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IMS-08-04-CAV: Health & Safety Serious Incident Review Procedure

Introduction and Aim

This procedure outlines the formal arrangements established to ensure that all serious incidents, including those resulting in fatalities, are subject to comprehensive and rigorous review. The aim is to ensure serious incidents are reviewed thoroughly to strengthen organisational safety and accountability.

The aim is to ensure serious incidents are reviewed thoroughly to strengthen organisational safety, culture and accountability. It operates independently of the initial incident investigation procedure and serves as a secondary assurance mechanism—verifying that the original investigation has been completed to a satisfactory standard and that all findings, recommendations, and outcomes have been appropriately considered and addressed.

Is the document supporting a policy?
What will it achieve?

Objectives

- **Ensure Comprehensive Review:** To establish a structured process for the thorough examination of all serious incidents, including fatalities, beyond the initial investigation.
- **Validate Investigation Quality:** To confirm that the original incident investigation has been completed to a satisfactory standard, with all findings, contributing factors, and outcomes properly considered.
- **Identify Systemic Issues:** To uncover underlying causes, organisational weaknesses, or cultural factors that may have contributed to the incident.
- **Drive Corrective Action:** To ensure that appropriate corrective and preventive actions are identified, implemented, and tracked to completion within defined timeframes.
- **Promote Organisational Learning:** To facilitate the sharing of lessons learned across relevant teams and departments, enhancing safety awareness and risk mitigation.
- **Support Accountability and Transparency:** To reinforce a culture of responsibility and openness in the handling of serious incidents, ensuring senior leadership oversight and stakeholder confidence.
- **Enable Continuous Improvement:** To use insights from serious incident reviews to inform policy updates, training programs, and operational improvements.

Scope

This procedure is to be used by all Clinical / Service Board directors and relevant line managers.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed for the Health and Safety Policy and confirmed there is no adverse impact
Documents to read alongside this Procedure	IMS-01-01-CAV: Health and Safety Policy. **Other References:**

	UHB135: INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY UHB 433: INCIDENT, HAZARD AND NEAR MISS REPORTING PROCEDURE
Approved by	Operational Health and Safety Group

Accountable Executive or Clinical Board Director	Executive Director of People and Culture
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Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	Operational H&S Group	29/01/2026	New document to support the Health and Safety Policy and fulfil the UHB statutory obligations under the Management of Health and Safety at Work Regulations 1999

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1 Introduction

This document details the procedure for the review of Health and Safety related serious Incidents including fatalities at Cardiff and Vale University Health Board.
It is to ensure all serious incidents—including fatalities—are thoroughly investigated, lessons are learned, and corrective actions are implemented. This process promotes transparency, accountability, and continuous improvement in safety culture. This document is not a procedure to perform the incident investigation.
Some examples of incidents requiring an SIR may fall within the following categories:

- **High Consequence**: Serious Injuries and Fatalities (SIFs) represent the most severe outcomes of workplace hazards.
- **Prevention Focus**: Identifying and mitigating SIF precursors is critical to preventing future undesirable events.
- **Regulatory & Legal Implications**: SIFs often trigger mandatory reporting, investigations, and potential legal action.
- **Cultural Impact**: These incidents deeply affect morale, trust, and the organisation's safety culture.

2 Serious Injury or Fatality (SIF)

Any actual or potential incident that:

- Results in a **fatality**, or
- Causes a **life-altering injury**, such as:
  - Permanent disability
  - Loss of limb or major organ function
  - Severe burns or trauma
  - Long-term hospitalisation
- OR had the potential to cause such outcomes, even if no injury occurred it is referred to as SIF-potential.

3 Why Undertake an SIR?

Undertaking SIR's when an incident has occurred provides the Health Borad with assurance that all mitigating actions have been recognised, implemented and complete to minimise / alleviate future occurrences. SIR's are also a good opportunity for perspectives and skill sets to be applied and allow for all aspects of the incident to be considered, and continual improvement achieved. Other reasons for conducting SIR may include:

- **Trend Analysis**: Review of incident data to identify patterns.
- **Training Updates**: Revise training needs or programs based on findings.
- **Policy Revisions**: Update safety policies and procedures as needed.
- **Risk Assessment**: Revise any relevant risk assessment as needed.
- **Validate Investigation Quality:** confirming that the original incident investigation has been completed to a satisfactory standard, with all findings, contributing factors, and outcomes from varied perspectives and experience.
- **Drive Corrective Action:** To ensure that appropriate corrective and preventive actions are identified, implemented, and tracked to completion within defined timeframes.
- **Promote Organisational Learning:** To facilitate the sharing of lessons learned across relevant teams and departments, enhancing safety awareness and risk mitigation.
- **Support Accountability and Transparency:** To reinforce a culture of responsibility and openness in the handling of serious incidents, ensuring senior leadership oversight and stakeholder confidence.
- **Enable Continuous Improvement:** To use insights from serious incident reviews to inform policy updates, training programs, and operational improvements.

