type of incident where personal injury or damage does not occur but the potential for injury or damage exists, e.g. tripping on an uneven surface but not falling over and injuring oneself.

RIDDOR Reportable Incidents are those where the specified injury / occupational disease / dangerous occurrence arises out of, or in connection with work, where an employee has an over-seven days absence from work (or is unable to carry out their normal duties for more than seven days) as a result of any of a work-related physical injury, or where a member of the public is taken to hospital and given treatment after an incident that occurred because of work processes or problems with QMUL's infrastructure/estate.

7. Responsibilities

7.1 Managers must ensure staff, students, visitors and contractors working or visiting in their area are aware of the incident reporting and first aid arrangements and have an appreciation of the importance of reporting incidents and near misses.

7.2 Staff and students must report all accidents, near misses and dangerous occurrences occurring on Campus to their line manager and the OHSD.

7.3 The Line Manager must ensure that an incident report form is completed to a satisfactory standard, ensuring the data provided is complete and accurate.

7.4 Staff and students who are involved in, witness, or discover an incident on another employer's premises must report in accordance with the host organisation's incident management policy. QMUL staff or students must also report any work-related incident they are involved in on another employer's premises on a QMUL incident report form to the OHSD.

7.5 The Line Manager must inform the Occupational Health and Safety Directorate immediately if the incident / accident / dangerous occurrence is likely to be reportable or when it is known that a QMUL employee has been, or will be, absent (or unable to carry out their normal duties) for seven days or more. The seven days include weekends and rest days, but not the day of the accident. The OHSD should also be informed if injuries prevent an employee attending work or carrying out their normal duties for more than three days after the accident (including weekends and rest days).

7.6 Incident forms should be sent to the OHSD as quickly as possible after the incident occurrence.

7.7 The OHSD is responsible for reporting relevant incidents to the HSE

7.8 It is the responsibility of the line manager of the injured person, or the manager of the area in which the incident occurred, to ensure that the situation is investigated and remedial action is taken to prevent recurrence. A copy of the investigation report should be forwarded to the OHSD.

7.9 The OHSD will review incident reports, ensure that incident investigations have been carried out where required and will assist managers to investigate serious and/or complex incidents and derive suitable corrective actions.

7.10 The OHSD will ensure that any remedial actions identified during incident investigations are suitable and actioned within recommended timescales.

8. Operational Arrangements

Incident Management - Immediate action following any incident

The priority is to ensure the immediate safety of the person (s) affected

8.1 **Staff must:**

- Not put themselves in situations of danger
- If possible, make safe the situation / environment, and take interim action to prevent recurrence. NB. If the incident is serious, the scene of the incident may need to be preserved as a potential crime scene
- Ensure that the person(s) affected receives appropriate first aid/ other care /treatment as necessary. Phone security on 3333
- Inform the School/Institute/Directorate Safety Adviser and Line Manager/Supervisor **as soon as possible** after the incident has occurred to enable a full investigation and remedial actions to be taken.
- Contact the OHSD if the incident is serious (e.g. fatality or specified injuries that will obviously result in the injured person's absence from work, potentially catastrophic dangerous occurrences). See Appendix 1
- Remove any equipment / product involved in the incident immediately from use (If possible, take photographs of the equipment in situ first) - If it is safe to do so – and if the scene is not to be preserved as a crime scene. Store equipment in a secure place for inspection and ensure that it cannot cause harm to any person or be tampered with. Label the equipment as 'out of order'. Make a record of the make, model, serial number / batch number/unique identifier and expiry date if applicable.

