نظام الشارقة للسلامة والصحة المهنية
Occupational Safety & Health Sharjah

حكومة الشارقة
هيئة الوقاية والسلامة
Government of Sharjah
Prevention And Safety Authority

Code of Practice

Incident Reporting and Investigation

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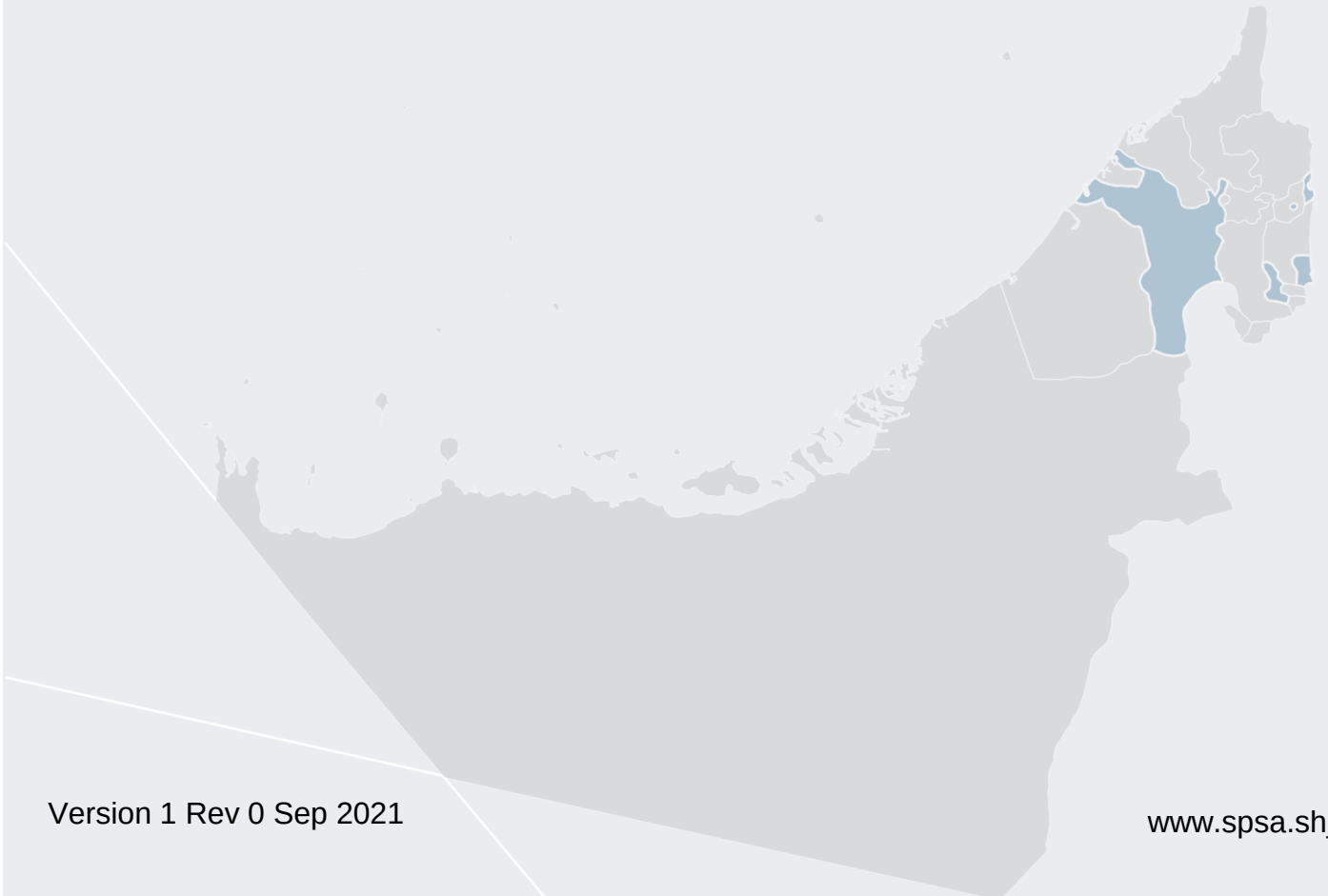

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1 Introduction

Reporting incidents is an important part of an effective safety and health system. It can help to identify work related safety and health hazards and risks. The purpose of reporting is to identify the causes of incidents, appropriate controls can then be put in place to prevent re-occurrence.

