UON Health and Safety Procedure: HSP 7.1

Incident Notification and Investigation

1. Purpose

To describe the University of Newcastle's processes involved in the reporting and investigation of health and safety (H&S) incidents, injuries, work related illnesses and near misses.

2. Scope

This document applies to all Faculties, Divisions and organisational units of the University of Newcastle and its controlled entities.

3. Definitions

In the context of this document, the following definitions apply:

- **Hazard:** A source or a situation with a potential for personal injury or ill-health, damage to property, damage to the environment, or a combination of these.
- **Incident:** Any event resulting in, or having a potential for injury, ill health, damage or other loss.
- **Injury:** Any physical or psychological damage caused by exposure to a hazard.
- **Dangerous Occurrence:** An event where there is an immediate and significant risk to any person in, on, or near the relevant place where the event took place, or where a person could have been in, on, or near the relevant place (whether or not a work-related injury occurs).
- **Near Miss:** An event which has the potential to cause personal injury, property or environmental damage.
- **Lost Time Injury (LTI):** A work related injury or illness which causes an employee or contractor to be unfit for work for one full shift on any day subsequent to the injury or illness occurring.

- **Medical Treatment Injury (MTI):** A work-related incident that results in injury or illness that requires medical treatment beyond the scope of the initial first aid treatment which is accepted as a Workers' Compensation claim.

- **Total Recordable Injuries:** A combination of LTIs and MTIs.

- **First Aid Treatment:** An injury which is any one-time treatment and subsequent observation of minor injuries such as scratches, cuts, burns, splinters, strains which does not become a Workers' Compensation claim. This includes an incident that requires medical assessment to determine if an injury has occurred where the assessment determines that no treatment is required and the person returns to their normal duties without modifications.

- **Notifiable Incident:** An incident that is to be reported to WorkCover and includes the following events:

  – A workplace fatality;
  – The amputation of a limb;
  – A person being placed on a life-support system;
  – Loss of consciousness to a person caused by impact of physical force; exposure to hazardous substance, electric shock or lack of oxygen;
  – Major damage to any plant, equipment, building or structure;
  – An uncontrolled explosion or fire or imminent risk of an explosion or fire;
  – An uncontrolled escape of gas, dangerous goods or steam or imminent risk of same;
  – A spill or incident resulting in exposure or potential exposure of a person to a notifiable or prohibited carcinogenic substance;
  – Entrapment of a person in a confined space;
  – Collapse of an excavation;
  – Entrapment of a person in machinery;
  – Serious burns to a person resulting in hospitalisation.

- **Leaders/Supervisors:** Any member of the University who is responsible for supervising staff and/or undergraduate or postgraduate students and/or for leading research projects.

- **Workers:** As defined in the NSW Work Health & Safety (WHS) Act 2011, workers include employees, conjoints, students on work experience, contractors, sub-contractors and their employees. Staff, conjoints, students on work experience, and contractors may be referred to collectively as workers, or separately as staff, conjoints, students, or contractors.

4. Responsibilities

4.1 Members of University Council

Monitor reports and the outcome from investigations in relation to incidents occurring across the University campuses.

4.2 The Vice-Chancellor and University Executive Committee,

- Monitor reports and the outcome from investigations in relation to incidents occurring across the University campuses;
- Ensure appropriate processes are in place for incident notification and investigation;
- Ensure actions arising from incident investigations are implemented and closed.

4.3 University Leaders/Supervisors

- Ensure all incidents are reported and recorded for their area of responsibility and that the UON Health and Safety (H&S) Team are notified straight away when an injury occurs that requires medical treatment;
- Ensure that incident reports are entered on the online University Incident Management System (IMS) within 24 hours of an incident occurring;
- Ensure that incident investigations are completed and the details entered into the IMS;
- Ensure that incidents are followed up to monitor implementation of corrective actions and closed when actions have been completed;
- Ensure that Notifiable Incidents are notified to the H&S Team immediately after becoming aware of an incident that is likely to be reportable to WorkCover so that the H&S Team can provide advice and support regarding the report to the authority.

4.3 Health and Safety Team

- Communicate incident recording and reporting requirements to all stakeholders and provide relevant training where required;
- Ensure all relevant staff are given access to the online IMS and provided with instruction on its use;
- Assist relevant staff members with notification of Notifiable Incidents to WorkCover when required;

- Assist staff who have been assigned the responsibility of investigating incidents when assistance is needed or when the severity determines that additional input is required;
- Report incident data to the Executive Committee monthly and to the University Council quarterly.

