Edinburgh Napier UNIVERSITY

Health & Safety
Accident, Dangerous Occurrence, Disease and Near Miss Policy

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[1] *or earlier if change in legislation or on risk assessment*

Amendment Control

Version	Date	Amendments
1.0	August 2015	
2.0	June 2018	Review (S Hughes)
3.0	March 2021	Review and change to accident reporting procedure (S Hughes)
4.0	May 2023	All sections reviewed (D Conner)
5.0	June 2023	Included diseases (B Rennie)

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Policy Summary

This policy covers:

- accident procedures and reporting
- accident prevention
- accident investigation
- Near misses, dangerous occurrences and diseases
- Accidents – intermediate and root causes

All accidents, dangerous occurrences, diseases and near misses require to be reported to the Health & Safety Team on the university Health & Safety incident report form. No matter how insignificant you think the incident/near miss/injury was, it must be reported.

When completing the university Health & Safety incident form ensure that the form is completed with as much detail as possible. A contact number is very important so the injured person can be contacted. Full details of witnesses must also be provided so that they can be contacted, wherever possible and statements taken.

Definition(s):

accident:
an event that results in injury or ill health

incident:
near miss: an event not causing harm, but has the potential to cause injury or ill health (in this guidance, the term near miss will include dangerous occurrences)
undesired circumstance: a set of conditions or circumstances that have the potential to cause injury or ill health, e.g. untrained nurses handling heavy patients.

dangerous occurrence:
one of a number of specific, reportable adverse events, as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

disease:
certain occupational diseases, where these are likely to have been caused or made worse by their work, as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). These diseases include (regulations 8 and 9):

- 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

Policy Contents

1. Accident procedures and reporting

In the event of any illness or injury, contact the university first aiders via the Security Control Room (tel: 0131 455 4444, internal extension 4444). The Controller will then locate the nearest available First Aider. First aiders can also be contacted if you go to the campus iPoint. A list of all first aiders is also kept on the staff intranet.

When contacting the Security Control Room please provide the following information:-

- Location of the injured or ill person (campus, School or Service details and room number).
- Details of the injury or illness (e.g. faint, chest pain, broken bone).
- Extension number from which the call is being made and name of caller.

Person making the request must remain with the patient or make arrangements for someone else to do so until assistance arrives.

Notices are displayed throughout the university advising staff of this procedure.

Anyone approaching someone who has been injured must assess the scene and ensure that it is safe to proceed to help. If the area is deemed as dangerous and could cause injury to others entering the area, then you must keep people out and call Security Control who will contact the relevant emergency services and/or Property & Facilities who deal with all service supplies.

It is essential that the disturbance of the scene of such accidents/incidents is kept to the minimum and should be consistent with the necessity to remove any continuing risk to other personnel or further damage to plant or building.

Any accidents, incidents, dangerous occurrences or diseases require to be reported to the Health & Safety Team on the university H&S incident reporting form.

No matter how insignificant you think the incident/near miss/injury/disease was, it must be reported.

When completing the university H&S incident form ensure that the form is completed with as much detail as possible. A contact number is very important so the injured person can be contacted. Full details of witnesses must also be provided so that they can be contacted, wherever possible.

Records and registers of notifiable accidents, diseases and dangerous occurrences will be retained for 5 years by the Health & Safety Team.

Accidents, near misses, dangerous occurrences and diseases, type, cause and remedial actions will also be discussed at University and School/Service safety committees to assist in the reduction/prevention of a reoccurrence.

2. Accident prevention

The main purpose of the university health and safety procedures and indeed in all health and safety legislation is to prevent accidents and these procedures should not be seen as an end in themselves. Time and resources devoted to accident prevention are invariably well spent compared to the time and resources wasted after an accident has occurred, not to mention the traumatic effects of a serious accident on the persons involved.

Whilst accident reporting and investigation are a necessary requirement and can result in action to minimise the recurrence of similar accidents it is by necessity a reactive approach. A more pro-active approach involves assessing the risks associated with the activities of Schools and Services and introducing, where indicated, for example safe systems of work to reduce the risks.

Accident prevention should therefore be an integral part of the efficient operation of any School or Service and should rank as having equal importance with any other academic or management activity.

