Science and Technology Facilities Council

INCIDENT REPORTING AND INVESTIGATION

STFC SHE Code No 5

Rev. 1.11 Issued December 2019

Revisions

1	Initial Launch	January 2007
1.2	Inclusion of SoPS	December 2007
1.3	Minor edits to remove reference to ‘Major incidents’	January 2012
1.4	Changes for updates to RIDDOR Remove form from Appendix 3	April 2012
1.5	Minor modification to Appendix 4	September 2012
1.6	Amendments to audit checklist	May 2013
1.7	Add document retention policy appendix and updated Appendix 1	December 2014
1.8	Definitions for radiation incident severity added to Appendix 1	August 2018
1.9	Changes to reflect launch of SHE Assure	October 2018
1.10	Addition of clarification text to Appendix 1	June 2019
1.11	Minor change to training Appendix	December 2019

STFC SHE CODE 5

SAFETY, HEALTH AND ENVIRONMENT INCIDENT REPORTING AND INVESTIGATION

1 Purpose

Safety, Health and Environmental (SHE) incidents cause injury, ill health, property or environmental damage, adverse media reaction, and loss of time and money. SHE incidents are to a large extent preventable and the STFC's SHE management system is reviewed regularly and updated to reduce the risk of SHE incidents.

Investigating and understanding the causes of incidents is an important means of improving our SHE management system. It is essential that all SHE incidents, injuries and near miss incidents are reported to SHE Groups and investigated so that we can learn from them and minimise the potential for their recurrence.

Under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), the STFC (SHE Group) is legally required to notify the Health and Safety Executive (HSE) immediately of certain accidents, diseases and specified dangerous occurrences and to report the incident within 15 days. There are also requirements under Ionizing Radiations Regulations 2017 (IRR 17) to report certain incidents involving radiation to the HSE as well as requirements to report serious environmental incidents to the Environment Agency

2 Scope

This code applies to any SHE incident, irrespective of severity, that could or did result in injury to people, harm to health, damage to property or harm to the environment involving STFC staff, visitors, facility users, contractors working on behalf of the STFC, and tenants working on STFC sites.

This code applies to any SHE incident that could or did result in injury to STFC staff while travelling on Council business in the UK or overseas or working on non-STFC sites in the UK or overseas.

This code encompasses all SHE incidents and includes incidents involving radioactive materials and fire.

3 Definitions

SHE Incidents:

Incident		An unplanned or uncontrolled event.
Accident		An incident that has resulted in an injury or damage to property.
Near miss		An incident that, under slightly different circumstances, could have resulted in an injury or damage to property.
Occupational Ill Health		An abnormal condition or disorder of a person, caused by exposure to environmental factors associated with Council employment.
Environmental Incident		An incident that caused or had the potential to cause damage to the environment.
Fire		Any uncontrolled combustion, or suspected combustion, smoke, flames, sparks, fumes.
RIDDOR Incident		An injury specified in Schedule 1 of RIDDOR 2013. E.g. fatality, fractures, amputations or dislocations or where a person has been admitted to hospital for more than 24 hours.
	OR	An Incident that is specified in Schedule 2 of RIDDOR 2013. E.g. Failure of a load-bearing part of a crane, explosion or bursting of a pressure system, electrical failure causing a fire, collapse of a large structure or accidental release of a biological agent.
	OR	An injury which, although not a major injury, has resulted in the injured person being away from work or unable to carry out the full range of his/her duties for more than seven days (including weekends and rest days but excluding the day of the accident).
Serious or Potentially Serious (SoPS) Incidents		Those incidents (injuries, near misses, vehicle incidents, fire incidents) that **did, or had the reasonable potential to**, result in *significant and permanent harm* to staff, contractors, tenants, users, visitors at STFC sites or for staff while travelling and working on Council business away from STFC sites.

See Appendix 1 for examples.

4 Responsibilities

A summary flowchart of this code can be found at Appendix 2.

4.1 All persons witnessing, or involved in, a SHE incident or near miss shall:

4.1.1 Report incidents requiring local or emergency assistance immediately:

	RAL	DL	Chilbolton	Boulby Mine	UKATC	Swindon Office
First Aid	Locally listed and defined					
Occupational Health	6666	3234	n/a	n/a	n/a	n/a
Ambulance	2222	3333	(9)999	3333	222	2222
Fire	2222	3333	(9)999	3333	[(9)999 out of hours]	2222

4.1.2 Do not enter the area unless it is safe to do so.

4.1.3 Ensure that any casualties are seen by a first aider. Secure the immediate area, containing any escaped material as near to the source of the escape as possible, preventing further incidents or injury to others. In the event of major incidents, once safe and secure, the location should be sealed and impounded pending further investigation.