8.2 **Contractors must:-**

- Report an incident / accident on QMUL site within 24 hours of it occurring to the appropriate OHSD contact (e.g. Capital Projects H&S Adviser) on the OHSD accident & incident form (PUT LINK).
- Capital Project H&S Adviser will notify OHSD immediately so the event is logged on the system
- Within 5 working days of the event contractors must provide an accident / incident report to the Capital projects H&S Adviser if the event is deemed to have a potential consequence of moderate or above (see Appendix 3 for grading)
- Report should include:- **Statement from injured person**
  Witness statements
  Photographic evidence

Any corrective actions identified

- Capital projects H&S Adviser will send all documentation received from contractors to OHSD

8.3 **Actions to take following an incident once the injured person/scene have been dealt with – see flow chart in Appendix 2**

8.3.1 **Complete an incident report:**

- In the first instance, the person suffering the accident or observing the near miss/dangerous occurrence should complete a report form as soon as possible. However, in the case of an accident, if the person involved is unable to complete the form, then their manager, colleague or a first aider should do so. For serious incidents, the manager should also take photographs of the incident scene.

- NB - a first aider will not be responsible for investigating the accident, unless it is part of the person's role.
- Complete **all** relevant sections on the QMUL Incident Report form.
- Record only facts not opinions
- Avoid speculation and subjective statements
- Avoid the use of abbreviations and jargon
- Attach supplementary information as needed e.g. photograph, additional information sheet.
- If more than one person is affected / involved, a separate form **must** be completed for each individual.

8.3.2 **What to report**

Any accident, near miss, dangerous occurrence, event or circumstance arising during QMUL's operations that could have or did lead to unexpected harm, loss or damage. This includes incidents such as slips, trips, falls, equipment failure, fire, cuts, scalds, spills of hazardous substances, trapping and crushing injuries, animal bites, needle sticks, muscle sprains etc.

N.B. Sometimes an incident is not immediately apparent but identified at a later stage For example, a person may experience back pain a few days after a manual handling manoeuvre. It is important that this kind of incident is reported, albeit retrospectively.

Staff and students working off Campus should report any incident in which they were involved as soon as possible after returning to their base.

8.3.3 **When to report**

It is important that all incidents / near misses are reported as soon as possible and ideally within 24 hours of occurrence. **Significant incidents must be reported to the OHSD immediately**

8.3.4 How to report

You should report using the QMUL Incident Reporting Form, found here: - http://www.ohsd.qmul.ac.uk/documents/1/115613.docx For serious incidents, report by phone and then complete an incident report, giving full details of the incident and involved persons.

8.4 Incident Investigation

8.4.1 **For all moderate or serious incidents (as classified by Incident Grading Guidance in Appendix 3) an incident investigation must be initiated as soon as possible after the event:**

The Line Manager should lead the incident investigation and may be assisted by the OHSD if necessary. The OHSD should always be involved in the investigation of serious incidents. Please see the 'Incident Investigation Guidance' at **Appendix 4**

8.4.2 In the event of an incident where serious harm has occurred, the Line Manager should arrange a de-brief session for all staff affected by it. Circumstances will determine the most appropriate approach e.g. one-to-one or group sessions.

8.4.3 At the de-brief, the line manager should make staff aware of the QMUL Employee Assistance Programme.

NB Staff are entitled to request support from their Trade Union or professional body.

8.4.3 The OHSD will assist with and /or review incident investigation reports and ensure that the remedial/mitigating measures identified are appropriate.

8.5 Media Inquiries

In all instances, external enquiries regarding any incident must be referred to the Marketing and Communications (M&C) Director. He/she, with the appropriate Senior Manager, will agree a response to media enquiries. Communications with the media **will only be** via the head of M&C or another designated senior manager.
Managers should expect and prepare for media interest in any serious incident within QMUL.

8.6 Training

The OHSD can provided incident investigation training for safety coordinators and line-managers

8.7 Monitoring

The OHSD will monitor the implementation of this policy via the Annual H&S Return, during peer-review inspections and via audit. The policy will be reviewed every three years, or sooner if legislation/ QMUL's circumstances change.