Examples of accident prevention in the workplace:

- **Education and training** – Ensuring staff, students, and contractors are aware of potential hazards and are equipped with the necessary knowledge and skills to work safely.
- **Reporting of hazards** – Ensuring staff, students, visitors and contractors are aware of the importance of reporting hazards and understand who they should report them to (see Reporting of Hazards policy).
- **Engineering controls** – Designing and maintaining facilities, equipment, and machinery to minimise the risk of accidents.
- **Administrative controls** – Implementing policies, procedures, and guidelines to promote safe practices and behaviours.
- **Personal protective equipment (PPE)** – Providing appropriate protective gear for individuals to reduce the risk of injury when hazards cannot be entirely eliminated.
- **Emergency preparedness and response** – Establishing procedures for dealing with accidents or emergencies to minimise harm and ensure a prompt and effective response.

Accident prevention is crucial in promoting a culture of safety, reducing costs associated with accidents, and fostering a healthy, productive environment for individuals and the university.

Accident prevention is essential for:

- Safeguarding human life
- Promoting health
- Enhancing productivity
- Reducing costs
- Contributing to a positive reputation
- Improving staff and student morale
- Ensuring the university follows all legal compliance
- Environmental protection

3. Accident investigation

Where a serious accident or dangerous incident has occurred, whether or not person(s) were injured, all activities related to the incident should be suspended until an investigation has been undertaken and all equipment, plant or processes involved in the incident have been declared safe.

The responsibility for initiating investigations of accidents lies with the Health & Safety Team but these are carried out in conjunction with representatives of the injured person's/persons' School or Service and the injured person(s), if available. The right of Trade Union Representatives to investigate accidents is recognised and the university encourages their participation.

The investigation team will collate as much documentary evidence as possible at the time the incident. The depth and quality of the investigation, reporting and analysis will be proportionate to the seriousness of the incident as this information could be crucial in the event of an injury insurance claim and/or prosecution or enforcement at a later date.

The purpose of the investigation is not in any way to allocate blame, but to identify the basic cause of the accident and to recommend measures to prevent a recurrence.

Investigations will help:

- Identify why existing control measures failed and what improvements or additional measures are required.
- Plan to prevent the incident from happening again.
- Point to areas where any risk assessment needs reviewing.
- Improve risk control in the workplace in the future.
- Improve training deficiencies.
- Improve communications.
- Demonstrate the university's commitment to effective health and safety and improving morale and thinking towards health and safety.
- Provide essential information for insurers in the event of a claim, or if required later in a formal investigation or legal proceedings.

Written statements will be taken from the injured person and any witnesses. If the injured person is off work they may be contacted at home and an over the phone statement taken.

Copies of paperwork will be requested by the Health & Safety Team and photographs/video may be taken of the area where the accident has taken place.

The following documents could be requested:

- Risk assessment
- Safe systems of work
- Training records
- Maintenance and statutory inspection records
- Manufacturer's instructions
- Any other relevant documents

Where it is found to be caused by a dangerous action or piece of equipment, a Health and Safety Notice will be placed on that activity or equipment. This will mean that this action is suspended, cannot

be carried out or equipment used until the necessary control measures are put in place to ensure that it is safe.

On completion of the investigation the Health & Safety Team will forward any recommendations to the appropriate Dean of School or Director of Service for action. It is the responsibility of the Dean of School or Director of Service to implement measures to avoid a recurrence.

Since serious accidents, dangerous occurrences and diseases are notified to the Health and Safety Executive (HSE), they have a statutory right to investigate the scene of an accident, remove items for examination and take statements from witnesses, etc. All staff therefore must co-operate fully with these enforcing agencies.

Notification to the Health and Safety Executive (HSE) will be carried out by the Health & Safety Team in line with regulatory requirements (RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).

The HSE can also insist on an inspection if there has been a case of ill health, which may have been caused by workplace processes or exposure to a hazardous material and has been reported to the health and safety enforcing authority.

The HSE can place sanctions on the University and on work areas. These sanctions can include:

- Cautions
- Prohibition Notices
- Improvement Notices
- Fee for Intervention
- Prosecutions
- Fines
- Imprisonment
- Disqualification

The conclusions of such investigations often lead to prosecutions and staff are reminded that there is provision in the Health and Safety at Work Act (HSWA) for employees to be prosecuted as well as employers. Individual employees, including staff employed in educational institutions, have already been prosecuted in the UK under this legislation. The fee for intervention may also apply and it will be the relevant School or Service who will be required to fund this.