4.1.4 Report the incident or near miss in Evotix Assure, the STFC incident reporting database. Details of how to use the system can be found on the SHE group website. Wherever possible photographic evidence should be collected for inclusion in Evotix Assure to facilitate the incident's understanding. Alternatively the incident may be reported using local incident reporting pro-forma, see Appendix 3, and sent to the local SHE group. All incidents should be reported as soon as is practicable and no later than 2 working days after the incident has been identified. Staff without computer access should report the incident to their line manager to report on their behalf.

4.1.5 Inform their line manager of the incident. For incidents involving contractors the contract supervisor shall be informed. For incidents involving facility users or visitors their STFC host/contact shall be informed. The contract supervisor or STFC host shall report the incident via Evotix Assure.

4.1.6 Report any actual or suspected occupational ill health to their line manager to report through Evotix Assure.

4.1.7 Co-operate with STFC management in the investigation of the incident to identify its root case and, where possible, prevent recurrence.

4.2 Line managers or supervisors of those involved in SHE incidents or responsible for areas in which SHE incidents occur shall:

4.2.1 Ensure that all incidents in their areas of responsibility are reported to the SHE Group as soon as is practicable and no later then 2 working days after the incident is identified using Evotix Assure, or local incident reporting pro forma (see Appendix 3). Work related injuries that result in more than 7 days sick leave/lost time are by definition RIDDOR reportable.

4.2.2 Conduct local investigations of any incident for which they are the responsible manager within 2 weeks of the incident identifying the root cause(s) of an incident and actions to minimise potential for recurrence. See Appendix 4 for guidance on the conduct and format of local investigations.

4.2.3 For contractor injuries the STFC manager responsible for the activity under which the contractors work will assume the role of line manager and ensure that a local investigation is undertaken directly or through the contractor's management.

4.2.4 As appropriate inform the relatives of those injured via HR, the employer of visitors, tenants or facility users, or the contracting company for incidents involving their personnel.

4.2.5 In addition to any investigation discuss with any STFC employee, who has sustained an injury or been involved in a SHE incident, what happened and determine what can be learnt from the experience and what could be done differently as a result. The objective of such discussions is not to apportion blame but ensure that the organisation as a whole has learnt from the incident and minimised the possibility of its recurrence.

4.2.6 Ensure all actions arising from incident investigations are satisfactorily completed in a timely manner.

4.2.7 Inform Occupational Health professionals and SHE Group of any reported or suspected instances of occupational ill health for further investigation.

4.3 Directors shall:

4.3.1 Ensure that all staff, facility users, contractors and visitors are encouraged, in a "blame free" environment, to understand the importance of reporting all SHE incidents, irrespective of their severity to their line manager and local SHE Group.

4.3.2 Monitor SHE incident levels within their departments and formulate appropriate actions in consultation with their senior management and Safety Committees to improve SHE performance.

4.3.3 As appropriate commission or lead formal investigations into highly significant SHE incidents to identify their root cause and seek appropriate actions to prevent their recurrence, see Appendix 5 for guidance on the conduct and format of formal board of enquiry investigations.

4.3.4 The Chief Executive Officer and Directors with oversight responsibility for SHE at specified locations may at their discretion commission or lead formal board of enquiry investigations into highly significant SHE incidents

4.4 SHE Group shall:

4.4.1 Maintain a record of all incidents reported to them in Evotix Assure reviewing the quality of information reported, applying consistent incident classification criteria and ensure that incident investigations are appended to the incident report. Such records shall be maintained indefinitely.

4.4.2 Ensure that relevant personnel are informed of SHE incidents as soon as is practical. This shall include: the responsible line management and the relevant: Department Director; chair of the Departmental Safety Committee; Departmental Safety Contact; and employee safety representatives.

4.4.3 Where the incident has potential wider learning for the STFC, communicate the incident to Departmental Safety Contacts, Departmental Safety Committee Chairmen and management at all locations.

4.4.4 Inform relevant STFC Directors and senior management in the event of any SHE incident where there are significant reputational, financial or regulatory implications arising from any SHE incident as soon as is practicable.

4.4.5 Assess all reported incidents and as necessary report incidents to the HSE under RIDDOR 2013, or the Environment Agency (EA) gathering as required further information from responsible management, see Appendix 2. Where incidents involve ionizing radiation or radioactive materials the Radiation Protection Advisor (RPA) shall co-ordinate all communication and consultation with the regulatory bodies, HSE and/or EA ensuring that the Head of SHE is informed.

4.4.6 Report SHE statistics to STFC committees and management, reporting performance, identifying trends, and identifying and communicating STFC wide learning from incidents in a timely manner.

