

Safety Code of Practice 9

3rd Edition, May 2021

INCIDENT REPORTING AND INVESTIGATION

Summary			
This Code of Practice summarises the arrangements for the notification and investigation of incidents with health and safety implications or concerns that arise from activities, equipment or materials under the control of the University of Reading.			
Scope			
This policy sets out the responsibilities for the notification to the University of Reading of incidents with a health and safety implications or concerns, and the responsibilities for the investigation of incidents. This policy also describes the arrangements the University will follow for the formal reporting of specified incidents to the enforcing agency and how incident records are kept.			
This edition of the CoP is a major re-write using the new H&S Services template, managers no longer performing incident investigations, increased detail on RIDDOR-reportable incidents, amalgamation of 2 documents previously known as COP-9 pt1 and pt2, also known as CoP 09 and CoP 10.			
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Contents

1	Introduction.....	3
2	Scope and Application.....	3
3	Definitions.....	4
4	Responsibilities.....	4
5	Requirements.....	5
5.1	Reporting.....	5
5.1.1	Reporting in General.....	5
5.1.2	Reporting for Peripatetic Workers, Evening Classes, Events.....	5
5.1.3	Reporting for International Travel.....	6
5.1.4	Reporting for Agency, Contractor or Self-Employed Workers.....	6
5.1.5	Fatalities.....	6
5.2	Incident Investigation.....	7
6	Competence/Learning.....	8
7	Review & Audit.....	8
8	Records & Retention Requirements.....	9
9	Relevant Legislation.....	9
10	Useful Links.....	9
	Appendix A – RIDDOR Incidents.....	9
	Appendix B – Investigation Details.....	10

1 INTRODUCTION

Incident investigation is an important element within the University's overall health and safety management system. The initial response to incidents may focus on immediate concerns, such as providing first aid and making the scene safe. However, it is often important to investigate further - to understand how and why incidents happen, to improve risk management and prevent the recurrence of similar or more serious events, to prevent unfair accusations, and to comply with the University's legal duties. Decisions on the extent and thoroughness of investigation should not be determined simply by the injury or ill health actually suffered, but also by the potential consequences from, and the likelihood of, a future similar occurrence.

For incidents to be investigated properly the University must be notified about the incident. Therefore, arrangements exist for staff, students and others to notify the University of incidents and for them to be allocated to trained investigators for further enquiries, and investigation where appropriate. This Code of Practice sets out what arrangements Schools/Functions should establish to ensure incidents are notified to the University and investigated appropriately.

2 SCOPE AND APPLICATION

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 those under UoR's control, on the following premises: UoR campuses (including the Henley campus and the Sportspark), Bulmershe Pavilion, the UoR Boat House, Sonning and Hall Farms and non-tenanted areas of TVSP. It applies to road traffic incidents involving staff or students when travelling for work or study, to or between UoR premises, unless that travel is commuting from home to work or from home to study. It applies 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 applies to incidents with the potential to cause health and safety consequences to humans or the environment.

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. It does not apply to the University of Reading Malaysia, where separate local arrangements have been established.

3 DEFINITIONS

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

Near-miss. An event that could have resulted in an accident but no actual harm was received.

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. A list of the main RIDDOR incident types is given in Appendix A.

Investigation recommendations are born out of the investigation process with purpose to reduce the likelihood of incident reoccurrence and the severity of reoccurrence. The actions should be clearly defined by 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 health and safety incidents involving staff/students/visitors using the [online notification system](#), and also informing managers/academic supervisors or others as appropriate.

Heads of School/Function are responsible for ensuring that staff and students understand how to notify the University of an incident using the online notification system. Heads of Schools/Functions must ensure that a Health and Safety Coordinator (HSC) is appointed for undertaking incident investigations, and that any changes to that appointment are communicated promptly to H&S Services.

HSCs are responsible for undertaking initial enquiries and alerting H&S Services if an incident may be a RIDDOR-reportable event. HSCs are responsible for considering if an investigation is appropriate, and investigating the incident. They must communicate their findings and

recommendations to those best-placed to action them to make improvement, and HSCs must communicate their investigation findings and recommendations to their H&S Services Liaison Adviser (LA) within 14 days of receiving the incident allocation. HSCs are responsible for managing any sensitive personal information in accordance with the University's rules on data security and protection.

H&S Services is responsible for ensuring HSCs have access to incident investigation training as soon as reasonably possible following their appointment. H&S Services allocates incidents to HSCs for investigation, and LAs will offer advice and support to HSCs during their investigations. H&S Services is responsible for deciding which incidents the University is legally required to report and submitting the University's RIDDOR or other reports to the relevant enforcing agency. H&S Services provides information to support Legal Services, Procurement and the University's insurers in responding to legal claims. Where the University's Major Incident Plan is activated following a health and safety incident, H&S Services is responsible for liaising with the MIT on progressing any health and safety investigation. H&S Services is responsible for maintaining the central database of incident investigation information.