The Corporate Homicide Act Scotland came into force on 6 April 2008, "*where if an organisation was found guilty of the new offence in the way in which its activities are managed or organised causes a death and amounts to a gross breach of a relevant duty of care to the deceased. A substantial part of the breach must have been in the way activities were managed by senior management. 'Senior Management' is not defined and the structure of any organisation will need to be considered on a case-by-case basis to determine if the failure has occurred at a sufficient senior level. Criminal liability lies with the organisation, not the senior managers whose failings may have caused the commission of the offence*". Although the Act does not create a new offence for individual directors who contribute to deaths, they can be charged with culpable homicide or with other offences under the Health and Safety at Work Act.

"The new offence applies where the organisation concerned owed a duty of care in the law of negligence to the victim. This may include duties of care owed to employees, as an occupier of

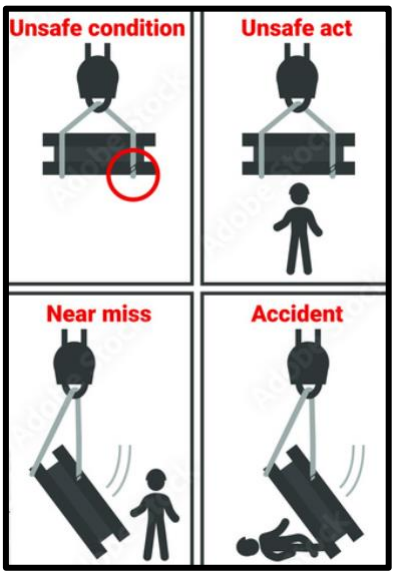
premises, in connection with supply of goods and services, construction and maintenance and commercial services, and the use of plant, vehicles etc., as set out in section 2 of the Act".

An organisation guilty of the offence will be liable to an unlimited fine.

4. Near misses, dangerous occurrences and diseases

Although not resulting in an injury it is still important to report and investigate any near misses, dangerous occurrences or diseases.

- Reporting a near miss helps to establish and continue safe practices within the workplace. It can enable Edinburgh Napier University to pro-actively resolve hazards before a tragic or costly accident or incident occurs.
- It engages the workforce (staff, students, contractors) in solving problems and any information provided enables Edinburgh Napier University to communicate the facts, causes, and corrective actions regarding near misses.
- Reporting of near misses provides valuable data and information to employees and management about how to avoid and prevent future hazards and injuries.
- Near misses provide a significant opportunity to identify weaknesses to improve the safety, health, and security in the workplace.
- With near miss reporting, Edinburgh Napier University can avoid complacency by constantly evaluating workplace activities and processes by looking for improvements.
- Reporting near misses increases safety ownership and can develop a positive and necessary attitude surrounding safety.
- Near miss reporting is a valuable collection of data over time and allows Health and Safety management to identify possible trends and potential risks.



Causes of near misses:

- Unsafe conditions
- Unsafe work practices
- Unsafe procedures
- Human error
- Lack of training
- Lack of safety awareness
- Employees that cut corners
- Lack of communication
- Unsafe tools/equipment

Examples of near misses:

- Slippery conditions could have led to slips or trips that cause serious injuries.
- Someone spills their cup of coffee in the refectory but does not wipe it up immediately.
- Working in a laboratory without PPE (Personal Protective Equipment) e.g. lab coat, gloves, eye protection etc.
- Unsafe use of equipment due to improper training or lack of maintenance of machinery.
- Coming into contact with possibly hazardous substances because of incorrect labelling on the container, but no injury occurs.
- Not reporting a faulty or broken light causing an area to be poorly lit.

These are all events which, if not reported, could happen again and with a potentially more serious outcome.

5. Accidents – intermediate and root causes

Accident investigations are an opportunity to establish what else needs to be done and what could have been missed previously when assessing workplace risks. As part of the investigation, the intermediate and root causes need to be identified in order that suitable measures to prevent re-occurrence can be put into place.

As a guide the following factors should be considered as part of the **'intermediate causes'**:

- Unclear instructions given by others.
- Suitability of people doing the work (i.e. insufficient knowledge about work methods)
- Training and competence of individuals.
- The method of work adopted at the time (i.e. deviating from the agreed safe system of work).
- Behaviour of the people involved (i.e. keenness, lack of concentration and tiredness).
- Poor working practices or conditions provided.
- Increased workload on the individual.

Similarly, the following factors may apply when identifying the possible '**root causes**':

- Deficiencies in method statements or risk assessments.
- Lack of supervision.
- Poor control and co-ordination of work activities.
- Lack of consultation/communication with employees.