4.4 Workers, Students & Other Members of the University Community

- Report all workplace injuries, illnesses, incidents, near misses and hazards to their direct supervisor as soon as it occurs and no later than the end of the day in which the incident occurred.

5. Procedure – Reporting Incidents

5.1 Immediate Report

All incidents must be reported by employees, contractors and visitors to their supervisor, or the person in charge of the visitor, as soon as the incident occurs but not later than before the end of the day. This includes vehicle incidents and also near misses where no injury or damage occurs, but where the resulting corrective action may prevent future serious injury, harm or damage.

The H&S Team are to be notified immediately when an injury occurs that requires medical treatment.

Where there are other people at risk of injury as a result of the incident, steps should be taken to control all immediate threats in the area.

5.2 Medical Treatment

Where an injury has occurred, immediate treatment should be rendered by the first aid officer for the location, and where further medical assessment and/or treatment is required, arrangements will be made for prompt referral to the University Health Service at the Callaghan campus or to a preferred medical provider at other campuses.

Where a serious injury has occurred an ambulance will be called and Security informed so they can direct the ambulance to where the injured person is on campus.

5.3 Contacts

The supervisor or other person responsible for the location where the incident occurred will make the following contacts as soon as practicable to provide the initial details of the event. This is particularly important where a person has been seriously injured:

- Their direct supervisor;
- The relevant PVC, DVC and HoS;

- The H&S Team.

The H&S Team can provide help and support to the Faculty/School/Division/Unit where the incident occurred depending on the situation. For example;

- Providing advice to the treating medical practitioner regarding the UON Injury Management and Return to Work programs;
- Helping to determine if the incident is reportable to the WorkCover Authority and assisting with the communication to the Authority if necessary;
- Providing advice regarding the appropriate level of referral for treatment and initiating a Workers' Compensation claim if necessary;
- Providing immediate input to an investigation if required.

5.5 Recording

Once the immediate situation is under control, the supervisor, first aid officer, or other responsible person will enter the details of the incident into the University's online Incident Management System (IMS). The system will automatically email the person's supervisor and the H&S Team. It is important that the information is entered as soon as possible after the event, preferably on the same day.

Following notification the supervisor for the location will allocate responsibility for the incident investigation which should commence as soon as possible after the event when the details are fresh in everyone's mind.

6. Procedure – Investigation

The purpose of investigating incidents is to:

- Determine the causes and to prevent similar incidents recurring in the future;
- Identify any new hazards;
- Identify and choose suitable corrective and preventive actions;
- Fulfil legal and insurance requirements.

6.1 Investigators

- The supervisor or other person responsible for the location is the person that is responsible for carrying out the incident investigation;
- More than one person's input is valuable in any investigation. Other people who may be asked to contribute include members of an H&S Committee, other area supervisors, a staff member from the injured person's team or a member of the H&S Team;

- For serious incidents, an investigation team will be selected which may include other appropriate personnel who can provide specialist input e.g. an engineer if a piece of equipment has failed; an electrician if electrical energy was involved.

6.2 Levels of Investigation

The nature of the incident will determine the level of investigation required. Incidents are classified into 3 levels to determine the appropriate level of investigation response:

- ***Level 1 incidents: those which are a lower level of risk and are not categorised as*** being notifiable to WorkCover. Examples of Level 1 incidents may include:

– First aid injuries;

– Injuries which may require minor medical treatment with no lost time;

– Identified hazards which do not present a serious risk of injury;

– Minor property damage.

Level 1 incidents are investigated at a local level e.g. supervisors, managers and/or employees, to review the details of the incident, identify possible contributing factors, determine a cause of the incident, assess the risk of the hazard and implement appropriate corrective actions.

- ***Level 2 incidents:*** those which present a risk to health and safety but are not immediately threatening to life. They include:

  – An injury or illness (supported by a medical certificate) that results in the person losing time from work;

  – Damage to any plant, equipment, building or structure or other item that impedes safe operation.

  A Level 2 investigation is an in-depth assessment of the situation and will require an investigation team led by the manager of the location with input from the H&S Team. The investigation will include the following steps:

  – Collection of facts to consider all the possible contributing factors;

  – Determination of root causes;

  – Determination of corrective and preventative actions;

  – Record of findings;

  – Communication of findings;

  – Review of implemented corrective actions.