4.4.7 Where incidents involve lost time ensure that a signed hard copy of the incident report from Evotix Assure is obtained and retained.

4.4.8 As appropriate facilitate and participate in investigations of formal boards of enquiry or cases of occupational disease or ill health.

4.5 Head of SHE shall:

Where an incident involves ionizing radiation or radioactive materials the Radiation Protection Advisor shall undertake these duties ensuring that the Head of SHE is consulted.

4.5.1 Determine whether an incident should be classed Serious or Potentially Serious (SoPS) thereafter ensuing that a SoPS report, see Appendix 6, is completed by local management.

4.5.2 Determine for those incidents assessed to be SoPS whether a formal Board of Enquiry investigation is required, see Appendix 5.

4.5.3 Approve all reports to regulatory authorities: HSE; EA etc, prior to their release.

4.6 Occupational Health Department shall:

4.6.1 Report all visits to the occupational health department of actual or suspected work related injuries or cases of occupational related diseases to SHE Group and encourage first aiders to prompt injured staff to report all treated injuries.

4.6.2 Participate in investigations of cases of occupational disease or ill health.

Appendix 1. SHE incidents and their categorisation

SHE Incidents are assigned organisationally within STFC to the Department/Directorate responsible for causing or addressing the primary root cause of an incident. For example a member of Department A working in a Laboratory under Department B has an injury or non-injury incident, for example, relating to the state of equipment in the Laboratory then the incident would be assigned to Department B, if the injury or non-injury incident related directly to the activity of the individual, for example setting off a fire alarm, then the incident would be assigned to Department A.

Serious or Potentially Serious (SoPS) Incidents - those incidents (injuries, near misses, vehicle incidents, fire incidents) that did, or had the reasonable potential to, result in *significant and permanent harm* to staff, contractors, tenants, users, visitors at STFC sites or for staff while travelling and working on Council business away from STFC sites. Where the term Permanent harm – means that the harm requires surgery, ongoing medication, orthotic support or necessitates permanent adjustment of lifestyle.

SHE Incident type	Serious or Potentially Serious (SoPS) [Major]	Moderate	Minor
Injury Incident where a person suffers harm as a result of an incident at work, or when travelling on Council business, which requires medical treatment from Occupational Health, Emergency Services, First Aider or external Medical Staff. **Note:** work related injuries resulting in 7 days sick leave is by definition RIDDOR reportable and must be reported to SHE Group.	Any one of the 'Specified Injuries' identified in RIDDOR 2013 or where an injury occurred from an incident which clearly had the potential to have resulted in a 'Specified Injury'.	Injuries which require treatment at a minor injuries clinic or Occupational Health Centre, beyond the capability of local first aiders.	A minor injury which is: • self–treated; • treated by a first aider; or • requires no treatment

