Hazard / Incident Management Procedure

1. Purpose

This procedure outlines the requirements for the investigation and reporting of workplace safety hazards and incidents in WA Country Health Service (WACHS) sites or in the course of conducting WACHS business. It also outlines the procedural requirements for the statutory reporting of notifiable work-related injuries and diseases, a requirement of employers under the *Occupational Safety and Health Act 1984 (the Act).*

The purpose of incident / hazard reporting is to inform the employer of workplace hazards and risk to workplace safety which will:

- prevent any incident that may result from the hazard
- resolve the risk to prevent recurrence
- allow trends to be measured and programs to be implemented in order to reduce risks.

2. Scope

This document sets out the procedures for the management of hazards and incidents which present a risk to WACHS staff, contractors, students, volunteers or visitors. This procedure includes processes and accountability for:

- incident reporting
- internal escalation and external notification
- incident investigation
- remedial and corrective action.

3. Definitions

Causal Factors	Any behaviour, omission, or deficiency that if corrected, eliminated or avoided, probably would have prevented the incident.
Hazard	A source or a situation with a potential for harm in terms of human injury or ill-health, damage to property, damage to the environment, or a combination of these (Australian Standard 4801).
Safety And Health Representative (SHR)	Safety and Health Representatives are elected by co-workers to represent them in consultation about safety and health matters with the employer as per s31 of the Act.
Incident	An Incident is an event that during the course of undertaking work-related duties resulted in, or could have resulted in injury or disease. This includes Near Miss Incidents.

Investigation	A systematic examination of an event and its cause or contributing factors.
Near Miss Incidents	An incident which has occurred where no personal injury/illness, property or environmental damage actually occurred, but, given a slight shift in time or position, could have occurred.
Notifiable Work Related Injury	A work-related death, injury or disease required to be reported to WorkSafe WA as a requirement of the Act. See Appendix B for further details.
Risk	The likelihood and consequence of an injury or harm occurring.
System Failure	Systematic processes that fail to manage the task, activity, process or problem safely.

4. Roles and Responsibilities

4.1 Employees

Employees are responsible for:

- reporting all hazards, incidents, injuries, dangerous occurrences and system failures which occur or have the potential to occur
- in the event of an injury or unsafe situation, take action that will as far as is practicable ensure the safety of themselves and others.

4.2 Contractors, Volunteers and Visitors

Contractors, volunteers and visitors are responsible for:

- reporting all hazards, incidents, injuries, dangerous occurrences and system failures which occur or have the potential to occur to their site contact to enable hazard or incident reporting
- in the event of an injury or unsafe situation, take action that will as far as is practicable ensure the safety of themselves and others.

4.3 Supervisors and Managers

Supervisors and managers are responsible for:

- providing a safe place of work for employees
- ensuring that injured employees, contractors or visitors to WACHS receive, or are referred to, appropriate first aid or medical assessment for any reported illness or injury
- in the event of an injury or unsafe situation, take action that will as far as is practicable ensure the safety of themselves and others
- ensuring all hazards, incidents, injuries, dangerous occurrences and systems failures are appropriately reported for areas under their supervision

- ensuring contractors are inducted to WACHS sites and understand their reporting responsibilities
- conducting investigations into reported incidents and ensuring corrective actions are developed and implemented to eliminate or reduce the risk of injury
- reviewing the effectiveness of implemented corrective actions in consultation with employees.

4.4 Regional OSH Coordinator

The Regional OSH Coordinator is responsible for:

- monitoring and reviewing Safety Risk Report Forms (SRRFs) for effective incident management and reporting
- providing advice and recommendations on preventative and corrective actions where required
- participating in major incident investigations and assisting in corrective action reviews to prevent incident reoccurrences.

