



ECM NUMBER: #924048

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DEPARTMENT: Commercial and Corporate Services

UNIT: Safety and Wellness

1.0 Purpose and scope

Central Highlands Regional Council is committed to the health and safety of all persons in the workplace. The purpose of this procedure is to define the process for investigating incidents after they have been reported to a satisfactory standard, in attempt to prevent a recurrence and move towards continuous improvement. This procedure applies to workers who carry out work in any capacity for council.

2.0 Reference

QLD Work Health and Safety Act 2011

QLD Work Health and Safety Regulation 2011

QLD Electrical Safety Act 2002

QLD Electrical Safety Regulation 2013

AS 1885.1:1990 Workplace injury and disease recording standard

3.0 Definitions

Council refers to Central Highlands Regional Council.

Dangerous electrical event is any of the following as defined under section 12 of the QLD Electrical Safety Act 2002:

- When a person, for any reason, is electrically unsafe around high voltage electrical equipment, even if the person doesn't receive an electric shock or injury
- Significant property damage caused by electricity or something originating from electricity e.g., electrical fire
- Unlicensed electrical work
- unsafe electrical work
- unsafe electrical equipment or electrical equipment that does not have electrical equipment safety system approval markings.

Dangerous incident is an incident 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:

- An uncontrolled escape, spillage or leakage of a substance, or
- An uncontrolled implosion, explosion or fire, or
- An uncontrolled escape of gas or steam, or
- An uncontrolled escape of a pressurised substance, or
- Electric shock, or
- The fall or release from a height of any plant, substance or thing (*inanimate objects*), or

- 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 (*plant where WHSQ issue a licence for*), or
- The collapse or partial collapse of a structure, or
- The collapse or failure of an excavation or of any shoring supporting an excavation, or
- The inrush of water, mud or gas in workings, in an underground excavation or tunnel, or
- The interruption of the main system of ventilation in an underground excavation or tunnel, or
- Any other event prescribed under a regulation; but does not include an incident of a prescribed kind.

High voltage means a voltage above 1000V AC or 1500V ripple-free DC

Near miss refers to an event where there was any potential for injury, damage or loss.

Notifiable incident (under the QLD Work Health and Safety Act 2011) means:

- (a) the death of a person; or
- (b) a serious injury or illness of a person; or
- (c) a dangerous incident.

Notifiable incident (under the QLD Electrical Safety Act 2002) means:

- (a) a serious electrical incident; or
- (b) a dangerous electrical event

Regulator means the regulatory body representative for which an incident is notifiable (e.g., WHSQ Inspectorate, QLD Electrical Safety Office, QLD Mines Inspectorate, Heavy Vehicle National Law Regulator, QLD Environmental Regulator)

Serious injury or illness of a person under the QLD WHS Act 2011 means an injury or illness requiring the person to have—

- Immediate treatment as an in-patient in a hospital, or
- Immediate treatment for the amputation of any part of the body, or
- Immediate treatment for a serious head injury (*not a bump causing minor bruising or headache*), or
- Immediate treatment for a serious eye injury (*not merely causing irritation*), or
- A serious burn, or
- The separation of skin from an underlying tissue (such as degloving or scalping), or
- a spinal injury, or
- The loss of a bodily function (*loss of consciousness, loss of a sense of smell/taste/hearing, loss of an internal organ function*) but this specific category does **not** include fainting or strain/sprain/fracture, or
- Serious lacerations (*that cause muscle, tendon, nerve or blood vessel damage or permanent impairment, or deep or extensive cuts and tears of flesh or tissues*), or
- Medical treatment (treatment by a doctor) within 48 hours of exposure to a substance, or
- 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:
 - with micro-organisms,
 - that involves providing treatment or care to a person,
 - that involves contact with human blood or body substances,
 - that involves handling or contact with animals, animal hides, skins, wool or hair, animal carcasses or animal waste products, or

- The following occupational zoonoses contracted in the course of work involving the handling or contact with animals, animal hides, skins, wool or hair, animal carcasses or animal waste products:
 - Q fever
 - Anthrax
 - Leptospirosis
 - Brucellosis
 - Hendra virus
 - Avian influenza
 - Psittacosis

Serious electrical incident is an incident as defined under section 11 of the QLD Electrical Safety Act 2002 and includes where a person:

- Is killed by electricity, or
- Receives a shock or injury from electricity, and is treated for the shock or injury by or under the supervision of a doctor, or
- Receives a shock or injury from electricity at high voltage, whether or not the person is treated for the shock or injury by or under the supervision of a doctor.

Supervisor refers to supervisor, overseer, coordinator, manager, executive manager, general manager, chief executive officer or any other worker who is required to direct and control other workers.

4.0 Procedure

The primary focus of investigations must be to understand the contributing factors and root causes of an incident. Once these are determined, corrective and preventative actions must be identified and implemented to minimise and prevent recurrence of the same incident, and these actions monitored and reviewed to ensure they are effective.

