

**Serious Case  
Initial Findings (SCIF)  
UCD – GOV – 001 - SOP**

## 1. Document Control

### 1.1. Document Approval

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## **2. Introduction**

### **2.1. Purpose**

This Serious Case Initial Findings (SCIF) Standard Operating Procedure (SOP) supports the implementation of the Serious Incident, Incident and Complaints Policies across the Urgent Care Division (Greenbrook and Vocare). In practice, this SOP can encompass the initial fact-finding stages of any investigation when things have gone wrong. The process should identify the kind of and the level of investigation required, ensure an initial pre investigation risk assessment takes place and ensures that organisational ownership and Executive engagement is sought, and determines the basis on which the investigation should proceed.

### **2.2. Scope**

The SCIF does not seek to give guidance on an investigation; this is covered in full in the appropriate policies. The scope of this SOP is to establish if, having reviewed the initial findings SBAR, and discussed the case, whether or not the incident or complaint constitutes a serious incident, if it does, this will trigger a full serious incident investigation. If the SCIF concludes the issue is anything else, the appropriate policy should be followed. It may be that issues identified fall under any other Policy i.e.) HR process, in which case, this is documented, and HR take forward the case and Datix is closed. All parties involved in a Serious Case must treat them with the strictest of confidentiality, sharing information only on a need-to-know basis and only after permission from the chair of the SCIF or the Investigating Manager.

### **2.3. Definitions**

For the purpose of this SOP, a serious incident (SI) can be defined as an act/or omission occurring as part of an NHS-funded healthcare that results in:

2.3.1. Unexpected or avoidable death of one or more people. This includes:

- suicide/self-inflicted death; and
- killing by a person in receipt of mental health care within the recent past

2.3.2. Unexpected or avoidable injury to one or more people that has resulted in serious harm.

2.3.3. Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional to prevent.

- the death of the service user; or
- serious harm.

2.3.4. Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial (fraud) or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking, and modern-day slavery where:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
- were abuse occurred during the provision of NHS-funded healthcare

2.3.5. This includes abuse that resulted in or was identified through a Serious Incident Review Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation, where delivery of NHS funded healthcare caused/contributed towards the incident.

- 2.3.6. A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.
- 2.3.7. An incident, or series of incidents that prevents, or threatens to prevent, the Urgent Care Division's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
- Failures in the security, integrity, accuracy, or availability of information often described as data loss and/or information governance related issues.
  - Property damage.
  - Security breach/concern.
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population.
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards.
  - Systematic failure to provide an acceptable standard of safe care.
  - Activation of Major Incident Plan.
  - Media coverage or public concern about the quality of healthcare or an organisation.

*Serious Incident Framework, NHS England Patient Safety Domain, 27 March 2015*

## **2.4. Attendees & Responsibilities**

### **2.4.1. SCIF Chair**

The Chair of the Serious Case Initial Findings (SCIF) conference should be the Area or Regional Clinical, Medical or Operational Director for the location where the incident occurred. For incidents where there is clearly a high risk or threat at the outset, the SCIF should be chaired by a member of the Regional or Executive team. This includes but is not limited to deaths in our care of children or vulnerable adults (patients sectioned under the mental health act, undergoing a mental capacity act assessment or have a DOLS in place).

The Chair is responsible for ensuring that the appropriate people are invited to attend and that sufficient information is available to make an informed decision regarding the case. If the Chair feels that sufficient information is not available, they should reschedule the SCIF conference until such times as they have that information.

The Chair must ensure that any serious incident declared is justifiable and that any appropriate notification have been made to the Regional and Executive teams. All attendees must be reminded of the confidential nature of the SCIF.

The Chair is also responsible for ensuring that all actions are assigned and that the minutes are signed off for distribution.

### **2.4.2. Service Leadership Team**

Any member of the Service leadership team who understands the incident to present the initial findings in a SBAR format.

#### 2.4.3. Area / Regional Governance Team

A member of the Area or Regional Governance Team who will complete the actions following the conference call and can be asked to take the minutes and share these with attendees.

2.4.4. Divisional Governance Team – a member of the national governance team to advise and support the Regional Governance Team member. The Deputy Director of Nursing, Quality and Projects to be invited to all SCIFs for Divisional oversight.