9.0 References

Health & Safety Executive: **-** http://www.hse.gov.uk/

Guidance on Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR):- http://www.hse.gov.uk/pubns/indg453.pdf

Guide to investigating Accidents and Incidents at Work: - http://www.hse.gov.uk/pubns/hsg245.pdf

Appendix 1 – Incidents Reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013

(Important Note: The Queen Mary Occupational Health and Safety Directorate is responsible for reporting all 'reportable' incidents to the relevant enforcing authority – it is not the responsibility of the School/Institute or the individual to carry out this function. The information contained here is therefore for information and internal reporting purposes only.
For more information of reportable incidents/diseases see:
http://www.hse.gov.uk/riddor/reportable-incidents.htm

1. Reportable Specified injuries to workers

1.1 Fractures, other than to fingers, thumbs and toes

1.2 Amputation of an arm, hand, finger, thumb, leg, foot or toe

1.3 Any injury likely to lead to permanent loss of sight or reduction in sight in one or both eyes

1.4 Any crush injury to the head or torso, causing damage to the brain or internal organs

1.5 Specified burn injuries (including scalding)

1.6 Any degree of scalping requiring hospital treatment

1.7 Any loss of consciousness caused by head injury or asphyxia

1.8 Specified injuries arising from working in an enclosed space

What to do when the extent of an injury is unclear

In some cases, employers and self-employed workers may not be in a position to know the full extent of an injury, e.g. when a prognosis has not yet been established in relation to an eye injury, or when efforts are being made to treat an injured limb which may ultimately require surgical amputation. In such situations, there is no requirement to make precautionary reports of specified injuries. It is likely that the accident will in any case require reporting due to the injured person being incapacitated for more than seven days. The enforcing authority should be notified or updated as soon as a specified injury has been confirmed.

2. Injuries to members of the public on Campus

Accidents to members of the public or others who are not at work must be reported if they result in an injury and the person is taken directly from the scene of the accident to hospital for treatment to that injury. Examinations and diagnostic tests do not constitute 'treatment' in such circumstances.

There is no need to report incidents where people are taken to hospital purely as a precaution when no injury is apparent.

3. Over Seven Day Injuries

The OHSD must also notify the HSE of any other injuries that lead to a worker being incapacitated for more than seven consecutive days as the result of an occupational accident (not counting the day of the accident but including weekends and rest days).

Incapacitation means that the worker is absent, or is unable to do work that they would reasonably be expected to do as part of their normal work.

4. Reportable Dangerous Occurrences

4.1 Collapse of lifting equipment

4.2 Failure of pressure systems

4.3 Contact with overhead electric lines/electrical discharge

4.4 Electrical incidents causing explosion or fire

4.5 Fire or explosion caused by explosives

4.6 Release or escape of hazardous biological agents

4.7 Malfunction of radiation generators and radiography equipment

4.8 Malfunction of breathing apparatus

4.9 Collapse of scaffolding

4.10 Damage to or failure of pipelines or pipeline works

4.11 Structural collapse

4.12 Explosion or fire stopping normal processes for more than 24 hours

4.13 Release of specified volumes of flammable liquids and gases

4.14 Significant escapes of substances hazardous to health

5. Reportable Occupational diseases

Employers and self-employed people are required to report cases of certain diagnosed reportable diseases that are linked with occupational exposure to specified hazards. The reportable diseases and associated hazards are set out below.

5.1 Carpal Tunnel Syndrome: where the person's work involves regular use of percussive or vibrating tools

5.2 Cramp of the hand or forearm: where the person's work involves prolonged periods of repetitive movement of the fingers, hand or arm

5.3 Occupational dermatitis: where the person's work involves significant or regular exposure to a known skin sensitiser or irritant

5.4 Hand Arm Vibration Syndrome: where the person's work involves regular use of percussive or vibrating tools, or holding materials subject to percussive processes, or processes causing vibration

5.5 Occupational asthma: where the person's work involves significant or regular exposure to a known respiratory sensitiser

5.6 Tendonitis or tenosynovitis: in the hand or forearm, where the person's work is physically demanding and involves frequent, repetitive movements

5.7 Occupational cancer: Cases of cancer must be reported where there is an established causal link between the type of cancer diagnosed, and the hazards to which the

person has been exposed through work. These hazards include all known human carcinogens and mutagens, including ionising radiation.