The entity shall investigate all incidents with the aim of identifying root causes, evaluating findings and implementing corrective actions.

Incident investigation is a fact finding process to identify root cause(s) and correcting them, it is not a fault finding process to blame employees. Outcomes from reporting and investigating incidents is to prevent injury and ill health in the workplace and improve overall risk management.

2 Purpose and Scope

This Code of Practice (CoP) has been developed to provide information to entities to assist them in complying with the requirements of the Occupational Safety and Health System in Sharjah.

This Code of Practice (CoP) defines the minimum acceptable requirements of the Occupational Safety and Health System in Sharjah, and entities can apply practices higher than, but not lower than those mentioned in this document, as they demonstrate the lowest acceptable level of compliance in the Emirate of Sharjah.

3 Definitions and Abbreviations

Entities:	Government Entities: Government departments, authorities or establishments and the like in the Emirate. Private Entities: Establishments, companies, enterprises and economic activities operating in the Emirate in general.
SPSA:	Sharjah Prevention and Safety Authority.
Occupational Disease:	A disease that is due to a factor in a person`s work.
Occupational Injury:	A personal injury resulting from an occupational incident.
Occupational Illness:	Any acute or chronic disorder associated with or caused by exposure to workplace factors.
Incident:	An unplanned event, sequence of events or actions that either resulted or could have resulted in an adverse effect (loss).
Near miss:	An incident not causing harm or loss but had the potential to do so.

4 Responsibilities

4.1 Entity Responsibilities

- Establish procedures for the reporting and investigating of incidents;
- Encourage employees to report incidents;
- Adequately investigate all incidents;
- Notify SPSA of any reportable incidents and where required to other relevant authorities;
- Record all incidents internally and provide information and details of all recordable incidents to SPSA periodically;
- Provide adequate resources to investigate all incidents;
- Provide employees with information, instruction, supervision and training on incident reporting and investigation;
- Action the findings of investigations.

4.2 Employee Responsibilities

- Not endanger themselves or others;
- Cooperate with the entity during incident investigations;
- Cooperate with the entity and receive safety information, instruction, supervision and training;
- Report any activity or defect which they know is likely to endanger the safety of themselves or that of any other person.

5 Requirements

The entity must comply with the requirements of the Occupational Safety and Health System in Sharjah when it comes to incident reporting and investigation. There are two distinct types of reporting that the entity must comply with:

- Incidents Reportable to SPSA – The entity must report certain incidents to SPSA;
- Internal Reporting of Incidents – The entity must have a system in place for employees and others to report all safety and health incidents internally within the entity. The entity must keep record of all these incidents internally. Information on all incidents must be reported periodically to SPSA as part of entity OSH performance reporting.

Regardless of whether incidents are internally reported or reportable to SPSA, the entity must record and investigate all incidents.

5.1 Incidents Reportable to SPSA

This section covers the incidents involving employees and others that shall be reported to SPSA. This CoP does not cover the requirements for reporting to other relevant authorities

beside SPSA. The incidents that must be reported to SPSA fall into four different groups and include:

- Fatality;
- Injuries;
- Occupational diseases;
- Dangerous occurrences.

Where contractors are involved, it is the responsibility of the main contractor to report the incidents on behalf of sub-contractors. This is to ensure that there is clear reporting line and avoid any duplication in reporting to the SPSA.

The entity must follow the SPSA reporting procedure described in this CoP when reporting incidents to SPSA.

5.1.1 Fatality

Fatality of any employee(s) or other persons; contractors, visitors, students, public and others, from the result of a work related incident or disease. The entity must report fatalities within 24 hours from the person being pronounced dead. This also includes deaths that occur in hospital or at a later stage due to a work related incident or disease.

5.1.2 Injuries

The injuries that shall be reported by the entity to SPSA within 72 hours of occurrence, include:

- A bone fracture, other than to fingers, thumbs and toes;
- Amputation of an arm, hand, finger, thumb, leg, foot or toe;
- Permanent loss of sight or reduction of sight;
- Crush injuries leading to internal organ damage;
- Serious burn injury, which:
    - Covers more than 10% of the whole body`s total surface area; or
    - Causes significant damage to the eyes, respiratory system or other vital organs.
- Any degree of scalping i.e. separation of skin from the head requiring hospital treatment;
- 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; or
    - Requires resuscitation or admittance to hospital for more than 24 hours.