All reported incidents will undergo some form of investigation and the contributing factors and remedial/corrective/preventative actions will be documented in the first instance in MYOSH, or if not available on the approved hard copy [incident report form \(ECM #893728\)](#). Incidents identified as medium, high and extreme in councils risk framework will be investigated.

For maintaining professionalism and data consistency, throughout the incident investigation record, an injured or involved worker should be referred to in third person as the 'worker' and their individual name should not be populated throughout the record, apart from mandatory MYOSH fields where a name must be selected.

A more comprehensive investigation of an incident (major investigation process i.e., ICAM) will occur for:

- All lost time incidents,
- All regulator notifiable incidents (e.g., serious injury or illness, serious electrical event, dangerous electrical event, dangerous incident as defined in the legislation)
- Potential risk rating (medium, high and extreme)
- Management decision
- or any other classification of incidents where an investigation is specifically requested by the safety & wellness team.

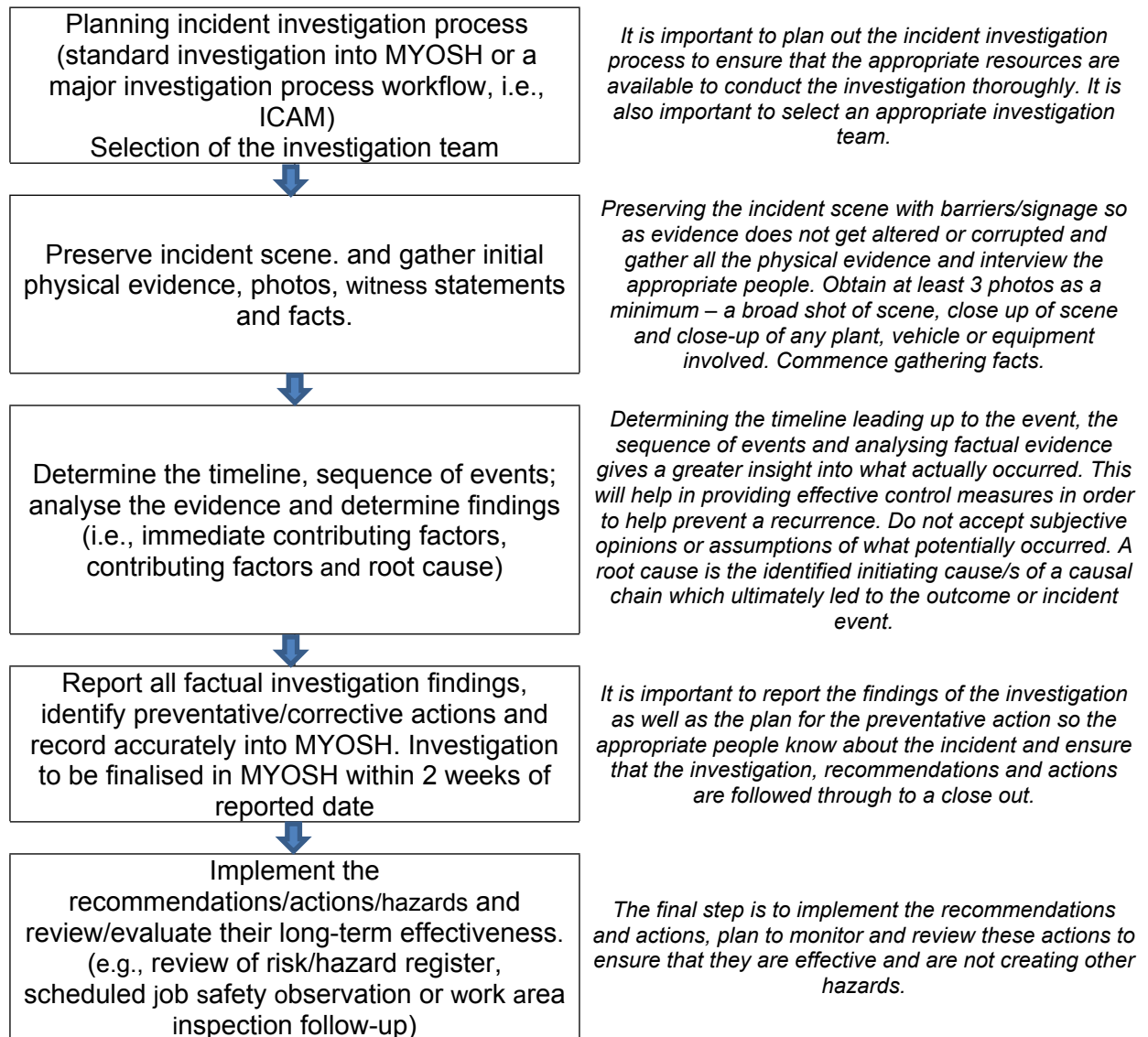
The major investigation process shall be facilitated by an investigation team including a lead investigator, health and safety representatives and content experts.

The investigation process will be initiated by the reporting of an incident into MYOSH (refer to [Incident reporting procedure \(ECM #893735\)](#)). All council incident investigations and associated information and evidence shall be recorded in MYOSH.

The investigation process will require direct input from the supervisor/s, affected persons and witnesses. Where appropriate, the work group Health and Safety Representative (HSR), or other technical experts may be involved.

