INCIDENT INVESTIGATION GUIDELINES

PURPOSE

These guidelines support the *Incident Reporting and Investigation Procedures* and provide assistance on completing health and safety incident investigations at the University.

DEFINITIONS

**Investigation team** Relevant personnel selected to investigate the incident, including: the line manager, Safety and Health Representative and any other personnel deemed required to complete the investigation.

**Hierarchy of controls** A range of control measures used to control risk to the lowest reasonably practicable level. In most cases a combination of elimination (most effective), substitution, engineering controls, administrative controls and Personal Protective Equipment (least effective) are chosen to control risks.

1. CONDUCTING THE INCIDENT INVESTIGATION

Incidents are caused by a range of different reasons. This can range from human factors, the working environment, work methods to plant & equipment used.

1.1. INITIAL INVESTIGATION

The investigation process needs to be systematic. The investigation team should:

- a) Act as soon as possible after the incident;
- b) Visit the scene before physical evidence is disturbed;
- c) Not prejudge the situation and remain impartial throughout the investigation;
- d) Not remove anything from the scene;
- e) Enquire if anyone else has moved anything; and
- f) Take photographs and/or sketches to assist in reconstructing the incident.

1.2. WHAT TO DO IN AN INVESTIGATION

The investigation team should:

- a) Identify, label and store all evidence. For example, tools, defective equipment, fragments, chemical samples etc.;
- b) Interview each witness separately;
- c) ascertain if there have been any other similar events;
- d) record all sources of information;
- e) keep records to show that the investigation was conducted in a fair and impartial manner;
- f) review all potentially useful information, including design specifications, operating logs, purchasing records, previous reports, procedures, equipment manuals, job safety analysis reports, records of training and instruction of the people involved and experiences of people in similar workplaces/industries; and
- g) reconstruct the incident (while ensuring that another incident doesn’t occur) to assist in verifying facts; identify what went wrong and what can be done to prevent it happening again.
1.3. WHAT TO LOOK FOR

Look for contributing factors and root causes, not blame. Systems fail for many reasons and the people involved are not always the cause of the incident. Build a chain of events to identify all the causes. For the investigation to be successful it is necessary to establish the following information.

Events leading up to the incident

Investigate:

a) The system of work being carried out and the adequacy or suitability of that system for the job;
b) the instructions and/or training given for the work;
c) any variation from instructions or standard work practices and the reasons for such variation;
d) the workplace conditions, such as lighting, floor surfaces, stair treads and handrails, warning signs, temperature and weather (if the incident occurred outside);
e) the exact location of the incident with sufficient detail for the spot to be readily identified by others reading the report;
f) the materials in use or being handled;
g) the type of transport or equipment in use; and
h) whether adequate supervision was provided.

Incident facts

Investigate:

a) the state of the system and the actions that occurred at the time;
b) the people directly and indirectly involved, including those rendering aid;
c) the tools, equipment, materials and fixtures directly connected; and
b) the time the accident or incident occurred.
e) any injuries or damage resulting directly from the incident;
f) any problems in dealing with the injuries or damage, for example faulty extinguisher, isolation switch difficult to locate.

1.4. CONTRIBUTING FACTORS AND ROOT CAUSES

To conduct an effective accident/incident investigation, it is essential to look at the following contributing factors in order to identify the root cause(s):

Work Organisation:

Assess how work is organised including work processes and production demands.

Work Methods:

Identify whether the job task being carried out at the time of the incident had been subjected to a job safety analysis.

If this job task has been subjected to a job safety analysis, and as a result analysed, then the relevant risk control measures may need to be changed or modified.

Likewise, if this job task has not been subjected to a job safety analysis and as a result not analysed then a job safety analysis could identify hazards associated with the job that contributed to the incident.
Work Environment:

Identify environmental surroundings and stresses that could have an impact on the health, safety and welfare of employees. For example, this could include various environmental factors including noise, chemicals, vibration, illumination, climate, radiation and biological agents.

Plant & Equipment:

Identify if the plant & equipment used is:
- Designed for the job task/work it was meant to be used for;
- Adjustable to adapt to the individual user;
- Safeguarded to a satisfactory standard;
- Inspected on a regular basis for defects and faults (and repaired if necessary);
- Maintained on a regular basis;
- Used within its rated capacity;
- Used in accordance with the manufacturer’s guidelines and specifications.

Human Factors and Behaviours:

Identify the knowledge, skills, competencies, experience, training, physical characteristics, behaviours of all employees involved.
Examples of unsafe behaviours include misuse of safeguards, improper use of tools and equipment, disregard of cautionary notices, failure to wear personal protective equipment, horseplay and poor standards of housekeeping.

1.5. DEVELOPMENT OF CORRECTIVE ACTIONS

Health & safety strategies will be identified from the systematic and thorough analysis of all facts gained from incident investigations.

Appropriate corrective actions will be identified in consultation with the investigation team. These will be determined in accordance with the hierarchy of controls.

Agreed corrective actions will be implemented and reviewed to prevent re-occurrence.

1.1. EXEMPTIONS

Incidents of bullying and stress are to be reported using the online incident/hazard reporting system. These incidents are not required to be seen by a Manager or SHR's and will be referred to PSCU.

1.2. RELEVANT DOCUMENTS/LINKS

- Online Incident/Hazard Reporting System
- Incident Investigation Quick Reference Guide
- Incident Reporting and Investigation Procedure
- Incident Reporting and Investigation Form
- Incident Reporting and Investigation Flowchart

CONTACT DETAILS

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<thead>
<tr>
<th>Contact</th>
<th>Health and Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ph: (08) 9266 4900</td>
<td><a href="mailto:healthandsafety@curtin.edu.au">healthandsafety@curtin.edu.au</a></td>
</tr>
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| Approval Authority | Director, Health and Safety |
## REVISION HISTORY

<table>
<thead>
<tr>
<th>Revision #</th>
<th>Date</th>
<th>Amendment Description</th>
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<tbody>
<tr>
<td>1</td>
<td>2/12/2011</td>
<td>New Guideline</td>
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<tr>
<td>2</td>
<td>23/08/2012</td>
<td>Incident Reporting and Investigation Flowchart updated</td>
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<tr>
<td>3</td>
<td>02/04/2013</td>
<td>Reformatted the guidelines to new format. Amendment all sections to provide clarification</td>
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<td>Updated <em>Incident Reporting and Investigation Procedure</em> link <a href="http://policies.curtin.edu.au/findapolicy/">http://policies.curtin.edu.au/findapolicy/</a></td>
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