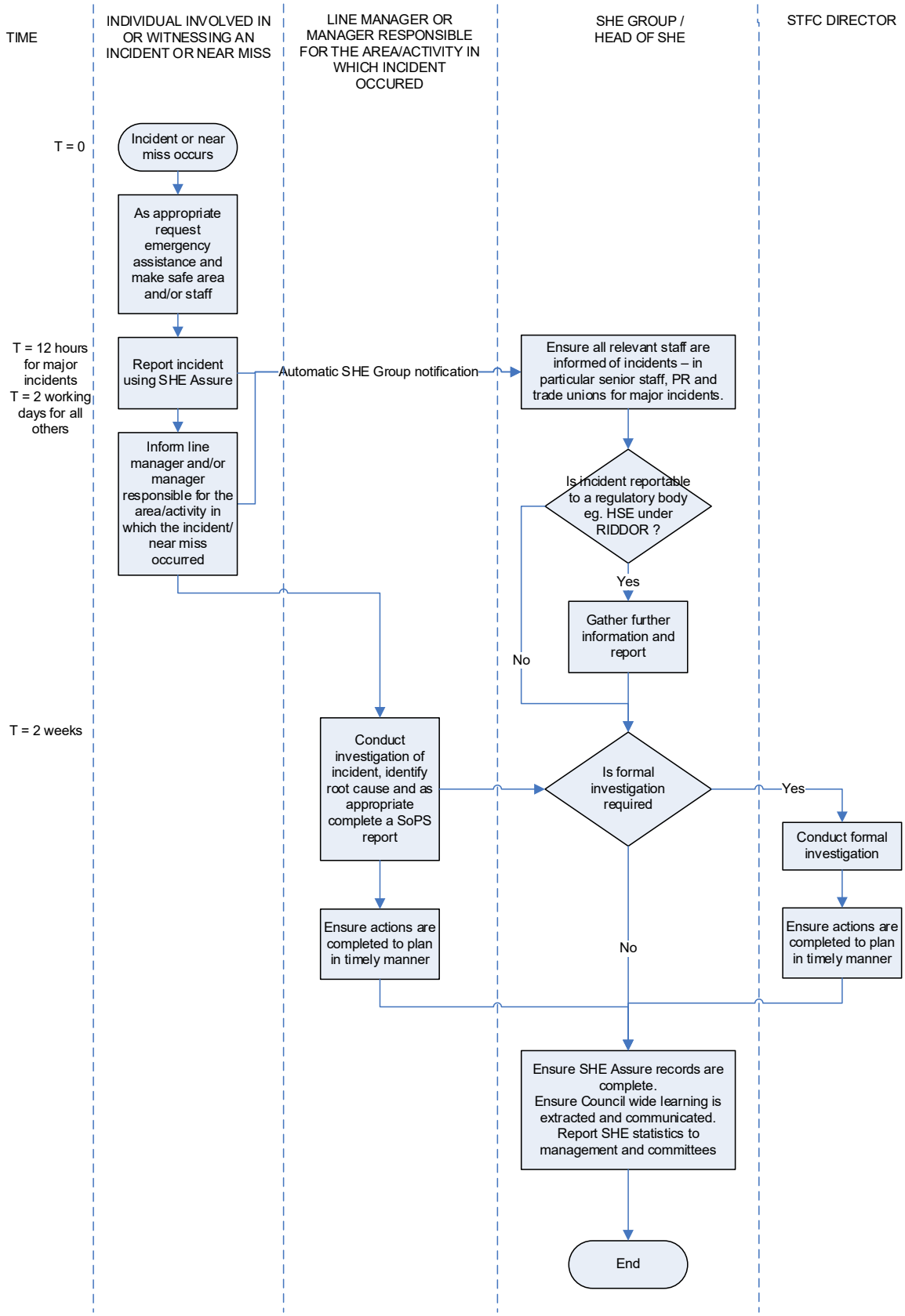
SHE Incident type	Serious or Potentially Serious (SoPS) [Major]	Moderate	Minor
Occupational Ill Health An abnormal condition or disorder of a person, caused by exposure to environmental factors associated with Council employment. It includes acute and chronic illnesses or diseases that may be caused by inhalation, absorption, ingestion or direct contact, WRULDs.	All Occupational Ill Health incidents are classed SoPS (Major). Any one of the eight 'Reportable Diseases' identified in RIDDOR 2013. These are: carpal tunnel syndrome; severe cramp of the hand or forearm; occupational dermatitis; hand-arm vibration syndrome; occupational asthma; tendonitis or tenosynovitis of the hand or forearm; any occupational cancer; any disease attributed to an occupational exposure to a biological agent or any occupational ill health that results in incapacitation that is permanent, requires on going medication, surgery or the use of orthotic support. **By definition, RIDDOR reportable ill health requires medical diagnosis.**		
Environmental Incident An incident that <u>caused damage to the environment</u>, including public complaints arising from STFC activity. For example: unauthorised releases to aqueous drainage systems – trade waste or surface water drainage, unauthorised gaseous releases, unauthorised disposal of solid waste, miss-classification of disposed solid waste. **<u>Unauthorised</u> in this context*:***	Any actual unauthorised discharge of solids or liquids to off-site land or water courses. A breach in environmental permits requiring a report to the Environment Agency (EA) and/or EA formal investigation/enforcement action; Aqueous or gaseous emissions escaping off-site causing alarm and/or damage or the attendance of emergency services; Incidents resulting in adverse public or media interest; Permanent environmental damage to STFC sites.	Incident causing a release contained within the site boundary, and having no affect outside STFC site boundaries.	Any other environmental incident.
Release of environmentally hazardous material excluding those related to ionising radiation.	All unauthorised gaseous releases are classed as major (SoPS) as containment to the site cannot be guaranteed.		

SHE Incident type	Serious or Potentially Serious (SoPS) [Major]	Moderate	Minor
Complaint A complaint received by the STFC, either directly or forwarded from neighbouring establishments, from members of the public or from official/regulatory bodies relating to STFC activity.	Any justified external complaint that has or could have resulted in action by a regulatory body. Any complaint that may attract adverse national media coverage.	Any complaint that did or could may attract adverse local media coverage.	Any complaint. For example: noise complaints; traffic complaints; light pollution; noxious smells.
Fire incident Any uncontrolled combustion - smoke, flames, sparks - manually or automatically extinguished.	A fire that required external emergency assistance to extinguish and or manage the incident. Fires involving flammable gases.	Fires that require the use of more than one fire extinguisher or by attendance of local firefighting team e.g. AIT or ET at RAL & DL respectively or by the activation of automatic extinguishing systems.	Smoldering material - generating smoke with or without flame, that was extinguished by use of a single fire extinguisher or it self-extinguished requiring no response.