#### 2.4.5. Subject Matter Experts

Experts in specific areas, for example Information Technology, Safeguarding (all staff and patient related SCIFs), Medicines Management etc

#### 2.4.6. Regional Directors

Regional Clinical, Medical and Operational Directors retain responsibility for all incidents and cases in their services. Relevant Regional Directors should receive an invitation to all local SCIFs but may delegate responsibility for attending the SCIF to Area Directors unless they are required to Chair.

#### 2.4.7. Executive Directors

Executive Directors may be requested to attend or Chair a SCIF if it is deemed to be of high importance to the organisation or has potential national implications.

### 3. Process

- 3.1. A Serious Case Initial Findings conference call must be arranged as soon as possible and at latest within 3 days the incident became apparent and obtain an initial briefing in the form of SBAR from the Service team to take to the conference.
- 3.2. Where there is concern that an issue or incident may meet the criteria for a serious incident the person to whom the initial issue was reported to should inform the Regional Clinical Director or another Regional Director immediately. The Regional Clinical Director will ensure that the Executive are informed immediately of any issue that is or that may require notification outside of the organisation. The CQC notifiable criteria are:
  - 3.2.1. Regulation 13 - Allegations of abuse or improper treatment (safeguarding).
  - 3.2.2. Regulation 8 - Application to deprive a person of their liberty (DoLS).
  - 3.2.3. Regulation 17 - Death of a detained mental health patient.
  - 3.2.4. Regulation 16 - Death of a person using the service. (The UCD extends this anyone with whom has contacted the service within 72 hours of the death).
  - 3.2.5. Regulation 18 - Events that stop a service running safely and properly.
  - 3.2.6. Regulation 18 - Police involvement in an incident (for example -assault, missing controlled drugs, theft, homicide, missing person).
  - 3.2.7. Regulation 18 -Serious injury to a person using the service.

<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers>

- 3.3. Agenda for Serious Case Initial Findings conference is appended as **Appendix 1** and should be used to guide the conference. A flow chart identifying the process is at **Appendix 2**. The SBAR template at **Appendix 3** should be used to gather initial findings to discuss in the SCIF. **Appendix 4** can be utilised to determine the level of risk associated with the incident under discussion.

## 4. Organisational Policy

Consideration should be made to all policies relating to the incident under discussion, the Serious Incident Policy but also other organisational Policies and Standard Operating Procedures, based on the incident under discussion. If it is not clear at the time of the SCIF what further Policy review is required, the SCIF should be rescheduled to ensure this is clear.

## 5. Internal Notification Process

There are certain circumstances which require direct notification to the Urgent Care Division Executive members. Notification should be made immediately on discovery of such an issue and should not wait until a SCIF takes place, although the SCIF will act as a safety net to ensure notifications are not overlooked.

Notifications should be made by telephone call followed by an email to [urgentnotification@vocare.nhs.uk](mailto:urgentnotification@vocare.nhs.uk) with details. In the out of hours period these notifications should be made to the executive on call. The Urgent Care Executive team will take responsibility for the immediate onward communication of these notifications to the relevant Totally Group Executive team.

The below list of reasons for executive notification is not exhaustive but intended to represent examples of where there may be a threat to the organisation, either related to service delivery or potential media interest.

### Services

1. Any significant issue, quality or otherwise, raised by an external organisation, e.g. commissioners, CQC, NHSE, statutory bodies etc.
2. Any incident deemed to be high risk, including deaths in our care, incidents requiring multisystem investigation, high profile events etc.
3. Incidents which require notifications to be made outside of the organisation e.g. Police, Home Office, NHS Digital (ICO), CQC, PHE, HSE etc.
4. All incidents identified as Serious (a SI) after the SCIF process.

### People

1. Any significant HR issue, including staff suspension decisions, referrals to professional bodies, or risks raised in relation to workforce.
2. Any incident involving a potential crime, including violence, alleged assault, sexual exploitation, misuse of systems, fraud, theft, missing controlled drugs etc.
3. Any significant staff welfare issues, including illness or injury requiring hospital admission or affecting multiple team members.

### Business

1. Any significant disruption to the delivery of care, including IM&T, application or telephony outages (Issues lasting more than 1 hour that have already been reported to IM&T).
2. Any risk to infrastructure, including power failure, fire, flooding, buildings or estates, and other serious issues affecting ability to deliver services.
3. Any approach from the press or media in relation to our services, or issues/incidents that may result in press or media interest.
4. Any request for information in regards to a legal case or requiring attendance at a court of law.