For example, the following diagnosed occupational cancers must be reported:-

- mesothelioma or lung cancer in a person who is occupationally exposed to asbestos fibres
- cancer of the nasal cavity or sinuses in a person who is occupationally exposed to wood dust

Reports are only required when the person's work significantly increases the risk of developing the cancer. In some cases, the medical practitioner may indicate the significance of any work-related factors when communicating their diagnosis.

Cases of cancer are not reportable when they are not linked with work-related exposures to carcinogens or mutagens. As with other diseases, cancers are only reportable if the person's current job involves exposure to the relevant hazard.

5.8 Any disease or acute illness caused by an occupational exposure to a biological agent: All diseases and any acute illness needing medical treatment must be reported when it is attributable to a work-related exposure to a biological agent. The term biological agent is defined in the Control of Substances Hazardous to Health Regulations 2002 (COSHH) and means a micro-organism, cell culture, or human endoparasite which may cause infection, allergy, toxicity or other hazard to human health. Work with hazardous biological agents is subject to specific provisions under COSHH.

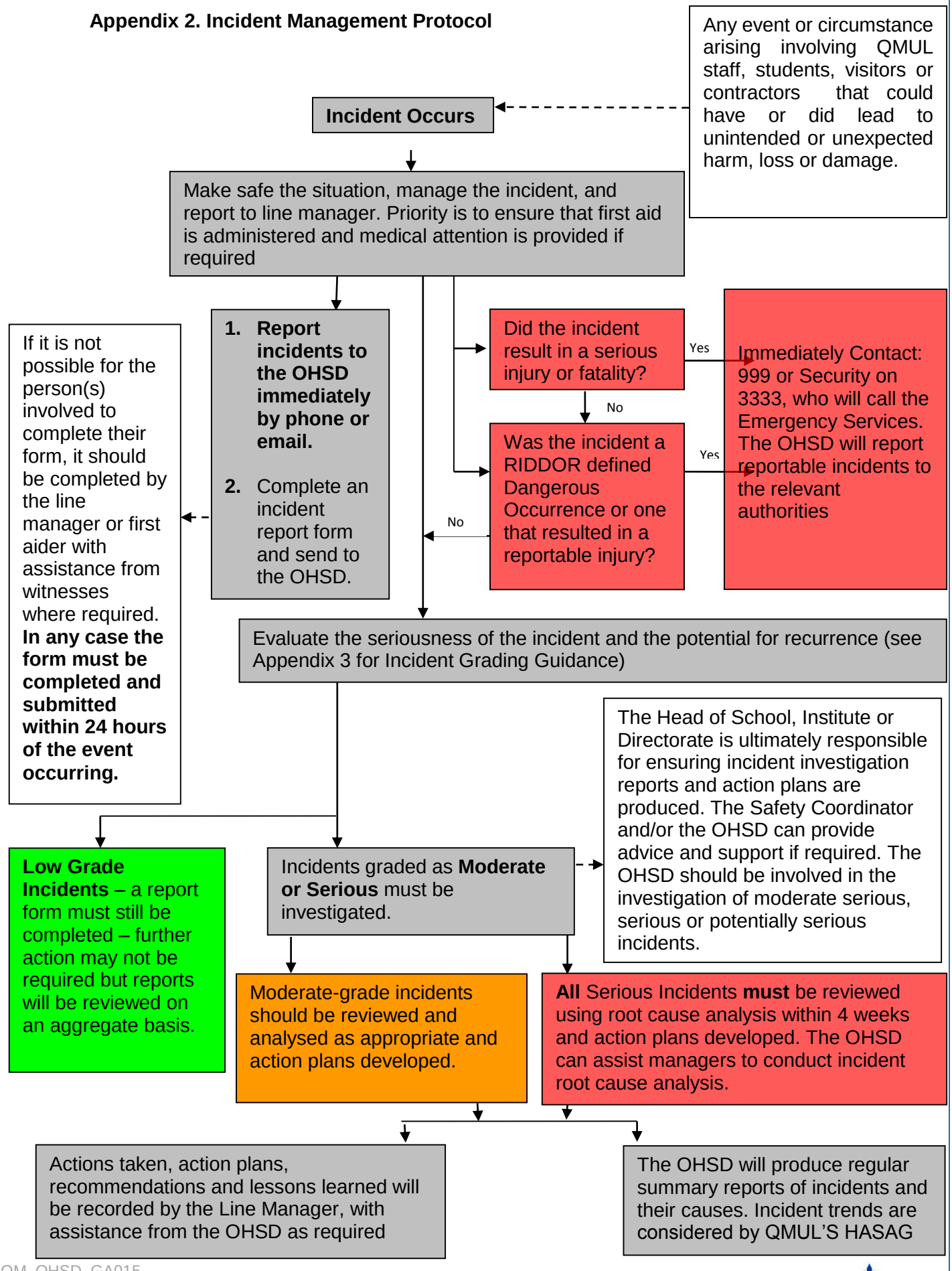
Work-related exposures to biological agents may take place as a result of:

- an identifiable event, such as the accidental breakage of a laboratory flask, accidental injury with a contaminated syringe needle or an animal bite

- unidentified events, where workers are exposed to the agent without their knowledge (e.g. where a worker is exposed to legionella bacteria while conducting routine maintenance on a hot water service system)

A report should be made whenever there is reasonable evidence suggesting that a work-related exposure was the likely cause of the disease. The doctor may indicate the significance of any work-related factors when communicating their diagnosis.

Appendix 2. Incident Management Protocol



Appendix 3. Incident Grading Guidance

Assess the likelihood and consequence of the incident occurring using the risk matrix below. See the guidance on the levels of likelihood and consequence.

Consequence – 1-5

Likelihood – 1-5					
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5

	Serious
	Moderate
	Low

Likelihood:

Descriptor	1	2	3	4	5
	Rare	**Unlikely**	**Possible**	**Likely**	**Certain**
Frequency of such an incident occurring	Very unlikely to occur Less than a 5% chance of occurring	Unlikely to occur 5 – 25% chance of occurrence	May or may not occur. 26 - 74% chance of occurrence	More likely to occur than not. 75 - 90% chance of occurrence	Almost certain to occur. More than a 90% chance of occurring
	So unlikely that it is not expected to happen again.	It is not expected to happen again in the foreseeable future	It may occur from time to time	It will reoccur, but not as an everyday event	It will happen again and soon

When deciding the 'likelihood' staff should consider the effective controls, such as policies, guidelines and training that are already in place. If effective controls are already in place this should have the effect of reducing the likelihood

Consequence:

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury (Physical / Psychological)	Minor injury not requiring first aid or no apparent injury	Minor injury or illness, first aid treatment needed	RIDDOR reportable	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Complaints / Claims	Locally resolved complaint	Justified complaint peripheral to health and safety arrangements	Below excess claim. Justified complaint involving inadequate health and safety arrangements	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim

Service / Business Interruption	Loss / interruption > 1 hour	Loss / interruption > 8 hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility
Financial	Small loss	Loss > 0.1% of budget	Loss > 0.25% of budget	Loss > 0.5% of budget	Loss > 1% of budget
Regulator	Minor recommendations Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Challenging recommendations. Non-compliance with core standards	Enforcement Action. Critical report. Major non-compliance with core standards	Prosecution. Zero Rating. Severely critical report
Adverse Publicity / Reputation	Rumours	Local Media - short term. Minor effect on staff morale.	Local Media - long term. Significant effect on staff morale.	National Media < 3 Days	National Media > 3 Days. MP Concern (Questions in House)

Risk Grading

Risk Grading	Risk Acceptability	Management Actions Required
Serious (15- 25)	Unacceptable	Investigate. Urgent action/senior management attention required to eliminate or reduce risk. Report to relevant risk management committee.
Moderate (5-12)	Tolerable, manageable	Investigate. Action that is cost efficient to reduce or manage risk. Local actions.
Low (1-4)	Acceptable	Investigation may not be required. Manage situation with routine procedures. Action if easy to implement and inexpensive

Appendix 4. Incident Investigation Guidance

Why Investigate?