- Language problems.
- Inadequate resources.
- Lack of monitoring.
- Lack of safety systems or barriers.
- Poor management of health and safety.
- Poor health and safety culture.
- Inadequate responses to previous accidents.
- Management based on one-way communications.
- Poor work planning.
- Poorly maintained equipment.
- Poor working conditions.
- Ineffective training.
- Inadequate/inappropriate PPE provided.

A further checklist for identifying intermediate and root causes is included in Appendix A.

Once the causes have been identified the '**actions taken to prevent re-occurrence**' can be implemented. Examples of such actions could be:

- Stop work while an investigation is carried out.
- Revising method statements/risk assessments.
- Further training for individuals.
- Re-briefing of method statements and risk assessments.
- Increased supervision.
- Increased resources.
- Toolbox talks/briefings carried out.
- Issue of internal Safety Prohibition or Improvement Notices.
- Disciplinary actions with individuals/supervisors/contractors.
- Contractor H&S Director involvement.
- Increased monitoring of the work activities.
- Better co-ordination of work activities.
- Meetings held with contractors/individuals concerned.
- Issues raised at Safety Co-ordination Meetings.
- Issues raised at H&S Consultation meetings.
- External investigations and reports.
- Increased H&S visits.
- Issuing of safety alerts.
- Revising University H&S Policies or Procedures.
- Amending University site rules.

Appendix A - Checklist for identifying immediate and root causes

Immediate causes (note – these lists are not exhaustive)

Actions	Conditions
1. Work at Height (including access) 2. Lifting (manual or mechanical) 3. Use of safety devices and equipment 4. Use of tools, equipment, plant and machines 5. Use of PPE 6. Decision making 7. Communications 8. Method of Work 9. Horse Play	1. Open/exposed edge (ext., int., platform, etc.) 2. Guards or protection 3. Walking surface 4. Tools, equipment, plant 5. Vehicles 6. Falling objects 7. Environment (heat, cold, ventilation, etc.) 8. Exposure (noise, vibration, etc.) 9. Live systems or equipment 10. Signs, barriers and warnings 11. Housekeeping

Root causes (note – these lists are not exhaustive)

Personnel Factors	Job Factors	Organisational Factors
1. Competence (skill, knowledge, experience) 2. Excessive demands (physical, mental, workload) 3. Fatigue (excessive work hours, personal issues) 4. Error (lapse, slip, mistake) 5. Violation (deliberate rule breaking) 6. Rushing work (programme, catch up, bonus, etc.) 7. Morale (bored, disheartened, personal issues) 8. Perception of risk – (unaware, underestimate, macho) 9. Perception of priorities (supervision, peers, site team) 10. Distraction (by colleagues, others, personal issues)	1. Risk assessment and safe method of work (done, adequate, appropriate, checked, etc.) 2. Task planning (complies with Risk Assessment and Safe Method of Work, adequate resources, buy in, communication, etc.) 3. Supervision (numbers, communication, competence, control, etc.) 4. Communications (shift hand over, changes, toolbox talks, language, induction, poster, etc.) 5. Provision and maintenance of plant/tools/equipment/PPE 6. Management of hazardous materials and emergency response 7. Maintenance of safe work environment (noise, layout, interfaces, atmosphere, etc.) 8. Compliance (Law, Safe Method of Work, permits, etc.)	1. Contractor management (selection, standard setting, liaison, monitoring, supervision) 2. Programme (time, co-ordination, progress, realism, change) 3. Design and planning risk management (elimination, assessment, control HSE risks) 4. Training (provided, adequate, recent) 5. Leadership (provided, adequate, visible, followed, credible, trusted) 6. Management of change (communication, evaluation, consultation) 7. HSE management system (document control, investigation, lessons learnt) 8. Communication (corporate, project, business unit) 9. Responses to emergencies and previous incidents 10. Allocation and fulfilment of responsibilities (just culture approach) 11. Allocation of staff and resources (competence, time, cost, equipment) 12. Community issues (lack of liaison – neighbours/regulators) 13. Client demands (time, cost, schedule, design, contractors, etc.) 14. External pressures (legal, market, environment)

Checklist for identifying environmental impacts (note – these lists are not exhaustive)

Environmental Impact
1. Pollution to air
2. Pollution to land
3. Pollution to surface water
4. Damage/loss to flora
5. Damage/loss to fauna
6. Damage/loss of archaeology
7. Pollution to foul water
8. Nuisance to residents
9. Pollution to groundwater
10. Light/noise pollution
11. Waste creation
12. Natural resources
13. Other