Human Resources is responsible for liaising with Trade Union Safety Representatives carrying out inspections following a RIDDOR-reportable incident.

5 REQUIREMENTS

5.1 Reporting

5.1.1 Reporting in General

All incidents involving staff/students/visitors involved in UoR controlled activities must be notified to H&S Services by the [online notification system](#) as soon as reasonably possible. Incidents can be reported by anyone, but individuals directly involved are strongly encouraged to notify with good detail to initiate an appropriate response. Where individuals have sustained loss of time from work or study due to injury or work-related ill health, notification must take place in their absence by their manager/academic supervisor, alternatively colleagues or next of kin. In all cases, 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). **Any serious incidents should be communicated to the Head of School/Function and H&S Services immediately (extn. 8888).**

5.1.2 Reporting for Peripatetic Workers, Evening Classes, Events

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, if necessary, communicate directly with other staff or managers, Estates or local HSCs ([using the published list](#)) if there are

any uncontrolled hazards (for example wet floors or damaged equipment) needing immediate remedial action to make the situation safe.

Incidents during evening classes should be reported, as appropriate, to Security and then notified to H&S Services by the individual in charge of the class. This includes but is not limited to any incidents of fire, the use of first aid or ambulance call out, or incidents involving the damage or failure of UoR workplace equipment, violent or verbal aggressive behaviour to staff or students, any dangerous occurrences.

Any incidents during organised events that involve staff, students or members of the public must also be notified to H&S Services (COP-33), either 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, Marketing Communication and Engagement, Security (especially for out-of-hours events).

5.1.3 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 FCO guidance. **In an emergency the leader should contact the University [Travel Management Company](#). 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/Function 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.

5.1.4 Reporting for Agency, Contractor or Self-Employed Workers

Incidents involving agency staff, contractors, service engineers, 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.

5.1.5 Fatalities

In the event of a fatality involving anyone on UoR-controlled premises, Security must be contacted immediately on 0118 378 6300. This is an addition to any direct contact made with the emergency services. In the event of a student fatality Security must follow the [deceased student policy](#). 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. In any case, Security must also inform H&S Services of all fatalities.

The incident scene must not be disturbed, unless essential to rescue or provide first aid to other casualties. The scene will typically be assessed as quickly as possible to ensure it is made safe and to gather initial essential facts. Contact details of witnesses should be gathered if possible and provided to Security. 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 Services.

5.2 Incident Investigation

H&S Services will allocate incidents to appropriate HSCs as soon as reasonably possible and typically within 24 hours of receipt. Incident allocation will follow the procedure published on the [H&S Services website](#). HSCs will be asked to make initial inquiries to determine the immediate causes and assess the significance of the incident and so decide the depth of the investigation required.

Where an HSC's enquiries identify a possible RIDDOR-reportable incident has occurred (see Appendix A), the HSC must promptly discuss this with H&S Services – preferably their LA, otherwise the H&S Services Director - to ensure any legally-reportable incidents are identified promptly (see Appendix A). H&S Services will submit reportable incidents to the relevant enforcing agency.

Further investigation should be proportionate to the likelihood for reoccurrence and the severity of the incident (e.g. potential for injuries, actual injuries received, number of individuals affected, damage to property). The level of involvement with others (site visits, interviews, access to records, etc) should be proportionate to the significance of the incident. HSC investigators should communicate their investigation findings and recommendations for improvement action to those best placed to take action.

HSCs should communicate their investigation findings and improvement recommendations to their H&S Services LA within 14 days of the initial incident allocation. Completion of the [incident investigation form](#) is preferred, but for simpler incidents summary in an email is acceptable. The LA may advise on or assist with the investigation. In exceptional circumstances H&S Services may take over the investigation or engage an external specialist to complete it.

A checklist to support investigations is shown in Appendix B. The aims of the investigation should be to verify what happened, establish the immediate and underlying causes of the incident, determine if risk is properly controlled and identify opportunities for improvement. Typically, injured persons and witnesses should be invited to provide their account of events, to establish the facts about what happened. Depending on prior experience and background some individuals may find this causes distress or anxiety, and investigations should try to be sensitive to individual needs while also establishing the facts. Photographs, measurements, and documents may be gathered depending on the significance and nature of the incident (Appendix B).

The lessons learnt should be used to reduce the likelihood or severity of reoccurrence, for example by reinforcing implementation of existing control measures or enhancing controls. This is to continually improve the University health and safety standards. Any recommendations arising from the investigation should be clearly communicated to specified individuals along with recommended timelines (immediately, following day, within one week, etc). Those individuals are responsible for taking action or assigned actions according to the significance of the risk.

Exceptionally, investigations may generate recommendations relating to individuals - these should be communicated to their manager(s).

