University Council – February 2022
Health & Safety update report

Progress against Objectives

Objective One: A near miss to incident reporting ratio of 5:1

Currently near misses appear to be underreported at the University (Heinrich 1931). Underreporting in this area can lead to preventive action being missed until such a time that a loss-event is experienced (injury, property damage, etc.). In some areas, there are concerns about the consequences of reporting. It must be noted here that the University does not seek to apportion blame arising from accidents/ incidents experienced, only to learn from these and to take action to prevent recurrence.

Ordinarily a reporting ratio of 10:1 should be observed however, it should be acknowledged here that reports may be made to EFM (via their Helpdesk) for repairs to infrastructure or to Security (in the event of an emergency) for immediate assistance. It should not be a requirement to double report.

Limited action has been taken to improve near miss reporting rates however the question of ‘What Departments are doing to improve near miss reporting’ has been asked in the Annual Planning tool currently with DHSOs and their HoDs.

Objective Two: Mandatory Training completion of over 90%

Previously only Fire Safety Training had been made mandatory (by e-learning). Revisions to the H&S Training Policy, approved in May 2021, now require the completion of DSE Training and Manual Handling (basics). The H&S Induction module will be rebranded as H&S Awareness with appropriate refresher period.

For other roles (First Aid, Radiation Protection, Departmental Health & Safety Officers, etc.) there are further mandatory training needs.
Minor improvements (+1 or 2%) in the last few months can be seen across all mandatory modules.

**Objective Three: Completion of all Actions arising from H&S activities (target 100%)**
Departmental Action Trackers have been shared (January 2022) with all DHSOs (who in turn have permission to share with their Departments as appropriate).

**Objective Four: Completion of Core H&S Activities for all Departments (target 100%)**
Annual Planning tool has been shared (January 2022) with all DHSOs for completion by deadline 4th February.

**Objective Five: H&S Department to carry out its review of the H&S Management System**

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**Appendix A: Control of Vibration, PPE, Drones/ UAVs and Laser Safety Policy brought to February UEBH&SC. Stress Policy postponed to May 2022 to allow for full consultation.**

**Appendix B: Audits due to start in 2021/22, some progress being made.**

**Appendix C: Fire Safety Risk Based Inspection Programme**

**Appendix D: Audit in Radiation in Chemistry due October 2021.**
Accident and Incident Statistics and Updates

In the period 1 September 2021 to 31 December 2021 there have been a total of 113 accidents and 118 near misses.

<table>
<thead>
<tr>
<th>Month</th>
<th>September 21</th>
<th>October 21</th>
<th>November 21</th>
<th>December 21</th>
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</thead>
<tbody>
<tr>
<td>Accidents</td>
<td>25</td>
<td>42</td>
<td>28</td>
<td>18</td>
</tr>
<tr>
<td>Near Misses</td>
<td>21</td>
<td>51</td>
<td>33</td>
<td>13</td>
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Eight of the recorded accidents resulted in formal notification to the Health and Safety Executive under RIDDOR; further details can be found below:

On **14 September 2021** the Health and Safety Department submitted a report of an Occupational Disease to the Health & Safety Executive. Details of this report are as follows:

The affected person (AP) who is a member of staff, noticed that they had a skin condition developing on the back of their hands. The AP visited the doctor who diagnosed the skin condition as ‘suspected contact dermatitis secondary to sweating in the nitrile gloves/contact with nitrile gloves’. The facility the AP works in has a requirement to wear nitrile gloves as personal protective equipment (PPE). The AP has been referred to occupational health.

**Remedial Action:** Laboratory risk assessments are being reviewed and updated (including whether additional hand care stations with barrier and moisturiser creams are to be installed). These will be circulated/communicated to all Cleanroom user groups and others who may need it, including the use of hand stations to all users of the facility. The use of hand stations will be included in the facility induction.

On **1 October 2021** a member of staff was carrying out their duties, emptying a recycle bin, as they pulled the bag out of the bin, they felt a pull in their shoulder. This resulted in an over 7-day lost time absence.