- Injuries where the employee is not at work or unable to work and perform their normal working duties for more than three consecutive days, not counting the day of the incident.

5.1.3 Occupational Diseases

The entity must report certain occupational diseases, where these are likely to have been caused or made worse by their work activities. These diseases include:

- 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.

5.1.4 Dangerous Occurrence

Dangerous occurrences are certain events that did not cause harm to a person, however, had the potential to do so and/or events that caused significant property damage but did not cause harm to a person. The entity shall report dangerous occurrences to SPSA within 72 hours of occurrence. The dangerous occurrences to be reported to SPSA are included in **Appendix 1: Dangerous Occurrence Definitions.**

5.1.5 Reporting to SPSA timeframe

Reportable incidents must be reported to SPSA within the notification period as described in Table 1: Reportable incidents and relevant notification period.

Type of Reportable Incidents	Notification Period to SPSA
Fatality	Within 24 Hours
Injuries	Within 72 Hours
Occupational Diseases	
Dangerous Occurrence	

Table 1: Reportable incidents and relevant notification period.

5.1.6 Process of Reporting the Incident to SPSA

The entity must report to SPSA the incidents described in sections 5.1.1 – 5.1.4 by submitting the Entity Incident Report through the online system to SPSA within the notification period in Table 1.

Upon notification of a reportable incident, SPSA reserve the right to:

- Request a copy of the entity internal incident investigation report;
- Conduct their own independent investigation;
- Appoint an independent investigation team;
- Request the entity to appoint an independent investigation team to conduct the investigation.

5.2 Internal Reporting of Incidents

The entity must have an internal system in place for employees to report all OSH incidents. Incidents can be reported in a variety of ways, such as a simple form, an email or incident reporting box. Regardless of what system the entity decides to use, employees should be encouraged to report hazards, near misses, incidents, dangerous occurrences, occupational disease and injuries, the entity must make sure the system is used and checked regularly.

The entity shall ensure employees receive training on what must be reported, how they should report and what the entity will do with the information they receive. Employees will feel valued if they see the entity taking actions on their reporting, regular feedback to employees is a good way to demonstrate commitment to safety and health.

The entity must record internally:

- All incidents, injuries, occupational disease or dangerous occurrences; and
- All occupational incidents causing injuries that result in employees being off work or incapacitated for more than three consecutive days, not counting the day of the incident but including any weekends, public holidays or other rest days.

Records of incidents are important, they ensure that the entity collects sufficient information to properly manage safety and health risks. This information is a valuable management tool that can be used as an aid to risk assessment, helping to develop solutions for potential risks. Using records in this way can help to prevent injuries and ill-health and control costs from incident loss.

The entity shall undertake internal investigation of all incidents and identify root causes to assist in the prevention of reoccurrence.

The entity shall record contractor safety and health incidents internally, however it is the contractors responsibility to submit their own OSH performance to SPSA.

5.2.1 Periodic Reporting of Incident Data to SPSA

The entity shall notify SPSA periodically on all incidents by completing the Entity OSH Performance Reporting through the online system to SPSA.

5.3 Incident Investigation

The Occupational Safety and Health System in Sharjah requires all entities to investigate all incidents and report these incidents to SPSA and any other relevant authority. An effective investigation requires a methodical, structured approach to information gathering, collation and analysis.

The incident investigation report must be submitted to SPSA through the online system within the timeframe contained in table 2.

In certain circumstances where the incident investigation report will not be available for submission to SPSA within the required timeframe, prior approval from SPSA must be obtained.

Type of Incidents	Incident Investigation Report to SPSA
Fatality	Within 30 Days
Injuries	
Occupational Diseases	
Dangerous Occurrence	

Table 2: Incident Investigation Report Submission to SPSA.

5.3.1 Which Events Should be Investigated?

All incidents, including near misses must be investigated, the level of investigation ie. time, effort and resources of the investigation required, depends on the severity of the outcome or the potential severity of the outcome and/or the likelihood of re-occurrence.