The fact an incident has occurred suggests that the existing risk control measures could be inadequate and an investigation is needed to determine whether it is necessary to review them. The main reasons for incident investigation include:-

- Legal Reasons

Whilst there is no specific legal requirements for QMUL to investigate following an incident it is clearly implied that they should do so in legislation such as RIDDOR and the Management of Health & Safety at Work Regulations. A thorough investigation and instigation of remedial actions is also important if the question of allocating legal liability (by enforcement agencies and insurers) arises.

- Discovery of Underlying / Root Causes to Prevent Reoccurrence

To identify and understand immediate and underlying causes of accidents and identify ways in which to prevent the reoccurrence of similar events

- Reassurance and Explanation

So all connected to the accident can be reassured appropriate action is being taken or that a satisfactory explanation has been given for what happened

- Monitoring of Performance

Investigations will produce data for the reactive monitoring of QMUL's health & safety performance

- Identification of Trends

A spate of similar minor accidents could expose a procedural or practical issue. If not treated, minor accidents could become major.

Who should investigate?

Depending on the level of the investigation, supervisors, line managers, health and safety professionals, union safety representatives, employee representatives and senior managers / directors may all be involved.

In addition to detailed knowledge of the work activities involved, members of the team should be familiar with health and safety good practice, standards and legal requirements. The investigation team must include people who have the necessary investigative skills (e.g. information gathering, interviewing, evaluating and analysing). The team must have sufficient time and resources to carry out the investigation efficiently.

When and what to investigate?

In general, adverse events should be investigated and analysed as soon as possible. This is not simply good practice; it is common sense – memory is best and motivation greatest immediately after an adverse event.
The level of investigation and analysis required for individual events should be dependent upon the incident grading (how likely it is to occur and how the serious the consequences of the incident could be) and not whether the incident is an accident or a near miss. It is important to note that a reasonable, common sense approach is needed when assessing whether a formal investigation is required, as not all incidents are preventable, e.g. some falls.

The investigation

Information Gathering

An investigation will involve an analysis of all the information available, physical (the scene of the incident), verbal (the accounts of witnesses) and written (risk assessments, procedures, instructions, job guides etc), to identify what went wrong

and determine what steps must be taken to prevent the adverse event from happening again.

1 Where and when did the adverse event happen?
2 Who was injured/suffered ill health or was otherwise involved with the adverse event?
3 How did the adverse event happen? Note any equipment involved.
4 What activities were being carried out at the time?
5 Was there anything unusual or different about the working conditions
6 Were there adequate safe working procedures and were they followed?
7 What injuries or ill health effects, if any, were caused?
8 If there was an injury, how did it occur and what caused it?
9 Was the risk known? If so, why wasn't it controlled? If not, why not?
10 Did the organisation and arrangement of the work influence the adverse event?
11 Was maintenance and cleaning sufficient? If not, explain why not.
12 Were the people involved competent and suitable?
13 Did the workplace layout influence the adverse event?
14 Did the nature or shape of the materials influence the adverse event?
15 Did difficulties using the plant and equipment influence the adverse event?
16 Was the safety equipment sufficient?
17 Did other conditions influence the adverse event?

Evaluate the information/evidence and establish incident causes

To prevent adverse events, it is necessary to provide effective risk control measures which address the immediate, underlying and root causes of the incident and therefore, an incident investigation must try to establish these.

Immediate cause:

The most obvious reason why an adverse event happens, e.g. the guard is missing; the employee slips etc. There may be several immediate agents/causes identified in any one adverse event (e.g. the blade, the substance, the dust etc.)