SHE Incident type	Serious or Potentially Serious (SoPS) [Major]	Moderate	Minor
Radiation Any incident involving radioactive material, radioactive waste and/or radiation generators	Implementation of a contingency plan that has been required where potential exposure in excess of 1 mSv have been identified from risk assessments. Breach of Permit conditions RIDDOR or other regulatory reportable event (e.g. loss of a source, failure of a source to retract) A trend of moderate events of a consistent nature	Contamination event that requires assistance of HP to clean up Exposure of personnel in excess of dose constraint without prior agreement to vary it Failure to update Isostock as soon as practicable (or appropriate database) with source movement/relocation A trend of minor events of a consistent nature Failure to comply with radioactive waste procedures, e.g. failure to dispose of active waste appropriately	Contamination event that can be cleaned up by the operator(s) Exposure of personnel in excess of daily dose control/alarm on electronic dosimetry activated Failure to comply with local rules Failure to comply with radioactive waste procedures, e.g. failure to remove radioactive markings/labels from non-active waste

SHE Incident type	Serious or Potentially Serious (SoPS) [Major]	Moderate	Minor
Learning Opportunity STFC uses the term Learning Opportunity/Near Miss widely to encompass: • Near Misses; • Hazardous Conditions; and • Failures of Safe Systems of Work Any incident that could have caused injury to any people working at STFC sites, those affected by the operation of STFC sites or those STFC staff working at non STFC sites. An incident in which a safe system of work hasn't been adhered to, but has not resulted in actual incident.	Any Dangerous Occurrence reportable under RIDDOR. Those incidents (injuries, near misses, vehicle incidents, fire incidents) that did, or had the reasonable potential to, result in significant and permanent harm to staff, contractors, tenants, users, visitors at STFC sites or for staff while travelling and working on Council business away from STFC sites. Any incident with the real potential to have caused a major SHE incident, see below, or be reported to the HSE, under RIDDOR, or to the Environment Agency. For example potential: overturn of a FLT, scaffold collapse, uncontrolled release of chemicals to surface water drains collected at outfall, failure to danger of radiation protection interlocks. Damage to any equipment, vehicle or building resulting in more than £50K of damage. Any explosion that results in the attendance of the emergency services. **If any major incident involves a secondary less severe incident which can be identified under a different category, then a separate incident report should be entered into Evotix Assure.**	Any near miss incident or hazardous condition that could have resulted in a moderate injury or other moderate incident. Any incident with wider learning for the STFC.	Any near miss incident or hazardous condition that could have resulted in a minor injury or other minor incident. For example: shelf collapse; falling objects; out of date lifting equipment used for lifts; pressurised equipment out of inspection date; reckless driving/speeding on site; failure of smoke alarm during test, failure to follow maintenance schedule for safety alarms Incident resulting in damage to a hire car; equipment explosion; FLT collision with building

Appendix 2. Summary flowchart of incident reporting and investigation



Appendix 3. Incident reporting routes

Where the Evotix Assure system is unavailable the incident details can be emailed to the STFC SHE Group

Appendix 4. Guidance on the conduct and format of local investigations

1 Why do we need to investigate incidents?

Investigating incidents and near misses is good management practice and an STFC requirement, for the following reasons:

- To identify both the immediate and underlying causes (there is rarely a single cause);
- To learn from the incident and put measures in place to prevent, where possible, a recurrence ;
- To reappraise existing risk assessments;
- To review risk control measures and their effectiveness;
- To satisfy legal requirements for accident reporting and recording ;
- To satisfy the expectation of the public and injured parties, who expect action following a serious incident; and
- To obtain details which might be needed if the incident later becomes subject to an insurance claim or legal action.

Line managers / Supervisors are responsible for conducting local investigations of incidents, although they may need additional expertise from the SHE and others depending on the type of incident.

Summary investigation details should be recorded on the Incident Report in Evotix Assure. You will need to complete an additional, more detailed report for the accident investigation. The following Incident Investigation Checklist should assist you to gather sufficient information, to ask the right questions and consider underlying causative factors. It is not an exhaustive list and will need to be adapted to each particular incident.