Investigating incidents is good management practice and a University requirement for the following reasons:

- To identify immediate and underlying/root causes.
- To reassure staff, students and visitors that notified incidents will be investigated and that this will improve health and safety standards as part of continuous improvement.
- To review the suitability and implementation of the existing risk controls born out of risk assessments. For example, is equipment suitable, are the operating procedures clear and trained out, is appropriate PPE available at the point of need, is the frequency of maintenance suitable, is the visibility of signage sufficient, etc.
- To identify if any job or human factors that may have contributed to the incident. For example, the timing of activities, the worker health or physical capability, effectiveness of communication, familiarity of the location/equipment.
- To prevent recurrence through implementation of the arising recommendations.
- To satisfy legal compliance and provide information for any future claims.

6 COMPETENCE/LEARNING

Heads of Schools/Functions must allow HSCs time from their other duties to undertake training. The training requirements for HSC roles from both lower and higher hazard Schools/Functions are published in [Safety Note 1](#). In addition to help maintain their competency, HSCs should aim to investigate three or more incidents per year and should regularly attend the HSC workshops. H&S Services LAs will also provide feedback to HSCs to support their on-going learning.

7 REVIEW & AUDIT

Chairs of local Health and Safety Committees should include an incident summary section when setting their committee agenda ([Safety Note 79](#)). Committees should discuss the main incident investigation recommendations and, as appropriate, monitor the completion of actions for implementing safety improvements. Where incidents recommendations cannot be resolved locally by the School/Function actions, even working in partnership with others such as Estates, the local Committee Chair can escalate items for consideration at the University Health, Safety and Wellbeing Committee (UHSWC) via the UHSWC secretary.

H&S Services LAs 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 UHSWC and provide a summary for inclusion in the University's Annual H&S Performance Report.

8 RECORDS & RETENTION REQUIREMENTS

H&S Services is responsible for maintaining records of incidents notified to H&S Services for at least 5 years, for assisting with any civil or criminal law investigations or possible insurance claims. Any claims will be dealt by the University Legal Services or Insurance Officer. Records of RIDDOR-reported incidents will be retained by H&S Services. Reports of occupational ill health or personal exposure should be retained for 40 years after the last incident under Regulation 10 of COSHH 2002 (ACOPs L5 6th edition 2013).

9 RELEVANT LEGISLATION

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

Control of Substances Hazardous to Health Regulations 2002 (as amended)

Management of Health and Safety at Work Regulations 1999

Safety Representatives and Safety Committees Regulations 1977 (as amended)

Health and Safety at Work etc. Act 1974

10 USEFUL LINKS

1). H&S Services online incident notification pages

<https://www.reading.ac.uk/internal/health-and-safety/IncidentReportingandEmergencyProcedures/IncidentNotification/>

2). HSE RIDDOR pages

https://www.hse.gov.uk/riddor/index.htm?utm_source=hse.gov.uk&utm_medium=referral&utm_campaign=riddor&utm_content=home-page-info

APPENDIX A – RIDDOR INCIDENTS

Below is a non-exhaustive list of RIDDOR-reportable incident types. Only incidents that arise out of work activities are reportable to HSE. Incidents that have no connection with the University work activities do not require reporting to the HSE, for example student sports, or student or staff illness not caused by work,

All RIDDOR incident types must be reported in writing to HSE within 10 days (by H&S Services).

Hence it is essential to notify H&S Services immediately of a serious incident, preferably by phone (extn 8888) to be followed by an Incident Notification Form submitted online.

- i. the death of any person as a result of an accident (e.g. not suicide)
- ii. a major injury as a result of a work-related accident (includes fractures; amputations; dislocations; serious eye injuries; crushing injuries to head or torso, serious burns including scalding, scalping, loss of consciousness by head injury or asphyxiation, any injury arising from working in an enclosed space, exposure/inhalation/ingestion of a harmful substance or biological agent)
- iii. someone who is not at work (e.g. a student or visitor) suffers an injury as a result of an accident and is taken from the scene directly to a hospital.
- iv. a reportable dangerous occurrence (includes failure or overturning of lifting equipment, failure of pressure vessels or any part of the associated pipework, collapse of scaffolding; damage to pipework, contact with overhead electric cables; electrical overloading or short circuits that result in fire or explosion; release of biological agents likely to cause severe human infection).
- v. an injury to an employee which results in them being unable to do their normal job for more than seven consecutive days (excluding the day of the accident but including any days which would not have been working days, including weekends - referred to as "over-7-day injuries").
- vi. a reportable occupational disease which is confirmed by a doctor's diagnosis (includes work-related upper limb disorders; occupational asthma; infections due to biological agents and/or micro-organisms; specific poisonings and cancers).

Note: this is a simplified summary of the Regulations. H&S Services are responsible for assessing the incident and deciding if it is reportable to HSE.

APPENDIX B – INVESTIGATION DETAILS

Obtain facts

- Date and time of incident.
- Name(s) and contact details of injured/affected person(s), age, sex, 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 Material 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 – eg 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 personal protective equipment 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/Function, 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