Underlying cause:

Unsafe acts and unsafe conditions - the less obvious 'system' or 'organisational' reason for an adverse event happening, e.g. pre-start-up machinery checks are not carried out by supervisors; the hazard has not been adequately considered via a suitable and sufficient risk assessment; work/production pressures are too great etc.

Root cause:

An initiating event or failing from which all other causes or failings spring, often remote in time and space from the adverse event. Root causes are generally management, planning or organisational failings (e.g. failure to identify training needs and assess competence, low priority given to risk assessment etc.).

Put corrective actions in place

Identify all possible control measures and then select the ones which are most suitable, this may involve justifying selected controls using formal cost-benefit analysis. Plan what you have decided to do and **do** it. This will involve setting timescales and allocating specific actions to specific individuals (action plans with SMART objectives). Ensure action plans deal effectively not only with the immediate and underlying causes but also with the root causes.

Monitor corrective actions

Arrangements need to be included to ensure the action plan is implemented and progress monitored. Without this there is a risk the full benefits of any investigation will not be realised and in the long term nothing will change.

Appendix 5. OHSD RIDDOR Reporting Guidelines

Introduction

The Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 2013 (RIDDOR 2013) require that work-related fatalities, specified injuries and specified dangerous occurrences must be reported as soon as possible to the Health and Safety Executive via the website: http://www.hse.gov.uk/riddor/report.htm.

The OHSD reports relevant incidents to the HSE on behalf of the organisation (see Appendix 1 for the types of RIDDOR Reportable Incident).

For most types of incident, including:

- accidents resulting in the death of any person
- accidents resulting in specified injuries to workers
- non-fatal accidents requiring hospital treatment to non-workers and
- dangerous occurrences

The OHSD must notify the enforcing authority without delay. Reports are usually made electronically but reports of fatal accidents or accidents resulting in specified injuries to workers **only**, may be made to the HSE by phone on 0845 300 9923.

NB: A report must be received within 10 days of the incident.

For accidents resulting in the **over-seven-day incapacitation** of a worker, the HSE must be notified **within 15 days of the incident**, using the appropriate online form.

Cases of occupational disease, including those associated with exposure to carcinogens, mutagens or biological agents should be made as soon as the responsible person receives a diagnosis, using the appropriate online form.

Over Three Day Injuries

QMUL must still keep a record of the accident if the worker has been incapacitated for more than three consecutive days by an injury sustained in the accident (including weekends or rests days but not the day of the accident).