The main reasons for investigating incidents, include but not limited to:

- Gather facts, identify the causes of the why the incident happened and put measures in place to avoid re-occurrence;
- Investigating incidents will help uncover and correct any breaches in safety and health legal compliance the entity may have been unaware of;
- The fact that the entity thoroughly investigated an incident and took corrective action to prevent further occurrences would assist in demonstrating to a court or other stakeholders that the entity has a positive attitude to safety and health;
- The investigation findings will also provide essential information for insurers in the event of a claim;
- Improve safety and health performance from lessons learned.

An investigation can help identify why the existing control measures failed and what improvements or additional measures are needed, including but not limited to:

- Improve management of risk in the future;
- Help other parts of the entity learn as findings of an investigation and improvements that follow can be applied in other parts of the entity;
- Demonstrate commitment to effective safety and health and improving employee morale.

Investigating near misses, where no-one has been harmed provides very useful information, can identify trends, and is generally easier to do than investigating incidents.

There is a statistical relationship between the number of serious injuries, minor injuries and near misses. When near misses are investigated and improvements are implemented, the number of near misses is reduced, which in turn reduces the number of serious injuries.

Therefore, tracking near misses and investigating them is a proactive way to identify hazards that exist in the workplace and introduce adequate control measures before they cause occupational injury or ill-health.

5.3.2 Who Should Conduct Investigations?

To ensure that an adequate investigation is undertaken, it is essential that management and employees are fully involved.

This joint approach will ensure that a wide range of practical knowledge and experience will be utilised and employees will feel empowered and supportive of any remedial measures that are necessary. A joint approach also reinforces the message that the investigation is for the benefit of everyone.

Depending on the level of the investigation, the following personnel could form a part of an investigation team:

- Direct managers or supervisors of the person involved in the incident;
- Direct managers of supervisors of the activity being undertaken at the time of the incident;
- A person with technical knowledge related to the incident. Such as a Lifting Specialist if the incident involved collapse of a crane, a chemical engineer or chemist if an incident involved hazardous substances.
- A person who is familiar with safety and health good practice, standards and legal requirements.

The investigation team must include people who have the necessary investigation skills; information gathering, interviewing, evaluating and analysing. The team should be provided with sufficient time and resources to enable them to carry out the investigation efficiently.

It is essential that the investigation team is either led by or reports directly to someone with the authority to make decisions and act on recommendations within the entity.

5.4 Investigation Process

All incidents shall be investigated and analysed immediately or as soon as possible, memory and motivation will be highest immediately after the incident.

The initial actions to be taken immediately following an incident:

- Make the area safe;
- Activate emergency response;
- Preserve the scene, relevant authorities such as the Police or Civil Defence may have to conduct their own investigation, their investigation takes priority;
- Note the names of the people, equipment involved and the names of witnesses;
- Report the incident to senior management who will decide what further action is to be taken;
- Report the incident to SPSA or other regulatory authorities, if required.

5.4.1 Gathering Information

It is important to capture information as soon as possible, this makes sure evidence is not moved, guards replaced etc. If necessary, work must stop and unauthorised access prevented. Interview everyone who was close when the incident happened, especially those who saw what happened or know anything about the conditions that lead to the incident occurring.

Collect all available relevant factual information, including but not limited to:

- Observations;
- Times and dates;
- Names of witnesses and others relevant to the incident;
- Sketches;
- Measurements;
- Photographs;
- Checklists;
- Maintenance records;
- Training and competency records;
- Documentation and records;
- Details of the environmental conditions at the time.

This information can be recorded initially in note form, with a formal report being completed later. These notes should be kept until the investigation is completed.

5.4.2 Analysing Information

An analysis involves examining all the facts, determining what happened and why. All the detailed information gathered should be assembled and examined to identify what information is relevant and what information is missing. The information gathering and analysis are actually carried out side by side. As the analysis progresses, further lines of enquiry requiring additional information will develop.

To be thorough and free from bias, the analysis must be carried out in a systematic way, so all the possible causes and consequences of the incident are fully considered.

It is only by identifying all causes, and the root causes in particular, that lessons can be learnt from the incident and prevent future re-occurrence. There are many methods of analysing the information gathered in an investigation to find the immediate, underlying and root causes and it is up to the entity to choose which method suits them best.

5.4.3 Incident Causation

Incidents have many causes. What may appear to be bad luck such as being in the wrong place at the wrong time, can, on analysis can be seen as a chain of failures and errors that lead to the incident occurring.

