4.3 Incident Investigations

4.3.1 Aims and Objectives
To prescribe the responsibilities and actions required to undertake incident investigations as per the Procedure: Work health and safety incident management and the National Self Insurer WHS Audit Tool (NAT CTH) as well as other relevant legislation and WHSMS Handbook requirements.

4.3.1.1 Objectives
To ensure the University and its Colleges, Schools and Service Divisions:

a) Have an adequate process in place to ensure incidents are investigated in a timely manner as per required in this Chapter;

b) Investigate incidents appropriately for their root causes using the methodologies specified in this Chapter;

c) Identify corrective actions to address the root causes of the incidents on WHSMS implementation deficiencies; and

d) Maintain documentation relating to incidents and investigations in Figtree.

4.3.1.2 Scope and Inclusion
This Chapter applies to all Schools, Colleges and Service Divisions of the Australian National University (ANU).

This Chapter applies to all workers of the ANU as well as Higher Degree by Research (HDR) students.

Exclusion
Construction contractor incidents will be investigated by the Contractor’s Representative or Principle Contractor and reported to ANU. ANU must be involved as a part of the investigation for notifiable incidents on construction site. See Chapter 3.6 Contractor Safety Management for detailed process.

4.3.2 Process

4.3.2.1 Resourcing and Planning

<table>
<thead>
<tr>
<th>Responsible and Accountable Person</th>
<th>Actions Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Directors</td>
<td></td>
</tr>
<tr>
<td>Service Division Directors</td>
<td></td>
</tr>
</tbody>
</table>

- Nominate/Appoint 1 to 2 workers to be Local Authorised Incident Investigators for areas under your control.

These Local Authorised Incident Investigators will be investigating incidents in your areas in accordance with the requirements of this Chapter.

They can be WHS Officers/Managers, HR Managers, School Managers, WHS Committee members (not HSRs) or any other interested workers.

HDR students are not suitable for this role.

- Ensure the Local Authorised Incident Investigators attend WEG Lunch and Learn sessions to upskill their incident investigation capability.

- Provide the names and ID number of the Local Authorised Incident Investigators in your area to Senior WHS Consultant: Systems and Audit.
4.3.2.2 Triage Stage

**WEG WHS Consultants**

- Continuously and actively monitor Figtree generated emails on incidents.
- Triage an incident (i.e. Incident classification and verify incident investigator in Initial Review) as soon as practicable within **24 hours** of receiving the notification.

**Triage Steps**

- Determine if it is an incident (including near miss) or a hazard:
  - If it is a hazard, in the initial review, cancel the incident and raise a hazard on behalf of the person who made the initial report and follow Chapter 3.16 instructions to manage the hazard.
  - If it is an incident (including near-miss), follow the steps below.

- Determine if the incident is the University’s incident in relation to health and safety. Is the incident:
  - on or caused by the University's infrastructure;
  - caused by the University's property;
  - related to the University’s processes;
  - related to the University’s activities; or
  - happening because of the University's branding and reputation.

- If you answer:
  - **No to all of the above** - In the initial review, it is not the University’s incident. Put Incident Classification as Level 1 – Report Only or Not University’s Incidents and enter reasons in the “Comment” as to why this incident is level 1 (refer to above) – close the incident.
  - **Yes to any of the above** – Classify the incident in accordance with the table below.

<table>
<thead>
<tr>
<th>Incident Classification</th>
<th>Incident characteristics (examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Property damage, Traffic incidents, near-misses (not Level 4 near miss), First Aid Injury</td>
</tr>
<tr>
<td>Level 3</td>
<td>Medically Treated Incidents (not Level 5 Serious illness or injury) Lost Time Injury &lt; 1 week</td>
</tr>
<tr>
<td>Level 4</td>
<td>Notifiable incidents including</td>
</tr>
<tr>
<td>Level</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 5     | Notifiable Incidents including:  
|       | - Death of a person/s  
|       | - Serious illness or injury |
| 4     | Lost Time Injury > 1 week |
| 3     | Dangerous incidents and associated near-misses |

For any incidents that have a potential to fall into Level 4 and 5, they should have already been reported to Associate Director, WEG [refer to Chapter 3.16]. However, still refer these incidents to Associate Director, WEG immediately and upon confirmation by ADWEG, change the Incident Classification to Level 4 or 5 in accordance with the table above and change the Incident Owner to the Manager WHS WEG (currently Gerard Patron).

For Level 2 and 3 incidents, the incident owner and incident investigator will have already been autofilled with the Local Authorised Investigator of the area of the reporter. Determine whether they should be the actual investigator or whether a Local Authorised Investigator from another area should investigate the incident.

- If the incident investigator is correct – use the ‘Send Email’ function to notify the incident investigator to start investigation process.
- If another Local Authorised Investigator needs to investigate the incident, change the investigator name and notify them via ‘Send Email’.

For example, a traffic or tree incident may be reported by a person in HR but they should be investigated by F&S Authorised Investigator.

<table>
<thead>
<tr>
<th>Supervisors</th>
<th>Line Managers</th>
</tr>
</thead>
</table>
| Figitree will notify you when an incident is reported by persons you supervise.  
| The person or their colleagues should have notified you about the incident before submitting in Figitree unless at the time of incident you are not in Australia or ACT or are on leave. [See Chapter 3.16]  
| If they haven’t, call them and check that they are safe. Take actions to ensure the incident areas are made safe after the incident, if you have control.  
| If this is potentially a notifiable incident [see definition], preserve the site as much as possible.  
| Ensure workers and HDR students under your control understand and follow Chapter 3.16 requirements in incident reporting. |

<table>
<thead>
<tr>
<th>School Directors</th>
</tr>
</thead>
</table>
| You are not required to do the initial review in Figitree at this stage.  
| Monitor Figitree generated emails notifying you the incident. Read them to understand the context of these incidents. |
4.3.2.2 Level 2 – 3 Incident Investigation

<table>
<thead>
<tr>
<th>Responsible and Accountable Person</th>
<th>Actions Required</th>
</tr>
</thead>
</table>
| Workers, HDR students, Supervisors, Line Managers, Course Coordinators | - Participate in the incident investigation initiated by your Local Authorised Incident Investigator.  
- Provide factual information to the Local Authorised Investigators.  

