



# Safety Investigation Guidance

## When to Investigate

### Mandatory

- All safety events that have resulted in an injury to a person involved with or affected by the activities at Reading Athletic Club should be investigated.
- Any safety event that resulted in a near miss involving a hammer, discus or javelin whilst being thrown or about to be thrown must be investigated.
- Any safety event that resulted in a near miss where there is reasonable likelihood that an injury sustained would have led to three-day absence from work / school or hospitalization must be investigated.

### Discretionary

- Investigations of other near miss safety events are discretionary.

## Aim of Investigation

The aim of an investigation is to understand what caused the safety event including any underlying causes and then to recommend reasonable actions to prevent a similar event in the future.

The aim of an investigation is not to apportion blame on anybody.

## Level of Investigation

The more serious the safety event then the more time and effort should be put into a safety investigation. The outcomes of some safety events may need to be reported to a governing body or a court of law and should therefore be as robust as possible.

## Standardizing Investigations

The investigation should be captured on the club's 'Safety Event Investigation Form'.

To assist investigators the following sections of this document provide guidance on how to approach each part of the investigation procedure.

### Summary

Although the summary is at the top of the form it is likely to be the last part that an investigator completes. The summary should, where possible, in one or two sentences outline what happened. The summary should then, again in just a couple of sentences where possible, outline the conclusions and recommendations from the investigation.

As a guide, the summary should be no more than about twelve lines.

### Facts

The facts section should build a description of what happened leading to the event and sometimes what happened after the event if that is relevant to the conclusions and recommendations. If the facts are arguable, then this should be made clear.

## Analysis

The analysis takes the facts and is the space for the investigator to make considerations and to rule in or rule out any elements or factors. The analysis is also the place to look at common practices or other guidance and risk assessments and make comments on whether they were being followed or not or are insufficient. The contents of the analysis support the conclusions.

## Conclusions

The conclusions are derived from the facts and the analysis. The conclusions should state what the primary cause of the safety event was but also where possible any secondary or underlying cause.

Example: a primary cause of a person falling into the steeplechase water jump might have been a lack of concentration on the part of the athlete at the time of the safety event although an underlying cause might have been that there was no barrier in place to prevent a fall in the first place.

## Recommendations

The recommendations are drawn from the conclusions and should be aimed at preventing a future occurrence of this or a similar event occurring in the future. Sometimes there may be indirect recommendations.

Example: a recommendation after an athlete has been cut by starting block anchor may be that the storage of the blocks should be in a better location to limit the likelihood of a cut but an indirect recommendation might be that the sizes of the plasters in the first aid kit should be made bigger.

## Factors affecting the Investigation

This is the space for the investigator to record any in particular that affected the ability to complete the investigation in the way they feel they needed to such as evidence being lost, or delays in getting evidence, or people not being available to answer questions.

## Any Questions

If you have any questions on how to investigate safety events at Reading Athletic Club then please approach a member of the Club's Council.

## Review

This document was last reviewed:	Oct 2023
Reviewed by:	Lincoln Ball
The planned review period for this document is:	3 years