If there is any doubt as to whether a notification or escalation is needed, please make the notification anyway.

## Appendix 1

### Serious Case Initial Findings

### SCIF AGENDA

Date:		Time:		Reference:	
Chair:		Present:			
Item		Action	By Whom?	By When?	
1. Welcome		Statement regarding confidentiality to be made			
2. Purpose		1. Establish whether or not the incident will be classified as a serious incident or other type of issue 2. Ensure that the executive is aware if deemed a serious incident. 3. Establish whether or not the incident should be reported as a work-related incident and if so ensure that the executive is advised of any recommendation to report (RIDDOR). 4. Identify, assess and mitigate any risks arising from the incident 5. Identify and ensure the implementation of any immediate actions that may be required, including staff support 6. Agree the scope of the investigation and identify an appropriate investigating officer. 7. Consider and if needed implement any communication requirements, including any statutory or regulatory notifications, including duty of candour 8 Agree next steps including follow up meetings to ensure progress.			
3. SBAR - Briefing from incident, what has occurred. (Appendix 1)					
4. Incident Level Does the case presented indicate that this is an incident which will require a RIDDOR report to be submitted?  If confirmed that any of these apply the case will also meet the criteria for a serious incident. What level of incident/complaint is this? Definition SI - Appendix 2					
5. Risk (detailed below)					



<p>Review of the risks presented regarding the incident and a formal risk assessment if required. What immediate action/actions are required to ensure no further harm occurs, assess the risk of these actions?</p> <p><b>Risk - Appendix 3</b></p>			
<p><b>6. Staff Support</b></p> <p>Has full consideration been made to support the staff involved and reflective practice initiated, as required.</p> <p><b>IDT - Appendix 4</b></p>			
<p><b>7. Duty of Candour</b></p> <p>Does the patient or their representative need to be informed, who will do this and by when?</p>			
<p><b>8. Notification</b></p> <p>Who needs to be formally notified, for example Vocare Executive, Totally Executive, Health and Safety Executive (RIDDOR), Counter Fraud Officer, Totally Legal team, Totally Comms team, CCG, CQC, Insurers etc.</p>			
<p><b>9. Scope</b></p> <p>What is the scope of investigation required? Who will complete the investigation? When will the investigation be completed?</p>			
<p><b>10. Communications</b></p> <p>Is there a requirement to complete a media briefing or send out an internal bulletin/communication? Does the Comms Manager in Totally plc need to be notified?</p>			
<p><b>11. Learning</b></p> <p>What initial learning has been identified? Does any learning need to be shared now?</p>			
<p><b>12. Action</b></p> <p>What actions now need to take place in order to protect patient safety/prevent reoccurrence? Who will do this, by when? This should include all actions agreed during the course of the SCIF meeting.</p>			
<p><b>13. Follow up</b></p> <p>If deemed to be a reportable incident under the Reporting of Injuries, Diseases and Dangerous regulations 2013, the responsible Executive must arrange a meeting with the Urgent Care Division Executive to agree the recommendation for reporting.</p> <p>As an SI, the case should be reviewed by the RCD and I/O on day 20 and day 40.</p> <p>A formal Serious Incident Review Group should be arranged not for day 55-60, with a 60 day review with the SIRG panel to review all actions and learning.</p>	Agreed review dates:		
<p><b>14. Datix</b></p>	Review actions and complete action plan, save this document under SCIF folder and upload to Datix only after final draft has been approved by the Chair of the SCIF.		

## Appendix 2

### Process Flowchart

#### Incident awareness

- Identify a potential serious incident
- Discuss with **Service lead Clinical & Operational include any subject matter experts** – raise datix

#### Raising a SCIF

- **Governance regional team** collate information assign a document folder stored on datix
- **Service lead** writes SBAR completed within 3 days of becoming aware of the incident
- **Chair (Area Clinical / Medical or Operational Director)** reviews and ensures appropriate attendees, notifying **Regional Executive Team and Executive Team as identified in (Internal Notification Section) by phone or email urgentnotification@vocare.nhs.uk**