**NOTE:** The University adopts a no-fault incident investigation methodology that looks at what happened rather than who cause it unless it was a reckless action, manslaughter or deliberate and wilful act. |

<table>
<thead>
<tr>
<th>Initial Investigation - Fact Gathering</th>
<th></th>
</tr>
</thead>
</table>
| Local Authorised Investigators | - Continuously and actively monitor emails notifying you about incident investigation.  
- On receipt of an incident investigation notification, read the incident in full and determine whether the immediate actions taken are appropriate. If not, contact the supervisor who has control of the incident scene.  
- If an injury is involved, notify the HSR of the work group (if elected) via the “Send Email” function under Notes and tick “HSR Notified” in the initial review.  
- Attend the scene where the incident has occurred as soon as possible and take photos of the scene for attachment into Figtree incident report.  
- Call the person reporting the incident as soon as possible on the day to:  
  - Conduct a wellness check, if they are injured/may be injured, and provide & offer EAP or Student Counselling details should the person need it; or  
  - If the person is not available, call the supervisor of the person to discuss the incident, if applicable; and  
  - Start gathering initial incident details, depending on the incident situation such as:  
    - Whether police, ambulance, fire services have been involved (if not reported already);  
    - Are there any witness and get the details of these people (if not reported already);  
    - What happened during the incident, how did it happen, has the incident area been made safe after the incident (what has been done), and has everyone affected been removed from the incident area.  
- Determine whether a Full Investigation [See definitions](#) is required.  
  - If a full investigation is not required: |
| **Full Investigation** | | | 
| Local Authorised Investigators | | | 
| Together with | | | 
| Supervisor/manager who has control of the location where incident has occurred | | | 
| And | | | 
| Supervisor of the person involved in the incident | | | 
| Involving | | | 
| The Person involved in the incident | | | 
| Local Authorised Investigators | | | 
| | | | 
| □ Ensure Level 2-3 incident investigations are completed within 20 days of the incident occurrence and closed within 25 days of the incident occurrence. | | | 
| □ The investigation team must meet as soon as possible within 5 days of the initial review date and start gathering data in the meeting. | | | 
| □ **Invoke HSR of the Work Group, if elected, to the meeting for participation as an incident investigation team member.** | | | 
| In this meeting, record the sequence of events and the activity the person involved was undertaking. | | | 
| □ Use Appendix A. Level 2-3 Incident Investigation Template to conduct an objective, factual and evidence-based incident investigation. | | | 
| Appendix A may be used multiple times in a single incident to determine a number of root causes [See definition]. It is common for an incident to have more than one root cause. | | | 
| □ Upon agreement by the investigation team on the investigation outcome, i.e. the root causes, determine collectively what corrective actions are appropriate. | | | 
| □ Ensure each corrective action addresses a root cause of the incident. | | | 
| For example, if the root cause is ‘failure to identify a hazard’, the corrective action can be ‘review existing risk assessment to include an assessment of the hazard and identify controls’ or ‘conduct a risk assessment on XXX activity’ if there is no existing risk assessments. | | | 
| See Chapter 4.3 on the format of corrective actions. | | | 
| □ On completion of the full investigation, complete the Investigation Details section and the Causal Analysis section. | | | 
| □ Determine if a hazard is identified in this process: | | | 
| ➢ If the hazard is something relating to the infrastructure, identify as “YES” and conduct a risk assessment in Figtree. | | |
If the hazard should be part of an activity/task but failed to be identified, i.e. “failure to identify a hazard” is a root cause, identify as ‘NO’ but assign a corrective action for the root cause to be addressed.

- Ensure that you update the ‘comments’ section in the initial review as you go using a timeline format.

**Updated XX/XX/YYYY Person Name, Position. Details of the Update.**

For example:
Updated 15/02/2019 John Citizen, Manager WHS. A meeting is scheduled to be held on 18/02/2019 to further discuss the incident.

- Ensure all documents related to the incident (e.g. meeting notes, investigation templates, briefing notes with Director, risk assessment, reviewed risk assessment, safe work procedures, reviewed safe work procedures, training records, proficiency training records, interview notes, email communications, completion of corrective actions, maximo number/documents) **must be uploaded into Notes section.**

- Consider the wider application of the incident, findings and corrective actions to find existing problems in areas under your Director’s control and address them as preventative actions.

- Notify the School/Service Division Director of the incident investigation outcome, using ‘Send email’ function.

- Ensure you meet the following:
  - Investigations initial facts gathered within 20 days; and
  - Complete Incident investigation and closeout within 25 days.

<table>
<thead>
<tr>
<th>School Directors</th>
<th>Service Division Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Ensure that you read all email notifications sent by Local Authorised Incident Investigators on Full Investigation outcomes.</td>
<td>□ Provide direction to the supervisor involved in this incident and all supervisor/line managers in the School/Services Division should you be concerned about the failures identified in the root cause.</td>
</tr>
<tr>
<td>□ Provide resources should an incident need long term commitment/strategy to resolve issues identified.</td>
<td></td>
</tr>
</tbody>
</table>

