



HEALTH & SAFETY ASSURANCE COMMITTEE PWYLLGOR ANSAWDD IECHYD A DIOGELWCH

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 May 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting and COVID-19
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mandy Rayani, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Tim Harrison, Head of Health, Safety and Security

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

This report provides a summary of the decision making process with regard to the reporting of COVID-19 related incidents and in particular the Health Boards duty to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

There are processes and procedures in place for the management of staff who acquire COVID-19, which are in line with Public Health Wales guidance.

Cefndir / Background

Reporting Arrangements – all Wales

The Death of a British National in UK COVID-19 Death Protocol for Wales, 25/03/2020, outlines the tragic death of a health or social care worker as meeting the criteria of ‘unusual or requiring sensitive handling’.

The death of any employee with COVID-19 should be reported confidentially by the employing organisation through the Welsh Government ‘*No Surprises*’ reporting process. Due to potential media attention, the Health Board should notify Welsh Government within 4 hours of being made aware of the death.

Datix Incident Reporting

Staff incidents in relation to COVID-19 are recorded on the Datix system.

The following codes have been added:

- Person affected: Staff
- Category: Exposure to Environmental Hazards
- Sub-Category: Exposure to Unsafe Environmental Conditions
- Adverse Event: Infectious Agent

RIDDOR Guidance COVID-19

Although it is not a legal requirement to report all instances of COVID-19, this should occur when:

Dangerous occurrences

Something happens at work which results in (or could result in) the release or escape of coronavirus we must report this as a dangerous occurrence. An example of a dangerous occurrence would be a lab worker accidentally smashing a glass vial containing coronavirus, leading to people being exposed.

Cases of disease: exposure to a biological agent

For an incident to be reportable as an occupational exposure to a biological agent, the diagnosis of COVID-19 must be **directly attributed** to an occupational exposure. Such instances could include:

- Health and social care workers who have been involved in providing care/ treatment to known cases of COVID-19 patients, who subsequently develop the disease and this is **reliably attributed** to their work.
- COVID positive patient spitting in face of a staff member.
- Personal Protective Equipment (PPE) failure during treatment of a COVID-19 patient.

Work related fatalities

If a worker dies as a result of exposure to coronavirus from their work and this is confirmed as the likely cause of death by a registered medical practitioner, then we must report this as a death due to exposure to a biological agent using the 'case of disease' report form. We must report workplace fatalities to Health and Safety Executive (HSE) by the quickest practicable means without delay and send a report of that fatality within 10 days of the incident.

Asesiad / Assessment

The HSE do not anticipate receiving many cases of RIDDOR reportable incidents, as such cases will not be easy to identify, and are anticipated to be rare, especially as prevalence of COVID-19 increases in the general population.

In a work situation, it will be very difficult, if not impossible to establish with any certainty, whether or not any infection in an individual was contracted as a result of their work. Therefore, diagnosed cases of COVID-19 are **not** reportable under RIDDOR **unless a very clear work related link is established**.

In consultation with other Heads of Health and Safety across NHS Wales we agreed based upon the above paragraph that clear work related activity would have to be evident before a RIDDOR report was completed. Although there was slight variation in the interpretation of the HSE advice all the Health Boards represented felt a practical stance was needed in relation to what would be reported.

An investigation toolkit has been developed to ensure a consistent approach to any investigation of a reported COVID-19 death of a member of staff. In the tragic event of a staff fatality, then the Health & Safety Team in consultation with the Executive Director for Nursing, Quality and Patient Experience will assist the respective Senior Management Team in the review of a RIDDOR report before submission to the HSE and support any investigation.

Argymhelliad / Recommendation

The Health & Safety Committee are asked to:

- Support the approach being adopted by the Health, Safety & Security Team of providing clear guidance is to operational teams clarifying the HSE requirements.
- Support the approach of utilising the normal Datix reporting processes to identify and report appropriate cases to the HSE. This involves the Health and Safety Manager being notified and reports would only be written if there were clear work related links identified.
- Note that any staff deaths will be reported to Welsh Government as a 'No Surprises' report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.6 Ensure there is a process of review of accident, incident and notifiable disease statistics to keep an organisational focus on trends, ensure that corrective action and prioritisation of high risk issues are brought to the attention of the appropriate groups, and share learning across the organisation.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	Focus On What Matters To Patients, Service users, Their Families and Carers, and Our Staff
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Living and working well.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Public Health Wales guidance
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y	N/A

Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Assurance Committee:	
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Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No expected impact
Ansawdd / Gofal Claf: Quality / Patient Care:	N/A
Gweithlu: Workforce:	No adverse impact for the reporting of RIDDOR
Risg: Risk:	Risk mitigation in place in terms of PPE, safe systems of work and safe environments
Cyfreithiol: Legal:	RIDDOR Health and Safety at Work Act 1974 Management of Health and Safety at Work Regulations
Enw Da: Reputational:	Potential for political or media interest following staff death
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No