#### SCIF meeting

- **Chair** follows the SCIF Agenda welcomes attendees – reminder of confidentiality of the meeting
- **Governance regional team** attend take minutes and actions – have documents available for review if required (supported by divisional team where required)
- **Chair** follows the SCIF agenda, SBAR is read out by **service lead**
- **Attendees** decision reached on whether the case meets the criteria of Serious Incident / Adverse Event / HLI or continue as incident/complaint. Agree actions, notifications, scope, investing officer and dates for 20, 40 and 60 day reviews
- **Regional Governance** add information to datix, draft minutes sent to chair for review and sign off.
- **Chair** notifies Executive of decision reviews notifications before submission

## Appendix 3

### SBAR for SCIF

#### SBAR Template for Serious Case Initial Finding Conference

##### **Situation:**

*Set out the initial identification of the issue, by whom, when and how. Who else is aware, has a DATIX been raised (what is the Datix number), have any actions been taken immediately and what do we understand to be the consequences at this stage.*

##### **Background:**

*Any supporting information to identify what went wrong, any changes to process, staffing position, training requirements not met, resourcing levels poor, Policy or SOP breached ect. What do you believe to be the source and root cause of the serious case.*

##### **Assessment:**

*What did you establish on listening to calls, reviewing notes, speaking to staff initially (Do not interview staff). If this is a serious incident scene – do not touch anything and secure the scene. Any initial facts that you have found out without “investigating”. What actions have subsequently been taken based on the initial finding, if any. Explain the facts with the information available to you.*

##### **Recommendations:**

*Please number these and be clear regarding the actions that need to be considered. What do you feel went wrong (this is speculative as the investigation has not taken place), we are seeking your opinion of the situation? What do you feel we need to include in the scope of the investigation? What do you feel are the key factors that need to be resolved?*

## Appendix 4

### Definition of a Serious Incident (SI)

A Serious Incident can be defined as an act an act/or omission occurring as part of and NHS-funded healthcare that results in:

1. Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and killing by a person in receipt of mental health care within the recent past.
2. Unexpected or avoidable injury to one or more people that has resulted in serious harm.
3. Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent; the death of the service user; or serious harm.
4. Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial (fraud) or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking, and modern-day slavery where: healthcare did not take appropriate action/intervention to safeguard against such abuse occurring. Where abuse occurred during the provision of NHS-funded healthcare.
5. This includes abuse that resulted in or was identified through a Serious Incident Review Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation, where delivery of NHS funded healthcare caused/contributed towards the incident.
6. A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.
7. An incident, or series of incidents that prevents, or threatens to prevent, Vocare's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
  - 7.1. Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues, Property damage; Security breach/concern; Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population.
  - 7.2. Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards. Systematic failure to provide an acceptable standard of safe care. Activation of Major Incident Plan. Media coverage or public concern about the quality of healthcare or an organisation

*Serious Incident Framework, NHS England Patient Safety Domain, 27 March 2015*

## Appendix 5

### Risk Assessment

Assessing a risk to enable a score to be allocated is undertaken in three steps:

**Stage 1** – evaluate the impact of a risk occurring using the templates below.

Domain	Consequence Score and Descriptor				
	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Catastrophic
Patient/Public/ Staff Care/Injury	Minimal Near miss	Near miss with potential for harm e.g. cuts/bruises Less than 3 days absence from work	Significant effect on care Significant injury More than three days absence from work (reportable to HSE)	Critical impact on care Permanent disability Reportable to HSE	Life threatening Fatality Multiple life threatening Multiple fatalities
Financial Impact	Up to £50,000	£50,000 to £500,000	£50,000 to £1m	£1m to £5m	Over £5m
Organisational Impact	Within service/department only No impact on service but potential for future impact	Local press interest with less than one day's coverage Minor impact on service with potential for future impact	Regional concern Local media interest with less than 7 days coverage Loss of some local service	NHS Executive concern National media with less than 7 days coverage Loss of service(s) affecting more than one region	National media coverage of over 7 days duration Questions in the House of Commons International media coverage Loss of critical area which impacts on other services/department Major disruption to organisation's services
Litigation	Potential for litigation	Minor cost Court attendances	Civil action which is defensible CQC/HSE Improvement Notice	Civil action with no defense HSE Prohibition notice CQC Notice of Proposal	Criminal prosecution with no defence
Quality	Minor non-compliance	Single failure to meet internal standard	Failure to meet professional standards	Failure to meet professional standards	Failure to meet national standards
Human Resources	Short term low staffing level which temporarily reduces service quality	Ongoing low staffing level which reduces service quality	Late delivery of key objectives/services due to lack of staff (as a result of recruitment, retention or sickness/absence)	Uncertain delivery of key objectives/services due to lack of staff Serious error due to insufficient training	Non-delivery of key objectives/services due to lack of staff.  Very high staff turnover.  Critical error due to insufficient training
Service/ Business Interruption	Loss/ interruption of more than 1 hour	Loss/ interruption of more than 8 hours	Loss/ interruption of more than a day	Loss/ interruption of more than a week	Permanent loss of service or facility