**Remedial Action:** Arrangements have been put in place for the member of staff to retake the mandatory online and in-person manual handling training. A manual handling toolbox talk will be completed in the next monthly staff team brief.

On **19 October 2021** a member of staff was carrying out their duties. Using dry hands, they plugged a new extension lead into a wall socket (a vacuum cleaner was plugged into the extension lead). Upon finishing vacuuming the member of staff removed the extension lead plug from the socket, at which time they received a shock. The member of staff attended A&E and was diagnosed with nerve damage to their left-hand index and middle fingers. This resulted in an over 7-day lost time absence.

**Remedial Action:** The plug socket involved was checked by a competent person following this accident and did not reveal any faults. The vacuum cleaner had been PAT tested before (July 2021) and after the accident and passed. The new extension lead had been PAT tested prior to having been put into use (July 2021). As a precautionary measure the extension lead was taken out of use and checked by a qualified electrician to ensure it was safe to use. The extension was deemed safe to
use. As part of in-house training, cleaners are trained to visually inspect equipment before they carry out a task, this includes inspecting the cable, plug, body of the equipment and the plug socket to be used.

On **11 November 2021** a member of staff was walking up the steps (these steps are made up of concrete slabs) to the main entrance of Bartolome House. The steps were free from defects and there are handrails at both sides of the steps. The design of the steps mean they have a slight overhang. The member of staff caught their foot on the overhang of a step, which made them trip. This trip resulted in a fractured carpal bone in their right hand, traumatic bruising and swelling to their chin and right arm (fingers to shoulder) and they were signed off work for 2 weeks.

**Remedial Action:** - The Departmental building risk assessment is going to be reviewed (December 2021) and awareness of this accident will be communicated via the departmental staff newsletter (December 2021). Contrasting nosings have been requested to be painted on these steps to improve visibility.

On **15 November 2021** a member of staff attended the recycling yard to drop off some waste. Whilst there, they noticed a larger than standard pallet was overhanging, on the top of one of the pallet stacks (approximately 2.5m high). They climbed up about four or six pallets (approximately 1m) from the ground to take down the pallet. As the member of staff pulled the pallet off, the pallet that they were holding onto moved slightly causing them to become unbalanced and fall. The member of staff attended A&E and was diagnosed with a soft tissue injury to their foot and ankle. This resulted in an over 7-day lost time absence.

**Remedial Action:** - The Department took immediate action to ensure that the pallets were not stored higher than 1m. A recycling contractor was contacted to arrange removal of stored pallets. A risk assessment/safe system of work have since been developed. A schedule of inspection has been put in place for the recycling yard. The Department was going to remind staff to immediately report any unsafe conditions to their line manager and not attempt to rectify them themselves.

The member of staff had received manual handling training and was going to be re-inducted on their return to work.

On **15 November 2021** a member of staff stepped onto a floor vent in Information Commons. The vent collapsed and gave way causing them to drop suddenly (approximately 8 inches) into the void below the vent. The three separate metal vent sections that had given way caught the member of staff around their feet and ankle, causing scratches and a small puncture wound to their left foot and broke the skin on the outside of their foot. The member of staff attended hospital and was diagnosed with soft tissue injuries to their foot and ankle. This resulted in an over 7-day lost time absence.

**Remedial Action:** - The EFM team have commenced a process of checking every floor vent in the building. EFM is going to completely replace the current three section floor vents for a single floor plate which will remove the risk of the centre tile collapsing. The floor vents will be inspected annually.

On **29 November 2021** a member of staff was carrying out gritting duties. The activity involved taking grit from the back of a pick-up truck using a shovel and spreading it. The pick-up truck was unable
to access the area, so to avoid the need to keep going back and forth, the member of staff pulled one of the 25kg bags of grit off the truck and carried it approximately 60 feet, causing lower back pain. This resulted in an over 7-day lost time absence.