5. Procedure

5.1 Hazard/ Incident Reporting and Management

1. Immediate action is to be taken by all available staff to provide first aid to injured workers and/or prevent further persons from becoming injured, if possible.
2. Verbal report of hazard / incident to relevant manager / supervisor is to occur to ensure early notification, and immediate risk management to be implemented if required.
3. The employee, or another employee on their behalf, is to complete a SRRF to report the hazard / incident. The SRRF is to be emailed/ submitted to the employee's supervisor / manager and cc'd to the regional OSH electronic mailbox within 48 hours of occurrence or earlier if possible.
4. When the manager / supervisor receives the SRRF they must determine if the incident is categorised as a Major Incident. Major Incidents require a more complex investigation to be completed and must involve the Regional OSH Coordinator in the investigation and control process. Refer to Appendix A - Major Incidents.
5. If the incident is not classed as a Major Incident, the manager / supervisor in consultation with a SHR and relevant employees, completes Section C: Hazard / Incident Investigation and Control, and conducts an investigation and risk assessment to determine the risk associated with the hazard. Investigations are to occur within three days of the SRRF being received. Appendix C - Investigation Methodology provides guidelines for conducting hazard and incident investigations.
6. To control the hazard / incident, the manager / supervisor, in consultation with the SHR and relevant employees, must complete Section C: Incident / Hazard Investigation and Control and develop a plan to implement corrective actions. The corrective action strategy is to be developed in accordance with the 'hierarchy of controls'. Where necessary and appropriate, the manager / supervisor is to seek advice from the OSH Coordinator and others, as required, to ensure that risk controls proposed are adequate.

7. The manager / supervisor is responsible for verifying the effectiveness of the implemented risk controls within a timeframe mutually agreed by the manager / supervisor, SHR and Regional OSH Coordinator. The review is to involve consultation with the SHR and relevant employees.
8. Completed SRRFs must be submitted to the OSH Department for review by the Regional OSH Coordinator, entry of the investigation findings and controls into the safety database and electronic record-keeping.

5.2 Internal Escalation of Major Incidents

1. Immediate action is to be taken by all available staff to provide first aid to injured workers and/or prevent further persons from becoming injured, if possible.
2. The employee, or another employee on their behalf, is to complete a SRRF to report the hazard / incident. The SRRF is to be emailed/ submitted to the employee's manager / supervisor with a CC to the regional OSH electronic mailbox within 48 hours of occurrence or earlier if possible.
3. When the manager / supervisor receives the SRRF they must determine if the incident is categorised as a Major Incident. Major Incidents require a more complex investigation to be completed and must involve the Regional OSH Coordinator in the investigation and control process. Refer to Appendix A - Major Incidents.
4. The manager is to confirm the incident details and liaise with the Regional OSH Coordinator who is to send a Safety Alert form to the Regional Director, HR Director, Work Health and Safety (WHS) Manager and other managers as required.
5. The WHS Manager is to notify external stakeholders as appropriate and determine if, and what type of specialist support is required for the investigation process.
6. The manager, Regional OSH Coordinator and SHR are to undertake an incident investigation as described in Appendix C and apply interim controls to manage the hazard to avoid further injury, illness or damage. The investigation is to be completed within three working days.
7. The manager / supervisor is responsible for verifying the effectiveness of the implemented risk controls at a timeframe mutually agreed upon by the manager / supervisor, and Regional OSH Coordinator. The review is to involve consultation with the SHR, Regional OSH Committees and relevant employees.
8. Completed investigation reports must be submitted to the OSH Department for entry of the investigation findings and controls into the safety database and electronic record-keeping. Investigation reports must include copies of the SRRF and Safety Alert form.

5.3 Management of SRRFs relating to harassment, bullying, victimisation or workplace violence

SRRFs which allege harassment, bullying, victimisation or workplace violence instigated by another WACHS employee may be reported through the safety risk reporting system, however there are separate WA Health policies applying to the resolution of such matters, including the WA Health Preventing and Responding to Workplace Bullying Policy, the WA Health Grievance Resolution Policy and the WA Health Notifying Misconduct Policy. Safety Risk Report forms covering these matters are to be referred by the Regional OSH Coordinator to the Regional Human Resources Manager for appropriate action, with the reporting employee being advising in writing of this action. Note that the SRRF must be updated with any resulting resolution and risk assessment.

6. Legislation

Occupational Safety and Health Act 1984 (and Occupational Safety and Health Regulations 1996).

7. References

AS 1885.1-1990. Workplace injury and disease recording standard, Standards Australia, Homebush, NSW.