Domain	Consequence Score and Descriptor				
	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Catastrophic
Information Governance	Minor breach of confidentiality affecting 5-20 people. No significant reflection on any individual or body. Media interest unlikely.	Potentially a serious breach affecting between 5-20 people. Loss of encrypted files. Damage to an individual's reputation. Possible media interest.	Potentially a serious breach. Between 20 and 100 people affected. Loss of unencrypted files. Damage to an individual's or team's reputation. Local media interest that may not go public.	Serious breach with up to 1000 people affected. Loss of sensitive data. Damage to the organization's reputation Local media coverage.	Serious breach with potential for ID theft. Over 1000 people affected. Damage to the NHS's reputation. National media coverage.
External Inspection/ Audit	Minor recommendations. Minor non-compliance with standards.	Recommendations given. Non-compliance with standards.	Reduced rating. Challenging recommendations. Non-compliance with core standards.	Enforcement action Low rating Critical report Multiple challenging recommendations Major non-compliance with core standards	Prosecution. Zero rating. Severely critical report

**Stage 2** – evaluate the likelihood that the risk will occur using the template below.

Score	Likelihood Descriptor	Likelihood Description
1	Negligible/Insignificant	May only occur in exceptional circumstances 0-9% chance of occurrence
2	Minor	Not expected but could occur infrequently. 10-29% chance of occurrence
3	Moderate	May/will occur at some time 30-59% chance of occurrence
4	Major	Will probably occur, but not a persistent issue 60-89% chance of occurrence
5	Catastrophic	Likely to occur on many occasions, a persistent issue. 90-100% chance of occurrence

Likelihood can be scored considering: 1. How many times the consequence (impact) being assessed will actually occur or 2. The chance the consequence (impact) being assessed will occur in a given period. The table below shows this.

Descriptor	Score	Frequency	Probability
Rare	1	This will probably never happen/recur	>1 in 100,000
Unlikely	2	It is not expected to happen/recur, but it is possible	>1 in 10,000
Possible	3	It might happen/recur occasionally	>1 in 1,000
Likely	4	It might happen/recur, but it is not a persistent issue	>1 in 100
Almost Certain	5	It will undoubtedly happen/recur, possibly frequently	>1 in 10