2 Checklist for Investigating Incidents

i. Obtain the basic facts

- Date and time of incident
- Names and contact details of injured / affected person(s), age, sex, occupation, company / university (if a user)
- The nature of any injury / ill health / assault / environmental or property damage sustained, details of treatment received, from whom, hospital attended, length of stay, length of absence from work
- Location details and layout of the area in which the incident occurred
- 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 Council and/or regulatory authorities (HSE, EA) may need this evidence later.
- Any hazardous substances in use or present (obtain Safety Data Sheets if they are not already available), if applicable to the incident
- Names, contact details of any contractors involved, you may need to contact them later.

ii. Establish the circumstances of the incident

- Events leading up to the incident
- What was being undertaken 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?
- What instructions were given to those involved, before the incident?
- What were the established methods of work and procedures?
- 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?

iii. Identify the underlying causes of the incident

There is often far more to incidents than simply unsafe acts by individuals or unsafe conditions, you need to consider why the circumstances leading to the incident occurred, and went unnoticed and unchecked. How did things get this far? A very effective means of structuring this analysis is a "Why, Why" tree, see example attached. In completing a "Why, Why" analysis, consider the following:

- Has anything similar happened before? Check the accident records (available from the SHE Group), ask around
- 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 / this area, is it suitable and sufficient?
- Were Council 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 area 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?

iv. Establish whether the initial management and emergency response was adequate

- Was the initial response to the incident by STFC 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)?

v. Identify any further action needed to prevent, where possible, a recurrence

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 inspection, monitoring and audit systems
- Review similar risks in other sections

Once you have identified what action is required to prevent a recurrence of the incident in question, you should record your recommendations in the form of an action plan, making it clear what is required, by when and who will be responsible for implementing the improvements required.

Remember:

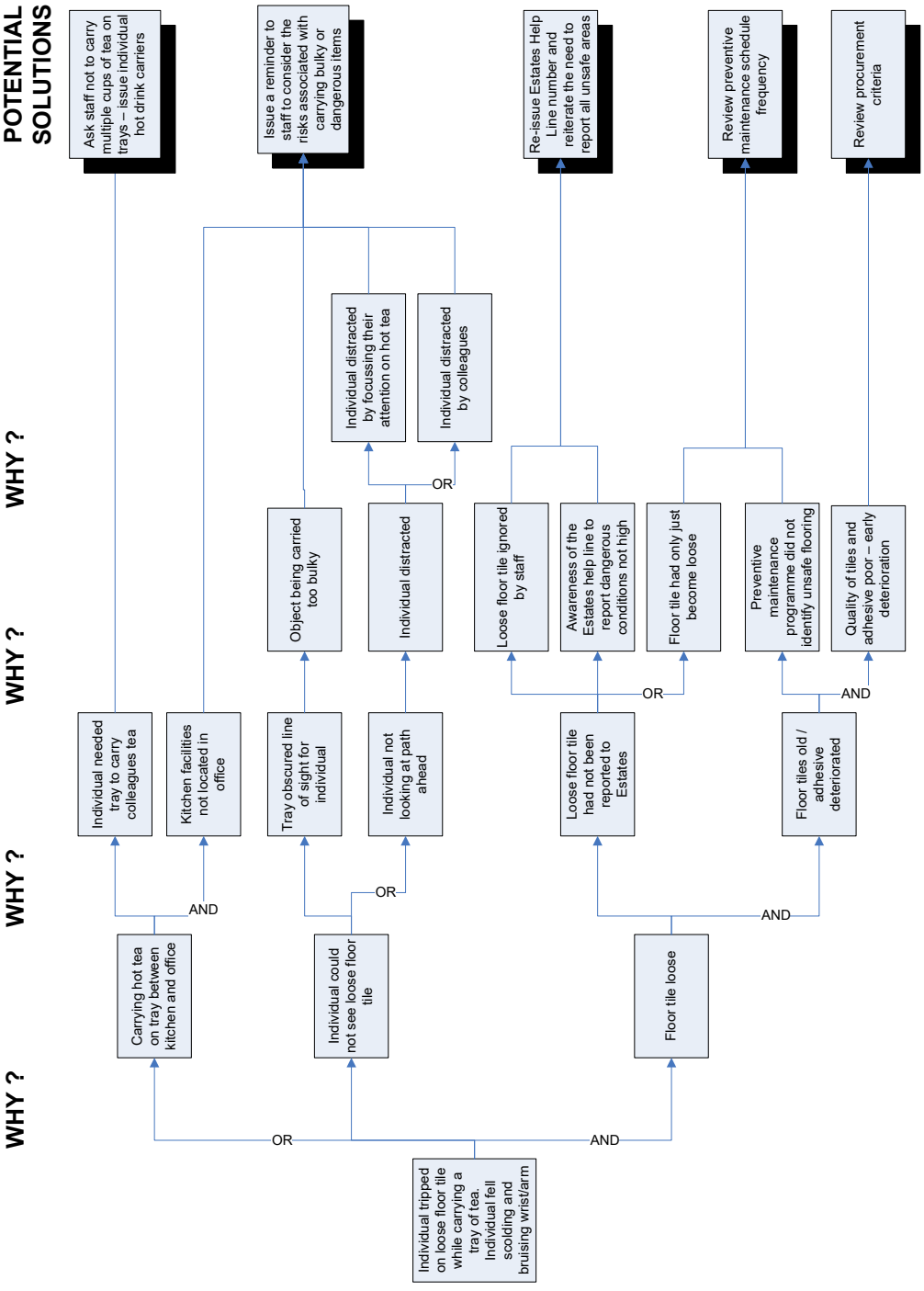
- Always talk to the injured person and witnesses to get their account of events
- Verify the facts – do not make assumptions about what happened
- The most important thing is not to apportion blame, but to learn from incidents, so as to continually improve SHE standards.