### 4.3.2.3 Notifiable Incident Investigations (Level 4-5)

<table>
<thead>
<tr>
<th>Responsible and Accountable Person</th>
<th>Actions Required</th>
</tr>
</thead>
</table>
| WHS Officers/Manager or Human Resources Managers, if no WHS Officers exist in the area | □ Upon becoming aware of a potential notifiable incident and after contacted Associate Director, WEG:  
  - Attend the scene if safe to do so; and  
  - Help supervisors to preserve the site. This may include lock the room, tag a whole location out, no access zone etc.  
□ Ensure the scene must be secured and preserved until further notice from Associate Director, WEG.  
□ Facilitate AD WEG appointed Authorised Notifiable Incident Investigation. |
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Director, WEG</td>
<td>- Appoint a delegate as an Authorised Notifiable Incident Investigator. This delegate must have completed ICAM training or have completed the University's internal Notifiable Incident Investigation Methodology training.</td>
</tr>
</tbody>
</table>
| Authorised Notifiable Incident Investigator | - Treat the investigation of Notifiable Incidents as a top priority.  
- Attend the incident site to gather initial facts (e.g. to take photos, identify the plant/equipment), but **DO NOT** remove or interfere with the incident site (including any plant, substance, structure or thing associated with the incident) until a Comcare inspector arrives at the site or directs otherwise (whichever is earlier).  
- Identify the workers who were involved in the incident and any other stakeholders (including witnesses) and conduct interviews with them separately. Note any key points from their recollections of the incident.  
- Continue to preserve the site, where instructed by Comcare (e.g. lock-out, signage and communication), until the Comcare inspector directs otherwise.  
- Arrange a meeting as soon as practicable with the supervisor of the incident/person, WHS Officer/Manager, the injured worker/student and HSR to conduct the full incident investigation.  
- Use [Appendix B. Level 4-5 Incident Investigation Template](#) to conduct an objective, factual and evidence-based incident investigation to identify root causes of the incident.  
- Upon agreement by Associate Director, WEG on the investigation outcome, i.e. the root causes, determine collectively what corrective actions are appropriate.  
- Ensure each corrective action addresses a root cause of the incident.  
- Assign corrective actions to relevant people (High Priority). See Chapter 4.3 on the format of corrective actions.  
- Ensure to meet the following:  
  - Investigations initial facts gathered within 15 days; and  
  - Complete Incident investigation and closeout within 45 days. |
| Supervisors of the incident or injured person | - Preserve the scene of incident after made aware of a notifiable incident. **DO NOT** allow anyone to continue to work in the area. All works in the area must be ceased until further notice from Associate Director, WEG.  
- Participate in the incident investigation of notifiable incidents as top priority and be co-operative in the investigation.  
- Provide factual evidence to the Authorised Notifiable Incident Investigator.  
**NOTE:** The University adopts a no-fault incident investigation methodology that looks at what happened rather than who cause it unless it was a reckless action, manslaughter or deliberate and wilful act.  
- Complete any corrective actions, arising from the investigation of the Notifiable Incident, assigned to you promptly within 4 weeks (High Priority). |
| Injured Person | - Treat the investigation of Notifiable Incidents as a top priority.  
- Attend the incident site to gather initial facts (e.g. to take photos, identify the plant/equipment), but **DO NOT** remove or interfere with the incident site (including any plant, substance, structure or thing associated with the incident) until a Comcare inspector arrives at the site or directs otherwise (whichever is earlier).  
- Identify the workers who were involved in the incident and any other stakeholders (including witnesses) and conduct interviews with them separately. Note any key points from their recollections of the incident.  
- Continue to preserve the site, where instructed by Comcare (e.g. lock-out, signage and communication), until the Comcare inspector directs otherwise.  
- Arrange a meeting as soon as practicable with the supervisor of the incident/person, WHS Officer/Manager, the injured worker/student and HSR to conduct the full incident investigation.  
- Use [Appendix B. Level 4-5 Incident Investigation Template](#) to conduct an objective, factual and evidence-based incident investigation to identify root causes of the incident.  
- Upon agreement by Associate Director, WEG on the investigation outcome, i.e. the root causes, determine collectively what corrective actions are appropriate.  
- Ensure each corrective action addresses a root cause of the incident.  
- Assign corrective actions to relevant people (High Priority). See Chapter 4.3 on the format of corrective actions.  
- Ensure to meet the following:  
  - Investigations initial facts gathered within 15 days; and  
  - Complete Incident investigation and closeout within 45 days. |

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*NOTE: The University adopts a no-fault incident investigation methodology that looks at what happened rather than who caused it unless it was a reckless action, manslaughter or deliberate and wilful act.*
### 4.3.2.4 Dealing with an Improvement Notice or Prohibition Notice

<table>
<thead>
<tr>
<th>Responsible and Accountable Person</th>
<th>Actions Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Director</strong></td>
<td>□ Display a copy of the notice in a prominent place at/or near the workplace where the work is being carried out or that is affected by the notice.</td>
</tr>
<tr>
<td><strong>Service Division Director</strong></td>
<td>□ Notify the College Dean or Service Division Director immediately after being issued an Improvement Notice or Prohibition Notice.</td>
</tr>
<tr>
<td><strong>Supervisors in control of the area where the incident has occurred</strong></td>
<td>□ Upload a copy of this notice into the Figtree incident under Notes section.</td>
</tr>
<tr>
<td>In consultation with <strong>Manager, WHS WEG</strong></td>
<td>□ In case of a prohibition notice, the prohibited activity must cease and cannot recommence until an inspector certifies in writing that the risk has been remedied.</td>
</tr>
<tr>
<td><strong>Associate Director</strong></td>
<td>□ Ensure to complete any actions directed by the Comcare inspector, to remedy the contravention before the specified date on the notice.</td>
</tr>
<tr>
<td><strong>WEG</strong></td>
<td>□ Ensure the notice is signed by the person who was issued the notice and returned to the Comcare inspector to certify that the requirements of the notice have been complied with, before the specified date on the notice.</td>
</tr>
<tr>
<td><strong>WEG</strong></td>
<td>□ Upload the signed copy of the notice into the Figtree incident under Notes section.</td>
</tr>
</tbody>
</table>

**Associate Director**

- Notify Director Human Resources and the COO should any areas in the University receive an Improvement Notice or Prohibition Notice.
- Assess the content of the notice, if in doubt, you may choose to challenge Comcare inspectors in accordance with information provided on Comcare website.
- Ensure the person who was issued the notice completes actions as directed by the Comcare inspector to remedy the contravention before the specified date on the notice.