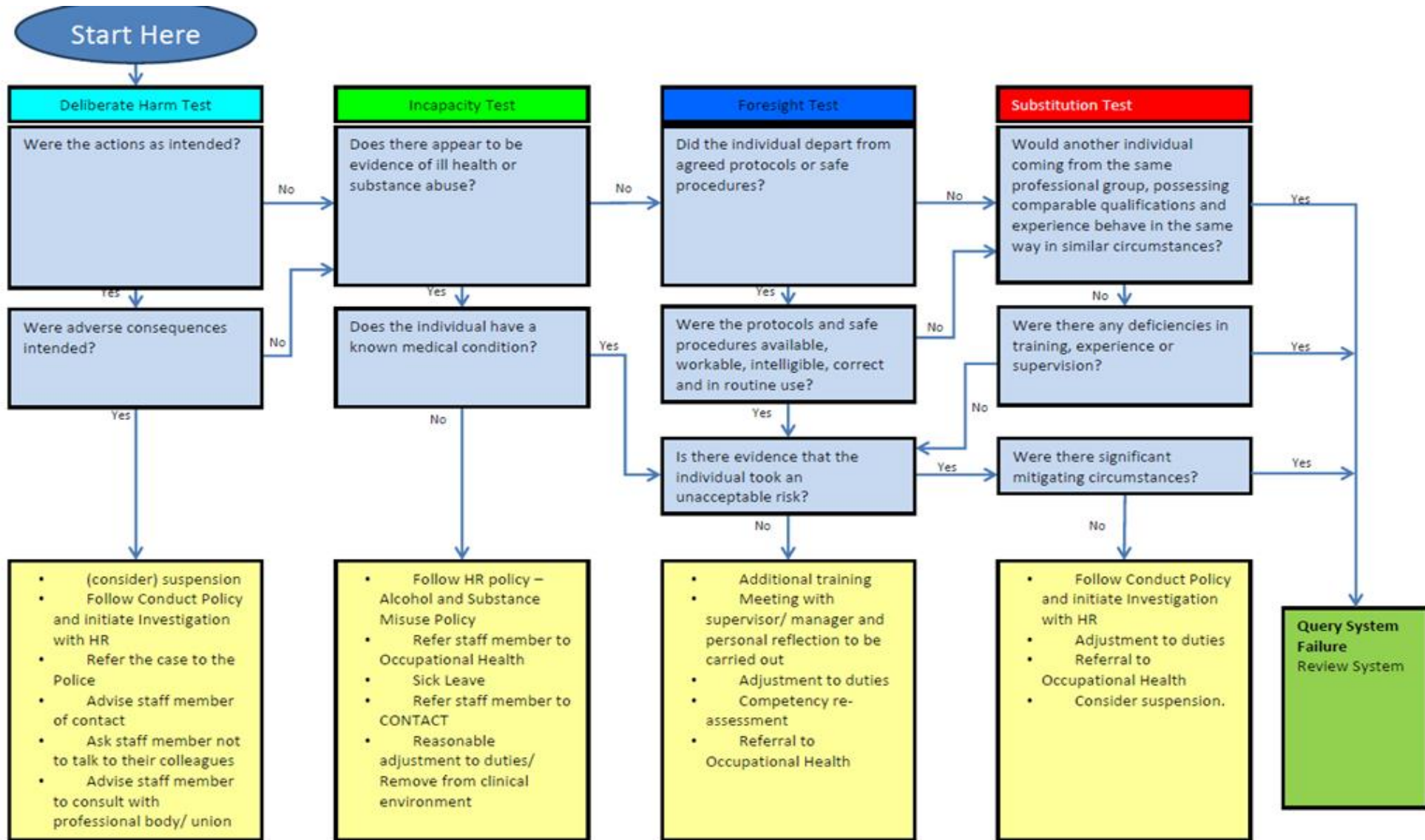
**Stage 3** – calculate the score by multiplying the impact score by the likelihood score, that is, **IMPACT SCORE X LIKELIHOOD SCORE = RISK SCORE** as shown in the table below.

LIKELIHOOD		IMPACT/SEVERITY OF CONSEQUENCE				
		Insignificant/ Negligible	Minor	Moderate	Major	Catastrophic
		1	2	3	4	5
Almost Certain	5	5 Moderate Risk	10 High Risk	15 Extreme Risk	20 Extreme Risk	25 Extreme Risk
Likely	4	4 Moderate Risk	8 High Risk	12 High Risk	16 Extreme Risk	20 Extreme Risk
Possible	3	3 Low Risk	6 Moderate Risk	9 High Risk	12 High Risk	15 Extreme Risk
Unlikely	2	2 Low Risk	4 Moderate Risk	6 Moderate Risk	8 High Risk	10 High Risk
Rare	1	1 Low Risk	2 Low Risk	3 Low Risk	4 Moderate Risk	5 Moderate Risk

It might be appropriate to assess more than one domain of consequence as this may give differing scores. Where there are multiple potential consequences of a risk, the highest score should be used as the overall score. Please refer to the Risk Management Policy (found on the Intranet).



## Appendix 6





LIKELIHOOD		Insignificant/Negligible	Minor	Moderate	Major	Catastrophic
		1	2	3	4	5
Almost Certain	5	5 Moderate Risk	10 High Risk	15 Extreme Risk	20 Extreme Risk	25 Extreme Risk
Likely	4	4 Moderate Risk	8 High Risk	12 High Risk	16 Extreme Risk	20 Extreme Risk
Possible	3	3 Low Risk	6 Moderate Risk	9 High Risk	12 High Risk	15 Extreme Risk
Unlikely	2	2 Low Risk	4 Moderate Risk	6 Moderate Risk	8 High Risk	10 High Risk
Rare	1	1 Low Risk	2 Low Risk	3 Low Risk	4 Moderate Risk	5 Moderate Risk

## Appendix 7

### Types of RIDDOR Reportable Incidents

Where a RIDDOR report is to be submitted to the HSE and where any Totally Urgent Care Division Service is acting as a sub-contractor, the head contractor must also be informed within 24 hours. This should only take place once the Executive have confirmed the recommendation to make the report and should be undertaken by a member of the Executive or by a regional director nominated by that executive.