8. Related Forms

WACHS Safety Risk Report Form

9. Related WA Health Policies

WA Health Risk Management Policy

10. Addendums

WACHS Safety Alert Template

WACHS Major Incident Investigation Template

WACHS 5 Whys Guide

This document can be made available in alternative formats on request for a person with a disability

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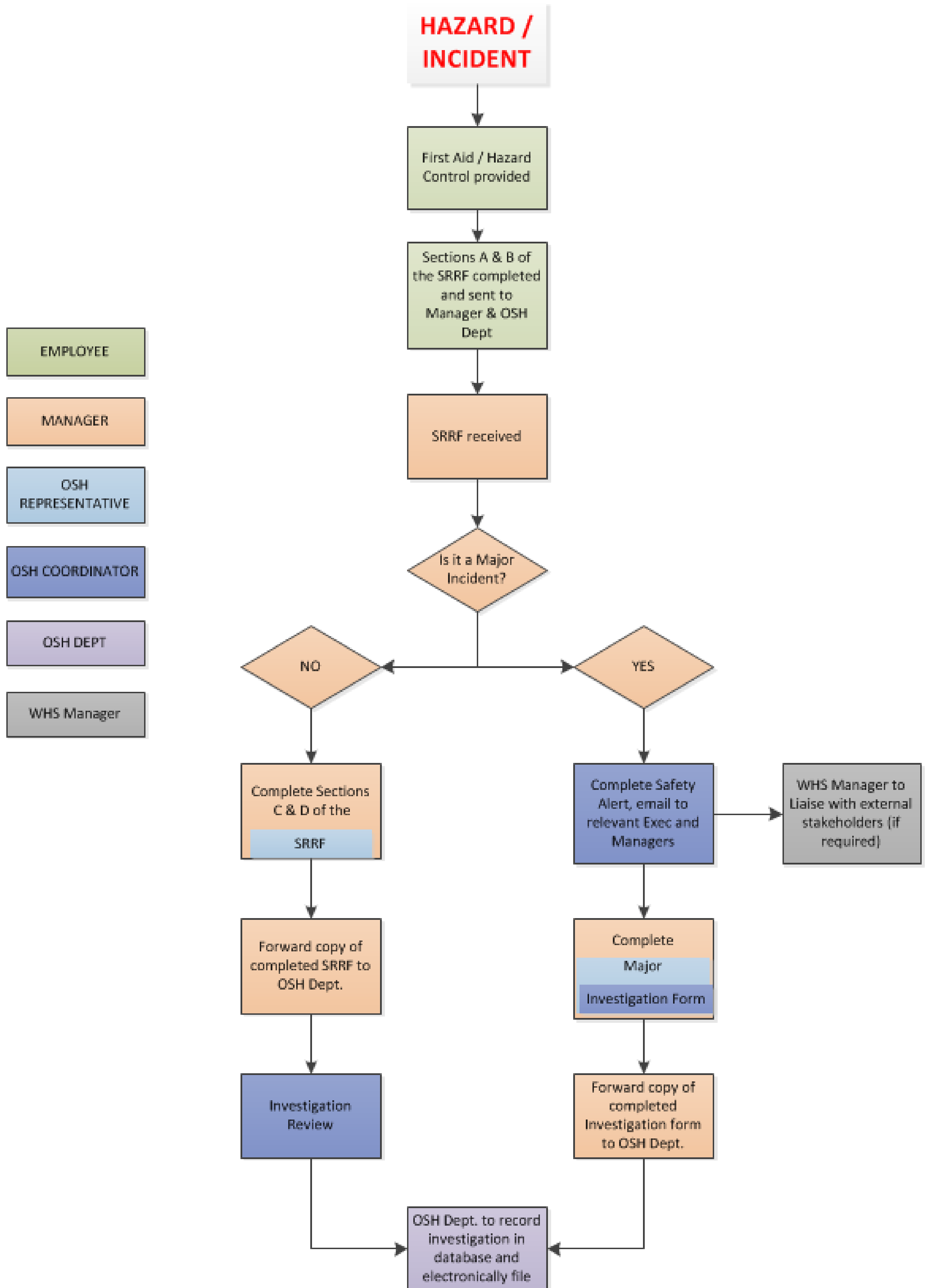
11. Hazard / Incident Management Process Flowchart



Appendix A – Major Incidents

Definition

A Major Incident is defined as, but is not limited to:

- a work-related death
- an injury that:
    - requires admittance to hospital as an inpatient
    - is from exposure to any substance that causes acute symptoms
    - electric shock (requires further reporting to EnergySafety - the energy regulator)
    - is a dangerous occurrence (examples include):
        - the damage to, or failure of major plant or equipment
        - the collapse of a floor, wall or ceiling of a building used as a workplace
        - an electrical short, malfunction or explosion
        - an uncontrolled explosion, fire or escape of gas, steam or other hazardous substance
- incidents identified by the WHS Manager or Directors as being ‘Major’ by virtue of their outcome or potential outcome and may be subject to:
    - legal advice (and establishment of legal professional privilege); and / or
    - more comprehensive root cause analysis investigation by a competent person
    - reporting to our insurance provider for public liability issues
- a statutory reportable incident to a Regulator.