- ***Level 3 incidents***: involve a fatality or life threatening injuries or a dangerous occurrence that requires immediate notification to WorkCover, as per the "Notifiable Incident" definition.

  As the incident has to be reported to WorkCover the scene of the incident must not be disturbed unless actions are required to help or removed trapped or injured persons, or are needed to make the site safe, or the actions are directed or permitted by a WorkCover inspector.

  The Associate Director, Health and Safety will liaise with WorkCover and undertake an investigation of the incident as per Level 2 incident investigation, and in accordance with any directions provided by WorkCover.

6.3 Contributing Factors

The first step of the investigation is the collection of all the information required to establish the facts relating to the incident. Information will include all or some of the following:

- Interviews with the people directly involved in the incident e.g. injured person; witnesses; manager and/or supervisor of the location;
- Inspection of the incident site;
- Use of photos, video footage and diagrams as required;
- Re-enactments to determine the sequence of events;
- Review of relevant documentation e.g. training records, risk assessments, Standard Operating Procedures (SOPs); hazard reports; previous incident reports; H&S committee minutes.

6.4 Root Causes

The objective of an investigation is to find the root causes of the incident, and not to jump to the most obvious reason, which may have only been the last step in a whole series of factors that led to the accident.

Once all the possible contributing factors have been identified a good methodology for identifying the root cause(s) is to use the "5 whys". An example of a process flow describing this method is in Attachment 1 which clearly links the cause and effect relationships which led to the incident.

When using the root cause diagram, the incident should be positioned to the left and by repeatedly asking "why" the causes identified are placed on the right. The process continues until no further causes can be identified by asking "why". In the example the event is a back injury, caused by falling down the stairs caused by the person slipping etc.

Root causes are almost always due to one or more system failures and the process described will lead to determining the system failures which include:

- Lack of or inadequate plant/equipment/PPE;
- Lack of or inadequate procedures/instructions;
- Lack of or inadequate training;
- Lack of or inadequate management/supervision;
- Inappropriate or inadequate work environment;
- Lack of or inadequate management of hazards and risks;
- Inappropriate actions and/or behaviour by an individual or team;
- Lack of or inadequate management system;
- Lack of or inadequate contractor management.

See Attachment 3 for a checklist that can be used to help to determine root causes.

6.5 Corrective and Preventive Actions

Once the root causes have been identified appropriate corrective actions can be determined.

Corrective actions should:

- Control the hazard to an acceptable level;
- Not introduce a new hazard or risk;
- Consider the "hierarchy of control" in structuring appropriate risk reduction activities.

The hierarchy of controls addresses the preferred methods for eliminating or minimising a hazard:

- Elimination: removing the hazard altogether e.g. by finding a different way of doing a task;
- Substitution: introducing a less hazardous process or substance;
- Engineering: introducing physical protection to separate the hazard from persons or to contain the hazard, or to modify plant and equipment;
- Administrative: procedures and processes such as training, risk assessments, SOP and safety meetings;
- Personal Protective Equipment (PPE): e.g. safety eye wear, hearing protection, safety footwear, safety gloves, protective overalls, the last line of defence.

For more information on the hierarchy of control see UON HSP 4.1, Risk Management.

6.6 Record of Findings

The template in Attachment 2 can be used to record the findings from the investigation. Once the investigation has been completed the findings and corrective actions are to be entered into the online IMS.

6.7 Communication of Findings

Once completed, the investigation report for Level 2 and 3 incidents is to be distributed to the Pro Vice-Chancellor, Head of School or Director and the H&S Team. A copy is also tabled at the relevant Faculty / Divisional Health and Safety Committee, and the University Health and Safety Committee for discussion and review of the corrective actions.

Where an incident and the investigation findings are relevant to other parts of the University, the H&S Team will generate a Safety Alert which is distributed to all Faculties and Divisions so everyone can share the learnings and apply them to their own areas of responsibility.

6.8 Review and Follow Up

To ensure that corrective actions arising from an incident investigation are implemented, progress will be monitored against assigned timelines and the actions recorded in the online IMS report.

Progress can be monitored during regular Faculty, School, Division or Unit meetings and through the relevant H&S committee meeting. Corrective actions which have not been implemented within the assigned time for completion will be raised with the supervisor or other person responsible for the location concerned.