### 4.3.2.5 Monitoring and Review

<table>
<thead>
<tr>
<th>Responsible and Accountable Person</th>
<th>Actions Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHS Officers-Managers or Authorised Investigators, if no WHS Officer is appointed in the area</td>
<td>□ Present a quarterly incident report to School Directors/Service Division Directors and discuss with them any significant incidents requiring attention.</td>
</tr>
<tr>
<td><strong>School Directors</strong></td>
<td>□ Conduct an annual Root-cause Incident Trend Analysis and present to School Directors/Service Division Directors and discuss with them the trend identified in areas under their control.</td>
</tr>
<tr>
<td><strong>Service Division Directors</strong></td>
<td>□ Review incidents in areas under your control quarterly and the Root-cause Incident Trend Analysis annually in:</td>
</tr>
<tr>
<td></td>
<td>□ Local WHS Committee meeting if your area has a committee; or</td>
</tr>
<tr>
<td></td>
<td>□ In any other management meetings if you area has no Local WHS Committee.</td>
</tr>
<tr>
<td></td>
<td>□ Provide strategic and operational directions or assign corrective actions should a trend identifies gaps.</td>
</tr>
</tbody>
</table>
Monitor corrective actions report quarterly to ensure no outstanding corrective actions are in areas under your control. Direct supervisors under your control to ensure all corrective actions, especially ones arising from incidents, are completed by the due date.

- Ensure authorised investigators under your control meet the following:
  - Investigations initial facts gathered within 20 days; and
  - Complete Incident investigation and closeout within 25 days.

| Associate Director, WEG | Report notifiable incident details and report incident and hazard numbers to:
| In consultation with Senior WHS Consultant, Systems and Audit | ➢ University Council and the Audit and Risk Committee every 2 months; and
| | ➢ University WHS Committee every 3 months; Via University Council WHS Performance Report.

- Take incident data and trend into consideration when conducting the WHSMS Management Review process.

| University WHS Committee | Review University Council WHS Performance Report quarterly, especially parts in relation to incident and hazard reporting and notifiable incident details.
| | Provide strategic and operational direction should any of the incidents show systematic failures across the University.
| | Take corrective actions or direct relevant people to take corrective actions to address any identified systematic failures arising from incidents across the University.

### 4.3.3 Record Management

<table>
<thead>
<tr>
<th>Record needed</th>
<th>Where to Archive</th>
<th>Frequency to Archive</th>
<th>How long to keep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident investigation reports – Notifiable Incidents (Level 4-5) and supporting materials, evident, communication with regulators and internally</td>
<td>Figtree incident entry</td>
<td>As conducted</td>
<td>No expiry</td>
</tr>
<tr>
<td>Incident investigation reports – Level 2-3 incidents and supporting materials, evident, communication internally and with HSRs</td>
<td>Figtree incident entry</td>
<td>As conducted</td>
<td>No expiry</td>
</tr>
<tr>
<td>Incident investigation reports – involving students or children under 18 years old and supporting materials,</td>
<td>Figtree incident entry</td>
<td>As conducted</td>
<td>No expiry</td>
</tr>
</tbody>
</table>
4.3.4 Definitions

**Electric shock** that are notifiable include, for example:

- a) minor shock resulting from direct contact with exposed live electrical parts (other than ‘extra low voltage’) including shock from capacitive discharge.

**Electric shock** that are NOT notifiable include, for example:

- a) shock due to static electricity;
- b) extra low voltage shock (i.e. arising from electrical equipment less than or equal to 50V AC and less than or equal to 120V DC); and
- c) use of a defibrillator to shock a person for first aid or medical reasons.

**Full investigation** means after initial gathering of the facts:

- a) There are questions needed to determine if there are key underlying factors that constitute root causes.
- b) Evidence gathered during reporting indicates there are system failures that need analysis (e.g. someone not trained who should have been or hazard and risk assessment are not conducted).

**Immediate treatment** means the kind of urgent treatment that would be required for a serious injury or illness. It includes treatment by a registered medical practitioner, a paramedic or registered nurse. It does not matter whether the person actually receives the treatment, just that the injury or illness could reasonably be considered to warrant such treatment.

**Incident/event** means an occurrence that could have or did result in harm to a person, the environment or property damage.

**Improvement and Prohibition Notices (issued by Comcare)**

- **Improvement notices** – are written directions requiring a person to fix an issue within a specified time. The inspector will include information on the notice about what must be done to comply with the WHS legislation. The person who receives the notice is responsible for achieving compliance with legislation or dealing with the immediate risk.
- **Prohibition notices** – are written directions prohibiting any activity that will, or is likely to, involve an immediate risk to the health and safety of any individual. If a prohibition notice has been issued, the prohibited activity cannot recommence until an inspector certifies in writing that the risk has been remedied.
Notifiable Radiation Incidents mean incidents prescribed under section 58 of Australian Radiation Protection and Nuclear Safety Regulations 2018 that must be reported to ARPANSA. In the context of ANU, this means:

a) A spill of more than 20 ALI (Annual Limit on Intake); or
b) Radioactive contamination on a person or clothing exceeding 50 Derived Work Limits (DWL); or
c) Above the International Nuclear and Radiological Event (INES) scale of an incident (Level 2).

Notifiable Incidents (to Comcare) are incidents prescribed under WHS Act 2011 (Cth) Section 35 including:

a) The death of a person; or
b) A serious injury of illness of a person; or

c) A dangerous incident.

and the incidents must arise out of the conduct of the University’s business or undertaking.