Finally:

The view of STFC is that disciplinary action **does not** form part of the response to a report of an incident, except in cases where one or more of the following applies:

- Where there are repeated occurrences of an incident by the same individual, despite re-training and mentorship;
- Where the incident/event is viewed as malicious, this may include involvement of the police should a crime be suspected;
- When in the view of STFC and/or any professional registration body, the action causing the incident is far removed from acceptable practice;
- Where there is evidence that safety interlock systems have been deliberately defeated/tampered with jeopardising their own safety and/or the safety of others; and
- Where a significant incident or event is not reported and attempted concealment of the event is apparent.

SIMPLE EXAMPLE OF THE USE OF A "WHY- WHY" DIAGRAM TO THE INVESTIGATE THE ROOT CAUSES OF SAFETY INCIDENTS OR NEAR MISSES



Appendix 5. Guidance on the conduct and format of formal board of enquiry investigations

INTRODUCTION

Where a serious incident occurs involving death, serious injury or substantial damage to property, or where circumstances otherwise warrant, for example a near miss with significant STFC learning, a Board of Inquiry will be convened as quickly as possible to investigate the circumstances.

PURPOSE OF BOARDS OF INQUIRY

The purpose of a Board of Inquiry is to establish the facts, to ascertain the cause of the incident and, where possible, to recommend actions to prevent a recurrence. The Board has no legal powers and it is not part of its duty to recommend disciplinary action or apportion blame.

HEALTH AND SAFETY AT WORK ETC ACT 1974 PROVISIONS

Under the Health and Safety at Work etc. Act 1974 an Inspector of the Health and Safety Executive may, if he chooses, conduct his own investigation into the incident and have access to the proceedings of the Board of Inquiry. However the Health and Safety Executive has assured the Council that it is most unlikely that a prosecution would be approved against an individual where the only evidence against him was an admission which had been made to a Board of Inquiry.

Safety Representatives may, not withstanding the Board of Inquiry and Safety Inspector's investigations, exercise their rights of inspection and examination of any incident under the Regulations on Safety Representatives and Safety Committees 1977.

COMPOSITION

The membership of a Board of Inquiry will be at the discretion of the convening authority and will consist of a Chairman, a Secretary and such members as the convening authority thinks fit; they will all be persons who had no direct responsibility for the operations during the course of which the incident occurred. The Chairman shall be a STFC Director independent of the incident. No member of the local SHE Group shall be a member of the Board. The Board will include one member nominated by the Staff Side and/or one by the Trade Union Side.

TERMS OF REFERENCE

The Board's terms of-reference will be prescribed by the convening authority but will normally take the following form:

"In accordance with the provisions of STFC SHE Code 5 to enquire into the circumstances of .....which occurred on .....at to make recommendations and to report to (the convening authority) as soon as possible".

A notice will be published setting out the terms of reference and composition of the Board and inviting witnesses who wish to give evidence to notify the Board's Secretary.

No employee of the Council can be compelled to give evidence, whether written or oral, to a Board of Inquiry. However, staff are reminded that in accordance with Section 7 (b) of the Health and Safety at Work etc Act 1974 it is the duty of every employee while at work, to cooperate with their employer on safety matters.

METHOD OF INQUIRY

The Board will meet as soon as possible after the occurrence of the incident and thereafter, whenever and wherever necessary (including as appropriate, a visit to the site) to collect all the relevant facts, to ascertain the cause of the incident and to make recommendations to prevent a recurrence. The inquiry will be conducted by formal questioning of each witness or expert (normally individually and not in the presence of other witnesses or experts) and by examining such plant, papers, drawings, etc., as are deemed necessary.

FORMAT OF REPORT OF A BOARD OF ENQUIRY

1 Introduction (terms of reference, membership etc) - Annex 1

- If required, Executive Summary

2 Conduct of the Enquiry (brief description of how the Enquiry was carried out) - Annex 2

3 Details of the Accident/Incident

- The Accident/Incident (description of what happened and when) - Annex 3

- Time line for the incident and the immediate response.