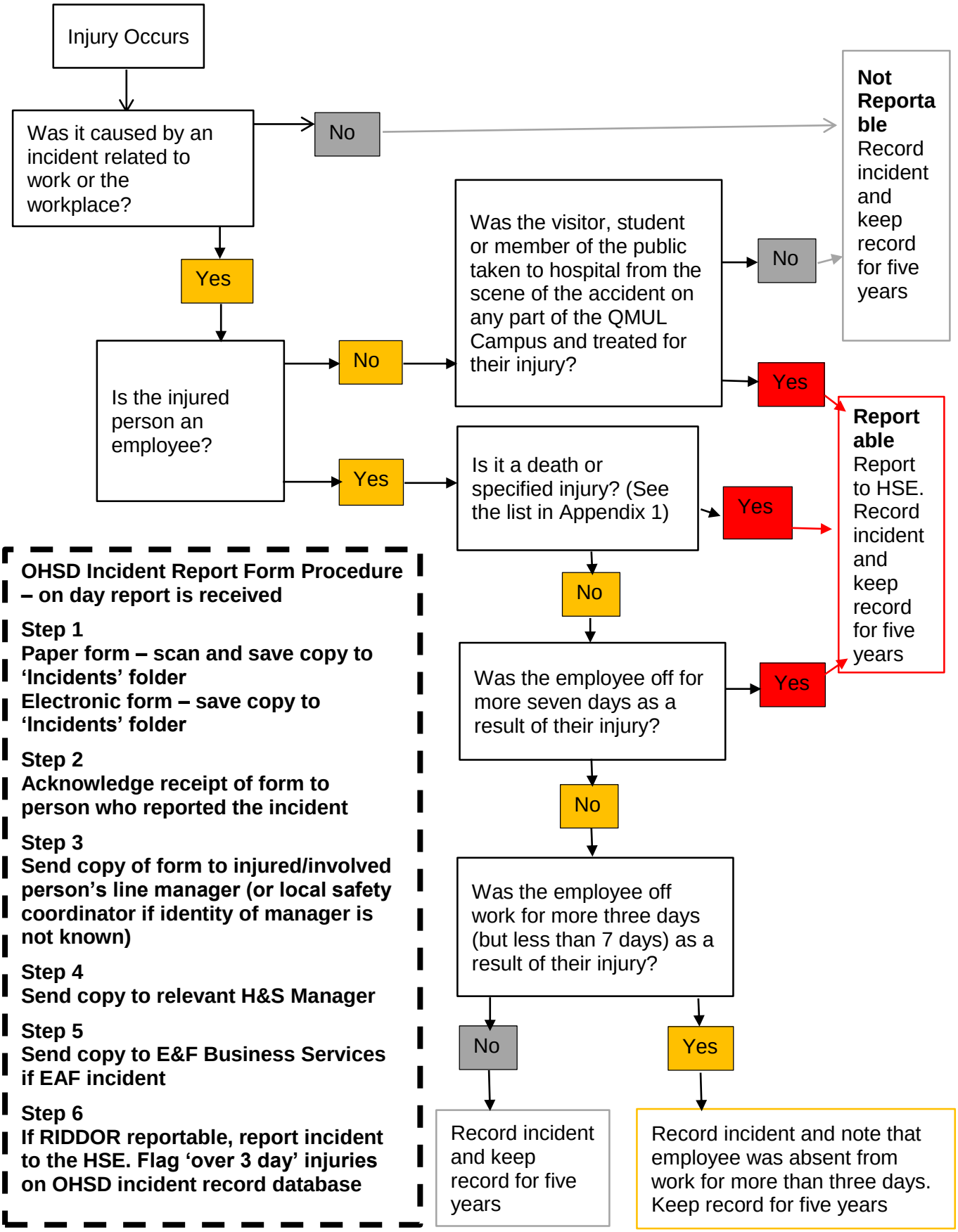
Reporting Injuries to Non-Employees

The reporting arrangements described in points 2 – 4 above apply to **employees** who are injured in connection with work or the workplace.

Death or Injury to **students** and **visitors** should only be reported to the HSE if the accident was to do with QMUL **work activities** or **problems with the QMUL workplace** and if the injured person was taken to hospital from a QMUL workplace and received treatment.

Injuries sustained by staff, students or visitors during sporting activities are not reportable to the HSE if the injury occurred because of the activity, and not because of a failure of the fabric and fittings of the building. For example: an injury caused by being hit in the eye by a squash ball is not reportable, but a specified injury or over-seven day injury caused by a player tripping over a loose floorboard is.

Appendix 6. OHSD RIDDOR Injury Reporting Flow Chart



OHSD Incident Report Form Procedure – on day report is received

Step 1
Paper form – scan and save copy to 'Incidents' folder
Electronic form – save copy to 'Incidents' folder

Step 2
Acknowledge receipt of form to person who reported the incident

Step 3
Send copy of form to injured/involved person's line manager (or local safety coordinator if identity of manager is not known)

Step 4
Send copy to relevant H&S Manager

Step 5
Send copy to E&F Business Services if EAF incident

Step 6
If RIDDOR reportable, report incident to the HSE. Flag 'over 3 day' injuries on OHSD incident record database

Document Control

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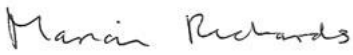
Signature:	
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