Serious Injury or Illness of a person means an injury or illness requiring the person to have:

a) immediate treatment as an in-patient in a hospital; or
b) immediate treatment for:
   i) the amputation of any part of his or her body; or
   ii) a serious head injury; or
   iii) a serious eye injury; or
   iv) a serious burn; or
   v) the separation of his or her skin from an underlying tissue (such as degloving or scalping); or
   vi) a spinal injury; or
   vii) the loss of a bodily function; or
   viii) serious lacerations; or

c) medical treatment within 48 hours of exposure to a substance;

and includes any other injury or illness prescribed by the regulations but does not include an illness or injury of a prescribed kind.

[a) to c) are prescribed under WHS Act 2011 (Cth) Section 36]

d) Any infection to which the carrying out of work is a significant contributing factor, including any infection that is reliably attributable to carrying out work:
   i) that involves providing treatment or care to a person;
   ii) that involves contact with human blood or body substances; and/or
   iii) that involves handling or contact with animals, animal hides, skins, wool or hair, animal carcasses or animal waste products.

e) The following occupational zoonoses contracted in the course of work involving handling or contact with animals, animal hides, skins, wool or hair, animal carcasses or animal waste products:
   i) Q fever;
   ii) Anthrax;
   iii) Leptospirosis;
iv) Brucellosis;  
v) Hendra Virus;  
vi) Avian Influenza; or  
vii) Psittacosis.  
\[\text{(d) – (e) are prescribed under WHS Regulations 2011 (Cth) Regulation 699)}\]

**Dangerous incident** means an incident, prescribed under WHS Act 2011 (Cth) Section 37, in relation to a workplace that exposes a worker or any other person to a serious risk to a person’s health or safety emanating from an immediate or imminent exposure to:

a) an uncontrolled escape, spillage or leakage of a substance; or  
b) an uncontrolled implosion, explosion or fire; or  
c) an uncontrolled escape of gas or steam; or  
d) an uncontrolled escape of a pressurised substance; or  
e) electric shock; or  
f) the fall or release from a height of any plant, substance or thing; or  
g) the collapse, overturning, failure or malfunction of, or damage to, any plant that is required to be authorised for use in accordance with the regulations; or  
h) the collapse or partial collapse of a structure; or  
i) the collapse or failure of an excavation or of any shoring supporting an excavation; or  
j) the inrush of water, mud or gas in workings, in an underground excavation or tunnel; or  
k) the interruption of the main system of ventilation in an underground excavation or tunnel; or  
l) any other event prescribed by the regulations;  
but does not include an incident of a prescribed kind.

**Medical treatment** means treatment by a registered medical practitioner (a doctor).

**Plant** includes:

- a) any machinery, equipment, appliance, container, implement and tool; and  
- b) any component of any of those things; and  
- c) anything fitted or connected to any of those things.

**Root cause analysis** allows the investigation of underlying or systemic failures and causes of an incident, rather than the generalized or immediate, causes of an incident.

**Structure** means anything that is constructed, whether fixed or moveable, temporary or permanent, and includes:

- a) buildings, masts, towers, framework, pipelines, transport infrastructure and underground works (shafts or tunnels); and  
- b) any component of a structure; and  
- c) part of a structure.

**Supervisors** for the purpose of this chapter mean employees of ANU who have supervisory responsibilities. This include line managers and academic supervisors.
Substance means any natural or artificial substance, whether in the form of a solid, liquid, gas or vapour.

4.3.5 Performance Measures

The University will use the performance measures listed below to assist in identifying areas of success and/or where corrective action is required to meet the objectives and targets of this process.

The level of compliance with the chapter and effectiveness will be determined during the internal audit process in turn to determine the compliance with WHSMS. Local areas can use below as a guide to improve compliance

<table>
<thead>
<tr>
<th>References</th>
<th>Performance Measures</th>
<th>Objective Evidence</th>
<th>Frequency</th>
<th>Indication of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3.1.1 a)</td>
<td>% of incident investigations for Level 2-3:</td>
<td>Figtree incident entries</td>
<td>Quarterly</td>
<td>100% = Success Otherwise corrective actions</td>
</tr>
<tr>
<td></td>
<td>- Investigations initial facts gathered within 20 days; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Complete Incident investigation and closeout within 25 days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3.1.1 a)</td>
<td>% of incident investigations for Level 4-5:</td>
<td>Figtree incident entries</td>
<td>Quarterly</td>
<td>100% = Success Otherwise corrective actions</td>
</tr>
<tr>
<td></td>
<td>- Investigations initial facts gathered within 20 days; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Complete Incident investigation and closeout within 25 days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3.1.1 b)</td>
<td>% of incident investigations are completed using University incident investigation methodologies</td>
<td>Figtree incident entries</td>
<td>Quarterly</td>
<td>100% = Success Otherwise corrective actions</td>
</tr>
<tr>
<td>4.3.1.1 c)</td>
<td>% of root causes having corrective actions against them</td>
<td>Figtree incident entries</td>
<td>Quarterly</td>
<td>100% = Success Otherwise corrective actions</td>
</tr>
<tr>
<td>4.3.1.1 d)</td>
<td>% of incident entries in Figtree having all evidence, documents, communication,</td>
<td>Figtree incident entries</td>
<td>Quarterly</td>
<td>100% = Success Otherwise corrective actions</td>
</tr>
</tbody>
</table>
### 4.3.6 Useful resources and links

<table>
<thead>
<tr>
<th>University documents</th>
<th>WHSMS Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Procedure: Work health and safety incident management</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other relevant WHSMS Handbook Chapters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 3.1 Hazard Management</td>
</tr>
<tr>
<td>Chapter 3.2 WHS Induction Training and Supervision</td>
</tr>
<tr>
<td>Chapter 3.16 Hazard and Incident Reporting</td>
</tr>
<tr>
<td>Chapter 3.20 WHS Committees and Representatives</td>
</tr>
<tr>
<td>Chapter 4.2 Corrective Actions</td>
</tr>
<tr>
<td>Chapter 5.1 WHSMS Management Review</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAT Tool Reference</th>
<th>National Self Insurer WHS Audit Tool (NAT CTH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards</td>
<td>3.4.3, 4.3.1, 4.3.2, 4.3.3, 4.4.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Work Health and Safety Act 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Work Health and Safety Regulations 2011</td>
</tr>
</tbody>
</table>
Appendix A, Level 2-3 Incident Investigation Template
The University adopts no-fault incident investigation methodologies that focus on what happened rather than who caused it unless it was a reckless action, manslaughter or deliberate and wilful act. The 5-Why methodology is adopted for the Level 2-3 Incident Investigations.
On completion of investigation, attach this form into Figtree incident entry.