Who will complete the relevant notifications, and by when?

**NOTE: RIDDOR notification should only be made by the Health and Safety Manager or Head of Clinical Governance.**

**(The 72-hour for CCG report to be approved by SCIF chair before sharing)**

#### Coronavirus (COVID-19)

- Where there has been an unintended incident at work has led to someone's possible or actual exposure to COVID-19. This must be reported as a dangerous incident (e.g. Lab worker exposure accident).
- Where a worker has been diagnosed as having COVID-19 and there is reasonable evidence that it was caused by exposure at work. This must be reported as a case of disease (e.g. Health and social care worker.)
- A worker has died as a result of occupational exposure to COVID-19.

#### Deaths and Injuries

If someone has died or has been injured because of a work-related accident this may have to be reported.

Not all accidents need to be reported, a RIDDOR report is required only when

- The accident is work related
- The accident results in an injury which is reportable

#### The death of any person.

All deaths to workers and non-workers, except for suicides, must be reported if they arise from a work-related accident, including an act of physical violence to a worker.

#### Specified Injuries to Workers

The list of 'specified injuries' in RIDDOR 2013 replaces the previous list of 'major injuries' in RIDDOR 1995. Specified injuries are (regulation 4):

- fractures, other than to fingers, thumbs, and toes
- amputations

- any injury likely to lead to permanent loss of sight or reduction in sight
- any crush injury to the head or torso causing damage to the brain or internal organs
- serious burns (including scalding) which:
  - covers more than 10% of the body
  - causes significant damage to the eyes, respiratory system or other vital organs
- any scalping requiring hospital treatment
- any loss of consciousness caused by head injury or asphyxia
- any other injury arising from working in an enclosed space which:
  - leads to hypothermia or heat-induced illness
  - requires resuscitation or admittance to hospital for more than 24 hours

***further guidance on specified injuries is available***

### **Over-seven-Day Incapacitation of a Worker**

Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury.

This seven-day period does not include the day of the accident but does include weekends and rest days. The report must be made within 15 days of the accident.

### **Over-three-Day Incapacitation**

Accidents must be recorded, but not reported where they result in a worker being incapacitated for more than three consecutive days. If you are an employer, who must keep an accident book under the Social Security (Claims and Payments) Regulations 1979, that record will be enough.

### **Non-fatal Accidents to Non-workers (for example members of the public)**

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. If the accident occurred at a hospital, the report only needs to be made if the injury is a 'specified injury' (see above).

### **Occupational Diseases**

Employers and self-employed people must report diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work: 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.

***Further guidance on occupational diseases is available.***

Specific guidance is also available for:

- occupational cancers
- diseases associated with biological agents

### **Dangerous Occurrences**

Dangerous occurrences are certain, specified near-miss events. Not all such events require reporting. There are 27 categories of dangerous occurrences that are relevant to most workplaces, for example:

- the collapse, overturning or failure of load-bearing parts of lifts and lifting equipment.
- plant or equipment meeting overhead power lines.
- the accidental release of any substance which could cause injury to any person.

***Further guidance on these dangerous occurrences is available.***

### **Gas Incidents**

Distributors, fillers, importers & suppliers of flammable gas must report incidents where someone has died, lost consciousness, or been taken to hospital for treatment to an injury arising in connection with that gas. Such incidents should be reported using the Report of a Flammable Gas Incident - online form.

Registered gas engineers (under the Gas Safe Register,) must provide details of any gas appliances or fittings that they consider to be dangerous, to such an extent that people could die, lose consciousness, or require hospital treatment. The danger could be due to the design, construction, installation, modification or servicing of that appliance or fitting, which could cause:

- an accidental leakage of gas.
- incomplete combustion of gas or.
- inadequate removal of products of the combustion of gas

***unsafe gas appliances and fittings should be reported using the Report of a Dangerous Gas Fitting - online form***