Appendix B – Reportable Injuries And Diseases

Regional OSH Coordinators are to report the below list of injuries and diseases to WorkSafe WA using the appropriate notification form.

Injuries:

- a fracture of the skull, spine or pelvis
- a fracture of any bone in the arm (other than in the wrists or hand) or in the leg (other than a bone in the ankle or foot)
- an amputation of an arm, a hand, finger, finger joint, leg, foot, toe or toe joint;
- the loss of sight of an eye
- any injury other than the above which, in the opinion of a medical practitioner, is likely to prevent the employee from being able to work within 10 days of the day on which the injury occurred.

Diseases:

- infectious diseases: tuberculosis, viral hepatitis, Legionnaires’ disease and HIV, where these diseases are contracted during work involving exposure to human blood products, body secretions, excretions or other material which may be a source of infection
- occupational zoonosis: Q fever, anthrax, leptospirosis and brucellosis, where these diseases are contracted during work involving the handling of, or contact with, animals, animal hides, skins, wool, hair, carcases or animal waste products.

Appendix C - Investigation Methodology

The following guidelines should be observed for incident investigations.

Planning the investigation

The manager responsible for the incident investigation (Lead Investigator) must identify those to be involved in the investigation team. While the manager is accountable for leading and completing the investigation, a number of additional people will be required to support this. The team is to include employee representatives and subject matter experts knowledgeable in the work being undertaken and the risks involved.

Gather information

The Lead Investigator must then gather relevant information. This is to be done soon after the incident, and in some cases immediately, in order to have accurate and reliable information. The types of information gathered may include existing records such as the incident report, inspection reports, pre-start records, training records, Safe Work Method Statements, Safety Data Sheets etc. In addition to this, the Lead Investigator may collect new information, such as emails, photographs, sketches or interview notes.

When interviewing employees or obtaining a statement, observe the following principles:

- Clearly explain the purpose of the interview / statement and have a structure, but keep the person at ease, don't be too formal or intimidating
- Focus on facts and direct observations, rather than hearsay
- Do not blame anyone
- Ask open-ended questions.

This information will enable an account of the incident to be recorded.

Identify causal and contributory factors

The process of information gathering will enable the Lead Investigator to identify causal and contributory factors specific to the incident.

A simple methodology to help identify causes, and ultimately 'root causes', is to ask '5 whys'. Starting with the incident / event, ask why it happened, and why to each and every subsequent response. This should lead to the identification of root causes within approximately five 'why' questions. See the 5 Whys Guide.

It is important to remember that the event, and other causes identified may each have more than one cause. Additionally, the quality of the investigation will depend on the knowledge and experience of the investigation team, and on the type and quality of the information it is based upon.

When identifying causal factors, consideration should be given to:

- personal factors and actions
- equipment factors
- environmental factors
- organisational system factors
- procedural factors
- supervision and leadership factors.

Finally, the causes identified must be fixable. This ensures that any corrective actions will ensure that relevant causes are addressed to prevent recurrence of the incident.

Identify contributory factors

Defined as a safety factor that, if it hadn't occurred/existed, the accident would probably not have occurred, or another contributing safety factor would probably not have occurred or existed.

Complete the investigation

Once all causes have been identified, for minor incidents record these in the investigation report section of the SRRF. Investigations of Major Incidents are to be recorded in the Major Incident Investigation Template. This completes the investigation process, and begins the corrective and preventative action process.

Value-Neutral Language

When documenting investigations, it is important to use Value-Neutral Language (VNL), which refers to language that is objective and factual in nature. When using VNL, you would largely employ descriptions of things that the writer can experience with their five senses – sight, hearing, touch, smell or taste. In addition, VNL tends to use denotative, rather than connotative words. The term “denotative” refers to the precise, dictionary definitions, rather than “connotative” language, which is often imprecise or emotional in nature. By using VNL, the writer will be able to describe an event, situation or scenario that is free of value judgments – directly or indirectly – about the information or facts described.

Further information on incident investigation can be found on the Worksafe WA tips for investigating incidents internet page.