<table>
<thead>
<tr>
<th>Figtree Incident No.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Authorised Investigator</td>
<td></td>
</tr>
<tr>
<td>Date of interview</td>
<td></td>
</tr>
<tr>
<td>Who are present at the investigation interview</td>
<td>Please list names here</td>
</tr>
<tr>
<td>HSR participation</td>
<td>□ HSRs are invited to the interview</td>
</tr>
<tr>
<td></td>
<td>Which HSRs attended the interview?</td>
</tr>
</tbody>
</table>

## Part A. Incident Details
Use this section to record **conversations or extra details of the incidents** at the interview that are not covered within the original incident report in Figtree. Make sure you update the Figtree entry as well when finished gathering facts.

Establish the facts of the incident, including:
- What happened?
- When and where did it happen?
- What task was being done?
- Who was involved?
- Were there any witnesses?
<table>
<thead>
<tr>
<th>Cause Category</th>
<th>WHY 1</th>
<th>WHY 2</th>
<th>WHY 3</th>
<th>WHY 4</th>
<th>WHY 5</th>
<th>Cause Sub-Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazard</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to identify a hazard.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to assess a risk or appropriately/adequately assess a risk. Ineffectively conduct hazard and risk assessments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to control a hazard.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to appropriately/adequately/effectively control a hazard (i.e. controls in place did not follow Hierarchy of Control).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to report hazards and incidents.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to provide health monitoring to workers and HDR students.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Inadequate or inappropriate mitigation controls (e.g. spill kits).</td>
</tr>
<tr>
<td>Information, instruction, training and supervision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to provide Tier 2 and Tier 3 inductions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ No/lack of provision of relevant WHS information.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Inadequate safe work procedure (SWP) or other safe work instructions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to provide Tier 3 Working Safely Proficiency Training.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to supervise or appropriately supervise workers (see Chapter 3.2).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to provide information on use, handle, maintain PPE to workers and HDR students</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to appropriately fit PPE for workers and HDR students.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Did not plan for contingency and/or no training provided to people who may be directly involved in a contingency plan scenario.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Did not review WHS performance or set WHS objectives or targets in PDR.</td>
</tr>
<tr>
<td>Plant Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to appropriately maintain, check and inspect plant/equipment or parts of the plant equipment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to Plan for maintenance and inspection - Equipment is lack of or lack maintenance or inspection of guarding, interlock, emergency stop or other safety devices.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Plant/Equipment/Material not fit for purpose.</td>
</tr>
<tr>
<td>Contractors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅ Failure to appropriately manage/control/monitor contractors.</td>
</tr>
<tr>
<td>Other: Please list</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other: Please list</td>
</tr>
</tbody>
</table>
### Part B. Root-Cause Analysis

<table>
<thead>
<tr>
<th>Cause Category</th>
<th>WHY 1</th>
<th>WHY 2</th>
<th>WHY 3</th>
<th>WHY 4</th>
<th>WHY 5</th>
<th>Cause Sub-Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Workplace Layout / design.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Infrastructure/facilities not fit for the activity being undertaken.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Poor housekeeping.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lack of facilities or amenities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other: Please list</td>
<td></td>
</tr>
<tr>
<td>Organisational</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Burn out and work-related stress.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Time and operational demands.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Poor work design (e.g. long working hours, fatigue, shift work, lack of sleeping etc)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lack of communication between supervisor and worker/HDR students.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other: Please list</td>
<td></td>
</tr>
</tbody>
</table>

### Part C. Corrective Actions

Document corrective actions discussed during the investigation interview. Each corrective action addresses 1 root cause. You can also assign actions towards contributing factors that are not root causes. The aim of the corrective actions are to prevent recurrence and reduce risks. These actions must be assigned to the relevant persons in Figtree via the incident in accordance with Chapter 4.2 requirements on priority and timeframe.
Appendix B. Level 4-5 Incident Investigation Template

The University adopts no-fault incident investigation methodologies that focus on what happened rather than who caused it unless it was a reckless action, manslaughter or deliberate and wilful act.

On completion of investigation, attach this report into Figtree incident entry.

### Level 4 - 5 Incident Investigation Report: [Insert Incident Title HERE]

| Figtree Incident No. | | |
|----------------------|------------------|
| Authorised Notifiable Incident Investigator | | |
| Date of Incident | | |

#### Part A. Incident Summary

Write a summary as to what occurred, whom was involved is to be documented. It must include the following information: what led up to the incident; a description of the incident; where it occurred; how it was handled by staff; position descriptions of all staff and contractors involved; interviews if done immediately after the incident; injuries / damage must be described.

It is extremely important that you describe the limits of the investigation i.e. what is in scope and most importantly what is not in scope. This then leaves no doubt for the reader as to the extent and limitation of the investigation.

The preferred method of documenting the facts by Legal and Secretariat is to write in the Passive "voice" rather than the active voice. A passive construction occurs when you make the object of an action into the subject of a sentence.

#### Incident Photos

Place any pictures of the incident here, ensure that they are labelled for reference within the report eg PHOTO 1

#### Incident Timeline

Include any supporting timeline to split out multiple activities. This is useful if things have not occurred in the correct order.