These causes can be classified as:

- Immediate causes, the cause of injury or ill-health;
- Underlying causes, unsafe acts and unsafe conditions;
- Root causes: the failure from which all other failings grow, often remote in time and space from the incident.

To prevent incidents, entities shall identify effective risk control measures which address the immediate, underlying and root causes.

5.4.4 Review of Risk Assessments and Other Relevant Documents

All relevant risk assessments and safe working procedures shall be reviewed after an incident.

6 Training

The entity shall ensure employees are provided with adequate information on incident reporting and investigation.

The entity shall provide employees with training in languages and in a format that employees understand, including but not limited to:

- Ensuring people involved in incident investigation have the necessary investigation skills, such as information gathering, interviewing, evaluating and analysing;
- Ensuring that employees know how to report incidents and issues of safety, health and wellbeing to the entity.

Periodic refresher training shall be conducted to ensure employees competency is maintained, including but not limited to:

- Where training certification has expired;
- Where identified as part of a training needs analysis;
- Where risk assessment findings identify training as a measure to control risks;
- Where there is a change in legal requirements;
- Where incident investigation findings recommend refresher training.

The entity must record and maintain accurate training records of OSH training for employees.

Further information on training can be found in OSHJ-GL-26: Training and Competence.

7 Record Keeping

Records of incidents and any relevant investigations shall be kept for a minimum of 5 years

8 References

OSHJ-GL-26: Training and Competence

9 Document Amendment Record

TITLE	Incident Reporting and Investigation		
DOCUMENT AMENDMENT RECORD			
Version	**Revision Date**	**Amendment Details**	**Pages Affected**
1	15-SEP-2021	New Document	N/A

APPENDIX 1. Dangerous Occurrence Definitions

Appendix 1: Dangerous Occurrence Definitions

No.	Dangerous Occurrence	Definition
1.	Lifting Equipment	The collapse, overturning or failure of any load bearing part of any lifting equipment.
2.	Scaffolding Collapse	The collapse, partial collapse or failure of any load bearing parts of scaffolding and accessories.
3.	Structural Collapse	The unintentional failure or partial collapse of any structure during construction, demolition, refurbishment and maintenance. The unintentional failure or partial collapse of any false-work/formwork or its supports.
4.	Diving Operations	The Failure of breathing apparatus, during testing, immediately before use and while in use. The failure or endangering of life support equipment, the trapping of a diver, an explosion close to a diver, or an uncontrolled ascent.
5.	Pressure Systems	The failure or explosion of any pressure system or container (at a pressure greater than atmospheric pressure) used for the storage of gas, gases and air or any liquid or solid generated from the compression of gas.
6.	Electricity	Any unintentional contact or close proximity with overhead or underground electricity cables by plant or equipment which causes an electrical discharge. Any explosion or fire caused by an electrical short circuit or overload which results in the stoppage of the plant involved.
7.	Pipelines	Any unintentional damage to, or failure of equipment in pipeline or pipeline works, or an inrush or outflow of substances which could cause injury or ill health to any person.
8.	Explosion or Fire	Any unintentional explosion or fire in any workplace from the ignition of dust, gas or vapor, which results in the stoppage, or the suspension of normal work.
9.	Biological Agents	Any incident which results in or could have resulted in the release or escape of a biological agent likely to cause severe human infection or illness.
10.	Radiation Generators and Radiography	The malfunction of a radiation generator or its ancillary equipment used in fixed or mobile industrial radiography, the irradiation of food or the processing of products by irradiation, which

No.	Dangerous Occurrence	Definition
		causes it to fail to de-energise at the end of the intended exposure period; or The malfunction of equipment used in fixed or mobile industrial radiography or gamma irradiation, which causes a radioactive source to fail to return to its safe position by the normal means at the end of the intended exposure period.
11.	Release or Escape of Flammable Liquids and Gases	The sudden, unintentional and uncontrolled release or escape inside a building— (i) of 100 kilograms or more of a flammable liquid; (ii) of 10 kilograms or more of a flammable liquid at a temperature above its normal boiling point; (iii) of 10 kilograms or more of a flammable gas; or The sudden, unintentional, and uncontrolled release or escape in the open air, of 500 kilograms or more of a flammable liquid or gas.
12.	Hazardous Escapes of Substances or Materials	The unintentional release or escape of any substance or materials which could cause injury or ill-health to any person.