- Nature of the work in progress and circumstances in which the incident occurred.

- Could the accident/incident have been more serious (ie was it also a narrow escape from something worse)

4 Examination of the Evidence

- Risk assessments, task instructions/method statements - did they exist? were they adequate? did they envisage the accident/incident which has happened? did the task instructions incorporate the findings of the risk assessment?

- Equipment - was the correct equipment being used? was it being used correctly? was it fit for purpose? did the equipment fail? was the equipment properly maintained (do records exist)?

- Operator actions - were the task instructions/method statement being followed? if the operators deviated from the instructions, why?

- Training - were the operators trained? are there records? was the training adequate?

5 Findings

- The Board's conclusions as to why the accident/incident happened

- The Board's conclusions about whether a similar accident/incident could happen elsewhere in STFC

6 Recommendations and Observations

- The Board's specific recommendations to avoid a repeat of the accident/incident

- More general recommendations and observations

Annex 1 - commissioning letter/memo

Annex 2 - list of people interviewed/other sources of information and evidence

Annex 3 - photographs, statements etc

SUBMISSIONS AND DISTRIBUTION OF REPORT

The report will be submitted by the Chairman of the Board to the STFC Chief Executive, Directors with responsibility for Safety at STFC laboratories and the Head of SHE.

No member of the Board may divulge the proceedings or findings of the Board except with the express approval of those to whom the report has been submitted.

Following its consideration by STFC Chief Executive, Directors with responsibility for Safety at STFC laboratories and the Head of SHE its further distribution will be determined. However, since, the main purpose of holding a Board of Enquiry is to analyse the adequacy of the Council's policy and practice in relation to the particular circumstances, copies of the report should be distributed to appropriate senior staff and to the designated Safety Officer(s) at each of the Council's Establishments.

Appendix 6. Serious or Potentially Serious Investigation guidance and pro forma.

Serious or Potentially Serious (SoPS) Incident investigation report format

SoPS reports are intended to be a basic report generated by a manager(s) responsible for a SoPS incident identifying what happened and why and the action(s) taken to minimise the potential for recurrence. SoPS incidents include near misses, vehicle incidents, fires, environmental incidents as well as actual injuries.

Format:

Incident title

1. **Incident summary**
   - short description of incident including the date/time and location of the incident, and as appropriate injuries sustained.

2. **Incident description**
   – clear description of the incident including activities leading up to the incident, the incident itself and how the incident was tackled with a clear chronology/ timeline.

3. **Incident analysis.**
   – including conclusions as to the incident's root cause(s).

4. **Actions**
   – to minimise the potential for recurrence of the incident in the form of a tabular action plan detailing the action(s) to be taken, responsibility for their completion and date by which action(s) should be completed.

Appendix 7. Training requirements

Role	Initial Training	Refresher	Frequency	Comments
Staff	Information to staff at Site SHE Induction and its routine refresh, including 'Evotix Assure' to report incidents. Provision of Evotix Assure Help Documents and Quick Start Guides.	Site SHE Induction and refresher.	5 Years.	
Visitors				
Facility Users				
Tenants				
Contractors	N/A	N/A	N/A	

Appendix 8. Audit checklist

Ref.	Item	Rating	Comments
1 (Section 4.1.4) (Section 4.2.1)	Are all incidents reported promptly? within the required timescales – 12 hours for significant and 2 working days for all other incidents.		
2 (Section 4.4.2) (Appendix 2)	Are all incidents communicated to relevant personnel promptly by SHE Group? Within 12 hours for major incidents to senior staff, PR and trade union representatives.		
3	Is the Evotix Assure description and information reported sufficient to describe the incident and determine its root cause?		
4 (Section 4.2.2)	Are local investigations carried out by line management within 2 weeks?		
5 (Section 4.2.2)	Have local investigations identified the incident's root cause?		
6	Are remedial actions SMART, assigned to individuals and delivered to plan?		
7	Is Evotix Assure data complete and consistent?		
8 (Section 4.5.1)	Have all major SoPS been investigated and SoPS reports generated by line management.		
9 (Section 4.4.5)	Is the HSE notified of all reportable incidents? In a timely manner?		

Appendix 9. Document Retention Policy

Records Established	Minimum Retention Policy	Responsible Record Keeper	Location of records	Comments/ Justification
Accident Records	Current + 50 years	SHE Group	Incident Reporting Spreadsheet and Evotix Assure	Required in case of litigation
SoPS Reports	Current + 50 Years	SHE Group		
Boards of Enquiry	Current + 50 Years	SHE Group		