Ensure that there is Date and time; The activity; Whom conducted the activity and if they are not internal, whom they work for.

Immediate actions taken by line management following the incident:

- Dot point 1
- Dot point 2

- Dot point 1
- Dot point 2

- Dot point 1
- Dot point 2
**Part B. Incident Data Analysis**

### 1. Analysis Overview

What happened, focus on the inadvertent negative outcome? Why did it happen? What should have happened (This must match in with a standard procedure, if such does not exist then the report has identified a process gap)? Actual consequence (This becomes a lessons learned)? Potential consequence (This must come from the risk assessment)?

In the summary of events following exceptional acts should be noted to demonstrate a balanced approach has been taken in the investigation. Once you have described the causal factors the description would normally for the first question in the 5 Whys analysis.

### Interview Participants

List interview participant names, position and phone number HERE

### Summary of Events

**Group 1**

**Exceptional and Expected Acts and Behaviours**
- 
- 
- 

**Causal factors**

**Human Errors – Slips, Lapses and Mistakes**
- 
- 
- 

### Root Cause Analysis – 5 Why

<table>
<thead>
<tr>
<th>5 Whys</th>
<th>Causal Factor 1</th>
<th>Causal Factor 2</th>
<th>Causal Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why 1</td>
<td>Answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why 2</td>
<td>Answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why 3</td>
<td>Answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why 4</td>
<td>Answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why 5</td>
<td>Answer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Root Cause Code**

**Risk Control Description**
## Part B. Incident Data Analysis

### Summary of Events

#### Exceptional and Expected Acts and Behaviours

- ...
- ...
- ...
- ...

#### Causal factors

**Human Errors – Slips, Lapses and Mistakes**

- ...
- ...
- ...
- ...

### Root Cause Analysis – 5 Why

<table>
<thead>
<tr>
<th>5 Whys</th>
<th>Causal Factor 1</th>
<th>Causal Factor 2</th>
<th>Causal Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Contributing Factors

Based on the evidence to hand, the Investigation Team believe the following were the main contributing factors to the incident:

**2.1 Defence, Absent or Failed (Controls)**

These contributing factors result from inadequate, incomplete or absent defences (Controls) that failed to:

- a) detect or inform of error conditions (Indicators etc)
- b) prevent error conditions
- c) trap errors and prevent migration (Contain)
- d) mitigate reduce harm / limit the consequences
- e) protect the system against technical and human failures (Interlocks)

These are the systems, conditions, equipment, measures or human factors which are intended to prevent this type of incident from happening. Highlight the failed defence in the table below by listing Y against the defence and bolding both the defence and the Y.

<table>
<thead>
<tr>
<th>Y</th>
<th>DEFENCE</th>
<th>Y</th>
<th>DEFENCE</th>
<th>Y</th>
<th>DEFENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interlock</td>
<td></td>
<td>Check on Check</td>
<td></td>
<td>SWMS</td>
</tr>
<tr>
<td></td>
<td>Guards / barriers</td>
<td>Isolation</td>
<td>JRAs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Warning indicator</td>
<td>SWPs</td>
<td>Awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervision</td>
<td></td>
<td>PPE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DESCRIPTION OF ABSENT/FAILED DEFENCE**

Place information here about what the defence is, include photos and instructions for use in pristine / ideal conditions.

You can have multiple defence items here, ensure that the linkages on how they interact and provide the defence is clear within the report.

If no defence exists, then a further investigation is required.
**Part B. Incident Data Analysis**

### 2.2 Actions, Individual or Team

The errors or violations made by people that led directly to the incident and are typically associated with personnel having direct contact with the equipment or working in the environment. Highlight human error and/or violation in the table below by listing Y against one and bolding both the error and the Y.

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td>What process did they not follow?</td>
<td></td>
</tr>
<tr>
<td>What did they alter / change the order of events in the process flow?</td>
<td></td>
</tr>
<tr>
<td>What part of the process did they not do / omit?</td>
<td></td>
</tr>
<tr>
<td>What did they add / augment to the process?</td>
<td></td>
</tr>
<tr>
<td>What did they ignore?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Y</th>
<th>ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Human Errors</td>
</tr>
<tr>
<td></td>
<td>Violations</td>
</tr>
</tbody>
</table>

**DESCRIPTION OF ACTIONS, INDIVIDUAL OR TEAM**

Place information here about the errors or violations that led directly to the incident. Individual or team actions are always “actively” committed and are directly related to the incident.
### Part B. Incident Data Analysis

#### 2.3 Conditions, Task or Environmental

These are the "situational characteristics" which existed immediately prior to the incident, that have directly influenced human behaviour or equipment performance. They must be what has caused the error or violation to take place. Highlight the condition task or environmental situation in the table below by listing Y against the condition and bolding both the condition and the Y.

<table>
<thead>
<tr>
<th>Y</th>
<th>CONDITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Working conditions, weather, room to move</td>
</tr>
<tr>
<td>Y</td>
<td>Time factors</td>
</tr>
<tr>
<td>Y</td>
<td>Cost pressure</td>
</tr>
<tr>
<td>Y</td>
<td>Resources</td>
</tr>
<tr>
<td>Y</td>
<td>Tool availability</td>
</tr>
<tr>
<td>Y</td>
<td>Job access</td>
</tr>
<tr>
<td>Y</td>
<td>Task complexity</td>
</tr>
<tr>
<td>Y</td>
<td>Fitness for work</td>
</tr>
<tr>
<td>Y</td>
<td>Workload</td>
</tr>
<tr>
<td>Y</td>
<td>Task planning</td>
</tr>
<tr>
<td>Y</td>
<td>Hardware / materials</td>
</tr>
<tr>
<td>Y</td>
<td>Noise</td>
</tr>
<tr>
<td>Y</td>
<td>Communication</td>
</tr>
<tr>
<td>Y</td>
<td>Emotional state</td>
</tr>
<tr>
<td>Y</td>
<td>Wildlife</td>
</tr>
<tr>
<td>Y</td>
<td>Equipment failure</td>
</tr>
<tr>
<td>Y</td>
<td>Illumination</td>
</tr>
<tr>
<td>Y</td>
<td>Equipment modifications</td>
</tr>
<tr>
<td>Y</td>
<td>Contaminants</td>
</tr>
<tr>
<td>Y</td>
<td>Wind/ vibration</td>
</tr>
<tr>
<td>Y</td>
<td>Inspection of equipment</td>
</tr>
<tr>
<td>Y</td>
<td>Air quality</td>
</tr>
<tr>
<td>Y</td>
<td>Acceleration</td>
</tr>
<tr>
<td>Y</td>
<td>Design of tasks eg deep excavation, traffic management</td>
</tr>
</tbody>
</table>