4 Incident requiring a Serious Incident Review (SIR)

A Serious Incident Review (SIR) is triggered when an incident involving staff, patients or visitors meet the criteria for significant harm, risk, or regulatory reporting requirements. Using Datix Cymru's coding system, incidents that typically require an SIR include:

- **Major Staff Injury or Harm** (e.g. major injury, physical assault, needlestick injury with potential infection risk)

- **Violence and Aggression Towards Staff**
  (e.g. serious physical assault, threatening behaviour leading to injury or significant distress)
- **Occupational Ill Health**
  (e.g. work-related illness, such as respiratory disease, infections, or mental health conditions caused/exacerbated by work)
- **Near Misses or Errors with High Potential for Harm to Staff**
- **Falls or Accidents at Work Resulting in Serious Injury or Hospitalisation**
- **Incidents reported under RIDDOR**

5 Attendance Requirements for SIR Scheduling

When scheduling a Serious Incident Review (SIR), the following delegates will be expected to attend:

- Assistant Director of Health, Safety and Fire (or delegate)
- H&S Advisor
- Specialist Advisor (e.g. Manual Handling / Violence and Aggression)
- Clinical Board Director (or delegate)
- Incident Manager (if deemed necessary by the CBD)
- Line Manager (or delegate if personal injury involved)

Attendance is considered essential to ensure a comprehensive review of the incident, facilitate multidisciplinary input, and support the development of effective action plans.

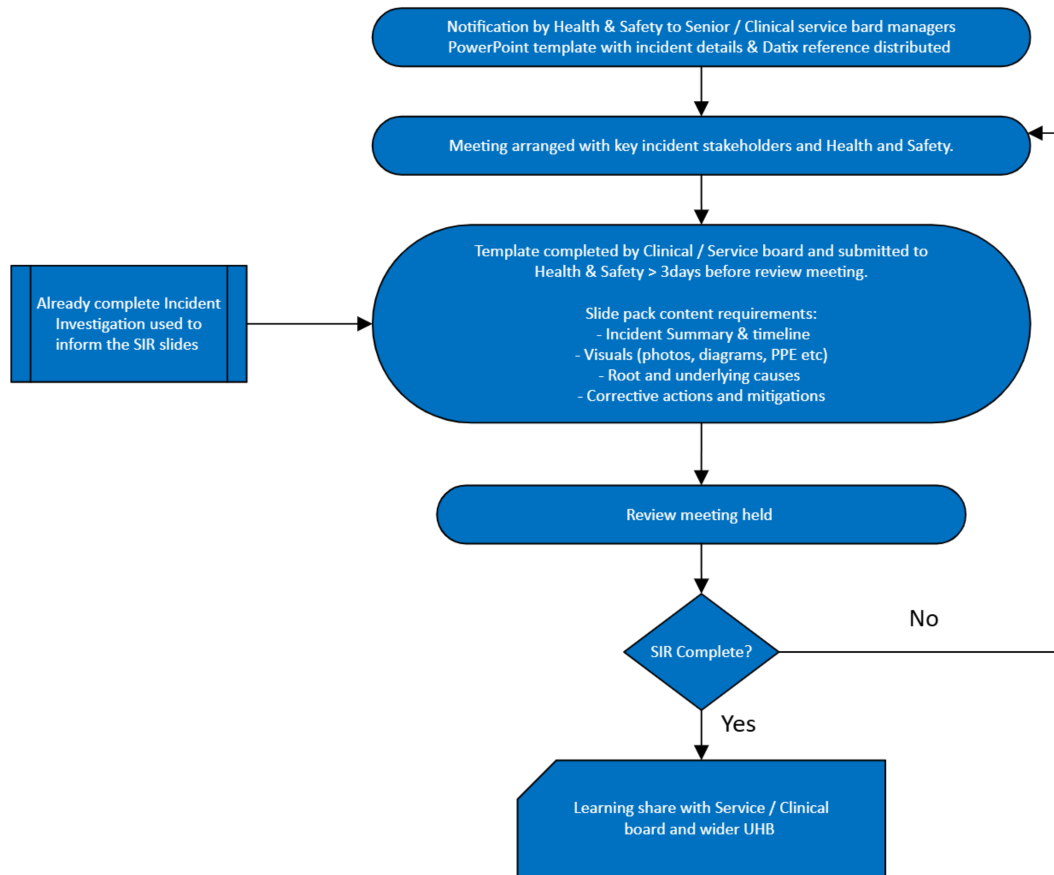
6 RIDDOR

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) all in scope incidents involving staff, patients and members of the public must be reported and reviewed including:

- Incident resulting in death

- Patient falls resulting in a specified injury that has arisen out of or in connection with a work activity. This will include where there has been a failure in a care plan
- Specified Injuries to Employees that arise out of or in connection with work, including:
    - Fractures (excluding fingers, thumbs, and toes)
    - Amputations
    - Dislocations of the shoulder, hip, knee or spine
    - Loss of sight (temporary or permanent)
- **Over-seven-day Injuries**
  Staff absence or inability to perform normal work duties for more than 7 consecutive days as a result of their injury if it has arisen out of or in connection with a work activity. This does not include the day of the accident but does include weekends and days off.
- **Work-related Occupational Diseases**
  Any instance where a Registered Medical Practitioner has confirmed in writing that an employee has been diagnosed with a specified disease where they undertake work that is linked with that condition e.g., occupational asthma, dermatitis, certain infections
- **Dangerous Occurrences** (near misses with potential for serious injury), such as:
    - Collapse of Scaffolding
    - Failure of load bearing part of a lift or lifting equipment
    - Sharps injury where the sharp is known to be contaminated with a Blood Borne Virus

7 SIR Process



8 Monitoring of the procedure

Line management shall monitor the implementation of the management of procedures in their areas of responsibility to ensure that persons are following procedures and maintaining the required records.

Where deficiencies are found, line management shall take corrective actions which may include instruction, re-training etc. as necessary.

9 Audits

The use of this procedure shall be subject to internal and external audit.

10 Review

This Procedure shall be subject to review every 3 years or in light of significant organisational change.