7. References

UON Health and Safety Management System Framework

UON HSP 4.1 Risk Management

UON HSP 4.2 Injury Management

8. Attachments

1. Process Flow for Root Cause Analysis
2. Incident Investigation Template
3. Root Cause Analysis Checklist

Document Control Table

Incident Reporting and Investigation – HSP 7.1					
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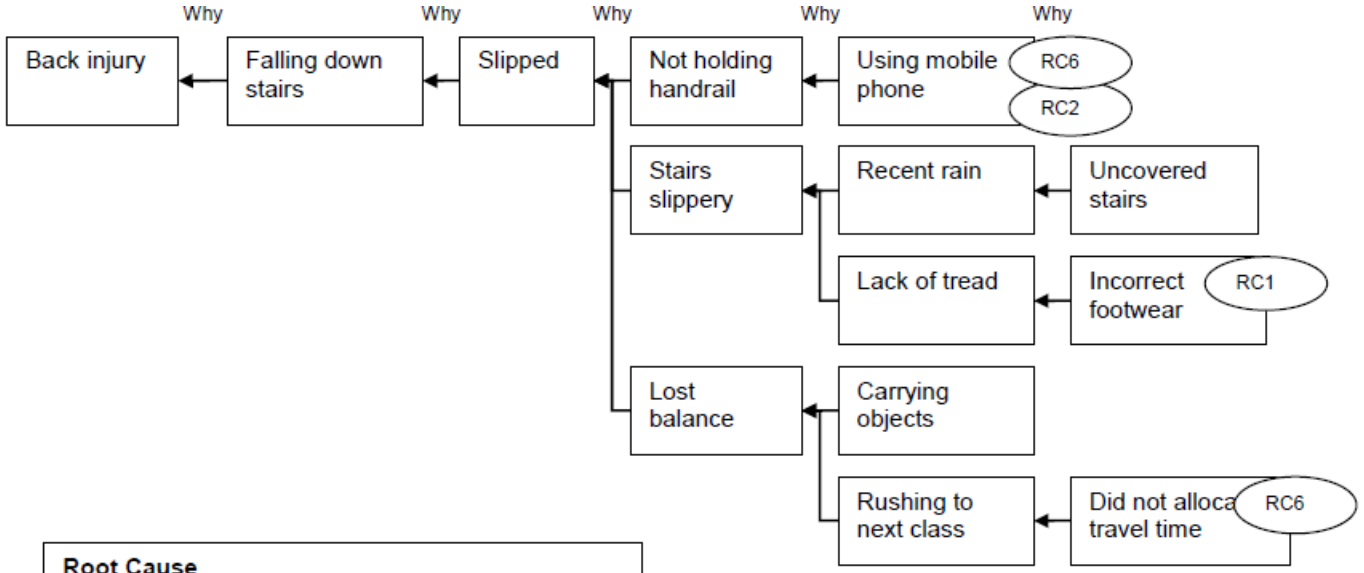
Attachment 1. Root Cause Analysis Process Flow



Root Cause

1. Lack of or inadequate plant/equipment
2. Lack of or inadequate procedures/instructions
3. Lack of or inadequate training
4. Lack of or inadequate management/supervision
5. Inappropriate or inadequate work environment
6. Inappropriate actions and/or behaviour
7. Lack of or inadequate management system
8. Other contributory issues

Attachment 2. Incident Investigation Report Form

Faculty / Division	
School / Unit	
Location of Incident	
Responsible Manager	
Supervisor	
Date of incident	

INSTRUCTIONS

Description of the Incident. *Describe what happened. Do not try to identify the cause at this stage. Provide a diagram and photos if possible. Keep the description anonymous, names of persons involved should not be included*

Equipment Being Used

Identify all equipment being used at the time of the incident

Any Environmental Conditions that could have contributed to the Incident

Describe factors such as weather conditions, visibility, lightness, temperature, accessibility, ventilation, hazard signage, labelling

Was there a Failure of any Existing Preventative Controls?

Identify any failure in current controls e.g. ventilation not operating, work permit not used, guard not in place, standard operating procedure not followed, etc

Were There Any Deficiencies in the Operating Procedures?

List any deficiency in the currently used standard operating procedure. Ie how does the procedure need to be changed?