**Remedial Action:** - The member of staff had completed manual handling training and the ‘Manual ice and snow clearance’ risk assessment had been shared with them. The risk assessment will be reviewed, and the changes communicated to all staff that undertake the activity and their supervisors. The staff members Line Manager will hold an informal meeting with them to reiterate the importance of following their manual handling training.

On **6 December 2021** a member of staff tripped over an office chair that was being used to hold open a door (the door hold open device was broken and awaiting repair) causing the member of staff to land on their hand and knee. The staff member attended A&E and was diagnosed with a broken patella and signed off work for 1 month.

**Remedial Action:** - The Department sent out an email informing staff that chairs should not be used to hold open a door. The area will be checked on a regular basis to ensure the door is not held open by unauthorised means.

The data below shows the number of accidents for the same period during September 2020 to December 2020. There were 71 accidents and 22 near misses.

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</tr>
</thead>
<tbody>
<tr>
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<td>17</td>
<td>20</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>Near Misses</td>
<td>5</td>
<td>3</td>
<td>10</td>
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**Notification of Significant Incidents**

During the period **1 September 2021 to 31 December 2021**, the Health & Safety Department has continued assisting with the University’s response to the threat from COVID-19. Also, worthy of note for the Committee are the following incidents which have occurred during this period:

On the **14 October 2021**, Security responded to a fire at St George’s church within the lecture theatre. Security reported that there was a fire which had been started deliberately, following which Security Control contacted the fire service on 999.

Security reported that a female had admitted to starting the fire and that she “Enjoyed it”. The Police arrived on site and subsequently detained the Individual.

The female had set fire to her own suitcase at the front of the lecture theatre in the area that was once the alter of the church. Damage was mainly limited to the contents of the suitcase because the ground under the suitcase was stone.

Four fire extinguishers were used by Security prior to the arrival of the fire service (SYFR).

There was some smoke logging which SYFR had removed through ventilation techniques.
On 19 October 2021, two Counter-Terrorism Security Advisors (CTSA) and an Environmental Agency inspector attended a planned (and announced) visit, along with Sam Fargher (Radiation Protection Officer) and Les Fullerton (Radiation Protection Advisor, Peak RPA). During the inspection, the irradiator room, containing a High Activity Sealed Source, in the Medical School was found open without any users present and without any security measures in use: the room door was propped open with a lead brick preventing the door auto-shut; the room key was left in the door; the room’s intruder alarm was disabled; the irradiation enclosure was unlocked, with the doors wide open, and making the irradiator visible from the corridor and accessible. In addition, a radioactive waste disposal bag (on a wheeled frame) was present in the room which, given the lack of security measures in place, could have been removed. This was a clear breach of the requirements for our permit and the EA inspector issued the University with a PACE Code B.

An investigation was undertaken by the Health & Safety Department and Security Services into the cause of the breach; a report is almost complete. Since the breach, all users have been retrained in the importance of securing the irradiator and new security measures and procedures have been introduced to increase security and accountability. During the investigation, it was also found that the room’s security camera was non-operational; this issue is in the process of being resolved.

On 22 October 2021, the Health & Safety Executive (HSE) inspected the industrial radiography unit at the AMRC, shared by TUoS and Castings Technology International (CTI), in response to a new consent application from CTI. TUoS had previously applied for consent from HSE for this unit, however, due to the joint occupancy of the facility, CTI was required to apply also. During the inspection, the University was commended on the Memorandum of Understanding that they had put in place to ensure the roles and responsibilities of both employers (TUoS and CTI) were known and understood.

Two issues were raised during the inspection regarding the frequency of dosimetry supplied to TUoS staff and not having written hand-over documentation present for transferring the responsibility of the unit between the two employers. As improvements were required, a Notice of Contravention (NoC) was issued to both TUoS and CTI. Actions were taken to remedy the issues and the HSE have accepted these actions as satisfactory. As an NoC was issued, a Fee For Invention is applicable, however, TUoS is still awaiting this invoice."