**DESCRIPTION OF THE CONDITION**

You can have multiple items here. Unless you can positively identify priority order or causation flow don't indicate such.

Describe how the condition is integrated with the defence

Describe how the condition was impacted by actions
### Part B. Incident Data Analysis

#### 2.4 Factors, Organisational

The latent system-based factors present before the incident which may have only become apparent and via combination with other factors contributed to the presence of specific adverse task or environmental conditions, individual or team actions, or absent or failed defences that led to the incident. Highlight the organisational factor in the table below by listing Y against the factor description and bolding both the factor and the Y.

<table>
<thead>
<tr>
<th>Y FACTOR</th>
<th>ICAM CODE</th>
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<tbody>
<tr>
<td>Hardware / equipment selection</td>
<td>HW&lt;sup&gt;i&lt;/sup&gt;</td>
<td>Training</td>
<td>TR&lt;sup&gt;ii&lt;/sup&gt;</td>
<td>Organisation</td>
<td>OR&lt;sup&gt;iii&lt;/sup&gt;</td>
</tr>
<tr>
<td>Incompatible goals / operational times</td>
<td>IG&lt;sup&gt;iv&lt;/sup&gt;</td>
<td>Communication / accessibility of defence information</td>
<td>CO&lt;sup&gt;v&lt;/sup&gt;</td>
<td>Procedures, existence validation, monitoring and modification</td>
<td>PR&lt;sup&gt;vi&lt;/sup&gt;</td>
</tr>
<tr>
<td>Maintenance management</td>
<td>MM&lt;sup&gt;vii&lt;/sup&gt;</td>
<td>Design</td>
<td>DE&lt;sup&gt;viii&lt;/sup&gt;</td>
<td>Risk management</td>
<td>RM&lt;sup&gt;ix&lt;/sup&gt;</td>
</tr>
<tr>
<td>Management of change</td>
<td>MC&lt;sup&gt;x&lt;/sup&gt;</td>
<td>Contractor management</td>
<td>CM&lt;sup&gt;xi&lt;/sup&gt;</td>
<td>Organisational culture</td>
<td>OC&lt;sup&gt;xii&lt;/sup&gt;</td>
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<tr>
<td>Organisational learning</td>
<td>OL&lt;sup&gt;xiii&lt;/sup&gt;</td>
<td>Regulatory influence</td>
<td>RI&lt;sup&gt;xiv&lt;/sup&gt;</td>
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</tbody>
</table>

#### DESCRIPTION OF THE FACTOR

Describe the factor, how did the factor contribute to the outcome:
- what environmental factor was altered / impacted
- what action was changed / performed
- what is the defence designed to do in this situation

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<sup>i</sup> The tools and equipment – this factor is concerned with the quality of the existing equipment and its material

<sup>ii</sup> This factor relates to the skills and knowledge of the employees. Under this organisational factor may be insufficient training, lack of resources, mismatch of ability and skill level to task.

<sup>iii</sup> This factor includes the structure of responsibility and accountability within the organisation, shortfalls can include lack of coordination, supervision and a chain of responsibility.

<sup>iv</sup> This factor refers to conflict between goals between different groups. Conflicts in safety planning, implementation, economic goals, and production goals become a major issue when the organisation has no procedure, policies or guideline in place.

<sup>v</sup> This factor refers to failure to communicate or failure to communicate adequately. When there is no procedure for communication within the organisation regarding hazards, this becomes a CO organisational factor.

<sup>vi</sup> This factor refers to the way organisational procedures are written, tested, documented and controlled.

<sup>vii</sup> This factor refers to the planning, resourcing and procurement of maintenance (rather than the maintenance task itself).

<sup>viii</sup> This factor refers to the way in which equipment is constructed which may leave vulnerabilities in the way the equipment is used or operated.

<sup_ix</sup> This factor refers to the application of risk management policies within the organisation. It also refers to the ongoing process of risk management within the workplace.

<sup>ix</sup> This factor refers to how well change is managed to operations. Examples include changes to operations, processes, equipment, services and people’s roles and accountability.

<sup>x</sup> This factor refers to how the organisation selects, monitors and reviews contractors.

<sup>xi</sup> This factor refers to the values and beliefs of the organisation and the people who work there. E.g. company policies and how effective decisions are managed and communicated.

<sup>xii</sup> This factor refers to the systems the organisation has in place for ensuring that lessons are learnt continuously via risk assessments, auditing and incident reporting.
This factor refers to the regulatory bodies influence on the safety culture of the organisation. This includes legislation, documentation and safety practices required by the regulatory body.

### Part B. Incident Data Analysis

#### 3. Recommended Corrective Actions

The following recommended corrective actions are put forward for consideration:

<table>
<thead>
<tr>
<th>No.</th>
<th>Immediate, Short Medium Term Action</th>
<th>Hierarchy of Control</th>
<th>Root Cause Code</th>
<th>Person Responsible</th>
<th>Manager/Supervisor Responsible</th>
<th>Completion Timeframe</th>
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