Contributing Factors to the Incident

From a review of the answers to the above questions list the factors that you think contributed to the incident. For instance:

- *Equipment Related: Maintenance, electrical failure, mechanical failure, poor design, poor layout, wrong tools, inappropriate equipment, no operating instructions, inadequate isolation,*
- *Environment Related: Poor housekeeping, lighting, signage, labelling, ventilation,*
- *Administrative Related: Inadequate instructions, instructions misunderstood, failure to follow instructions, supervision, planning, procedures, training, speeding/hurrying, fatigue, work permits, personal protective equipment, workplace inspections, system audits,*

Root Causes of the Incident

From the contributing factors that have been identified, determine the root causes of the incident. These are the fundamental deficiencies that led to a breakdown in the layers of preventative measures thus causing the incident to occur. There is generally more than one root cause and they usually relate to deficiencies in operating procedures or system failures. One way to determine the root causes is to take each contributing factor and keep asking "Why" until you run out of "Whys" – this will then be a root cause.

Corrective Actions Required to Prevent a Similar Incident

List all the actions that could be taken to prevent this incident from happening again

UON INCIDENT INVESTIGATION REPORT	
1. Description of Incident	
2. Equipment being used at the time?	
3. Environmental conditions that may have contributed to the incident?	
4. Was there a failure of any preventative risk controls?	
5. Were there any deficiencies in operating procedures?	
6. Contributing factors to the incident	1. 2. 3. 4. 5. 6.
7. Root causes	1. 2. 3. 4.

8. Corrective actions

Action	By Whom	By When

9. Incident Management System: has the outcome of the investigation been entered into the online IMS?	**Y/N**
10. Hazard Identification: has a new hazard been identified and does a risk assessment need to be completed?	**Y/N**

11. Person Responsible for the Investigation

Name:	Signature:	Date:

12. Other Investigation Team Members

Name:	Signature:	Date:
Name:	**Signature:**	**Date:**
Name:	**Signature:**	**Date:**

13. Senior Manager Comments

Name:	**Signature:**	**Date:**

Attachment 3. Root Cause Analysis Checklist

Occurrence Details
Incident/Ref No: _____ Time/Date Occurred:_____ Potential Risk Level_____
Person Involved:_____ Employee ☐ Contractor ☐ Other ☐

STEP 1 WHAT WAS THE RESULTOF THIS INCIDENT?	☐ Lost Time Injury (LTI) ☐ Medical Expense Only (MEO) ☐ First Aid Only (FAO)	☐ Hazard identification ☐ Environment ☐ Near Miss

WHY DID IT HAPPEN?

⇩

STEP 2 WHAT WAS THE TYPE OF INCIDENT? **Select one**	☐ Hitting objects ☐ Fall/slip/trip ☐ Hit by moving object ☐ Biological hazard ☐ Body stressing ☐ Exposure to sound and pressure	☐ Contact with electricity ☐ Exposure to chemicals and substances ☐ Exposure to heat and radiation ☐ Fire/explosion ☐ Mental stress

WHY DID IT HAPPEN?

⇩

	INDIVIDUAL OR TEAM FACTORS	WORKPLACE FACTORS
STEP 3 WHAT WERE THE IMMEDIATE CAUSES?	☐ Working without authority ☐ Failure to follow procedures ☐ Not using safety devices ☐ Incorrect tools selected ☐ Improper lifting/movement ☐ Horseplay/inattention ☐ Failure to secure ☐ Improper position ☐ Rushing	☐ Lack of guards ☐ Inadequate equipment ☐ Defective tools ☐ Congested workplace ☐ Inadequate warning system ☐ Fire hazard ☐ Noise/heat/dust/light ☐ Poor housekeeping ☐ Poor ventilation

WHY DID IT HAPPEN?

⇩

	PERSONAL FACTORS	JOB FACTORS
STEP 4 WHAT WERE THE UNDERLYING CAUSES? (CONTRIBUTING FACTORS)	☐ Inadequate capability of individual ☐ Lack of knowledge ☐ Lack of skill ☐ Motivation (lack of, or too much) ☐ Stress - physical ☐ Stress - psychological	☐ Inadequate leadership/supervision ☐ Inadequate engineering ☐ Inadequate purchasing ☐ Inadequate maintenance ☐ Abuse or misuse ☐ Poor process design ☐ Inadequate work standards

WHY DID IT HAPPEN?

⇩

	SYSTEM FAILURE	
STEP 5 THE ROOT CAUSES ARE?	☐ Leadership & accountability ☐ Risk assessment & management ☐ People, training & behaviours ☐ Engaging & working with contractors ☐ Design, construction & change ☐ Safe work practices & rules ☐ Reward & recognition ☐ Information & documentation	☐ Customers and products ☐ Communications ☐ Emergency management ☐ Incidents analysis & prevention ☐ Health and hygiene ☐ Hiring & placement ☐ Measurement & evaluation ☐ Planning & scheduling