4.1 Investigation process

After following the reporting procedure, the investigation process will follow a structured approach as outlined below:



4.2 Scene preservation

The supervisor or person in control of the workplace needs to secure and preserve the incident scene (i.e., using barrier tape, signage). In the event of a notifiable incident, nothing can be removed or interfered with without the authority of the Regulator or Police Officer. Exceptions under the QLD Work Health and Safety Act 2011 are only:

- to assist an injured person; or
- to remove a deceased person; or

- that is essential to make the site safe or to minimise the risk of a further notifiable incident; or
- that is associated with a police investigation; or
- for which an Inspector or the Regulator has given permission.

A member of the safety team will be assigned to the incident (hereafter the known as the investigation lead) must determine from facts gathered throughout the investigation process whether the incident is notifiable and if so, report this on in accordance with the [Incident reporting procedure \(ECM #893735\)](#).

4.3 Collecting evidence

Before attempting to gather information, examine the site for an overview, take steps to preserve the scene and evidence, and identify all the witnesses that need to be interviewed. Physical evidence should be collected and preserved as soon as practicable. Information, as well as statements, should be collected as soon as practical from persons who may have information about the incident.

Initial photographs should be taken before anything is moved; of the broad area, of the general incident scene, then closer pictures of specific plant/items. This may help in revisiting the scene and reveal conditions or observations that were missed in the initial investigation. During this phase of the investigation as many relevant facts as possible should be collected. This will provide an understanding of the incident and the events leading up to it.

The incident scene should only be returned to work after approval by the Chief Executive Officer and/or Manager Safety & Wellness or delegate, and shall ensure all necessary actions have been taken, and in the event of an incident requiring statutory notifications, that approval for a return of the scene to work, has been obtained from the relevant statutory authority.

4.4 Contributing factors and root causes

The identification of the contributing factors can be classified as follows:

- People factors
- Equipment factors
- Environmental factors
- Procedural factors
- Organisational factors

Other contributing factors include substandard conditions, substandard acts/practices. It is important to go through each identified factor so the root cause of the incident can be determined, and appropriate controls can be put in place to minimise the risk of a recurrence. A root cause is the initiating cause which ultimately led to the outcome or incident event. All of the additional contributing factors that are identified throughout the investigation shall be recorded in MYOSH.

People factors (human factors)

Identify what people issues influenced the incident (e.g., competency level, training, procedures followed, fitness for work etc.). Examples of questions that you might ask when considering people issues are:

- What were the people involved in the incident doing leading up to the outcome? Create a timeline and a sequence of events.
- Were there any sub-standard behaviours or practices that contributed to the incident? Determine the reason for them occurring rather than attempting to apportion blame (e.g., inadequate training).

- What instructions were provided and by whom?
- How were procedures being followed?
- Were there any deviations from how the task is 'normally' performed (i.e., incident free situation)?
- Had the individuals involved been inducted into the site/specific work area?
- What was the level of the training and competence of the individuals involved? How was competency assessed?
- Were the hazards of the task/activity identified with appropriate controls put in place prior to the job commencing?
- Were the individuals involved fit for the required work?

Equipment factors

What plant/equipment/material issues were involved in the incident (e.g., fit for purpose and maintained equipment, protective devices/guards, personal protective equipment (PPE), labelling etc.). Examples of questions that you might ask when considering equipment issues are:

- What equipment/tools/materials were involved/used?
- What damage resulted?
- What is the condition of the equipment/tools?
- Was the plant/equipment/tool/material appropriate for the task (e.g., bund of appropriate material, grinding wheel for grinding not cutting, etc.)?
- Was the equipment/tool used correctly (e.g., at rated operating speed)?
- Were protective devices (e.g., guards, bunds, cut-off switches, etc.) in place?
- Are the components of the equipment/tool to be used clearly labelled/identifiable?
- Was the equipment/tool still in use when it should have been tagged out?
- Did the equipment/tool move unexpectedly?
- Was the equipment/tool energised and unattended? Is this appropriate?
- Was the equipment/tool being serviced while still in operation?
- Were any warning devices associated with the equipment/tool operable?
- Is a safety data sheet available for the substance used?
- Is the substance container clearly labelled?
- Is the substance stored in an appropriate container?
- What PPE was required versus what was used?
- Was PPE appropriate for the task?
- Was the PPE in good condition?

Environmental factors

What issues concerning the work or natural environment were involved in the incident (e.g., noise, ventilation, ground conditions, wind, lighting, space, storage conditions, explosive atmosphere, etc.)? Examples of questions that you might ask when considering environment issues are:

- Were lighting conditions adequate and appropriate for the task?
- Was there excessive noise above the exposure standard?
- Were there extremes of temperature (too high, too low)?
- Was there excessive humidity?
- Was dust present above the exposure limits?
- Were gases, fumes and vapours released or present above exposure limits?
- Was there radiation exposure (e.g., UV, X-Rays, gamma, RF, etc.) above exposure limits?
- Was the ventilation adequate?
- Was the fire and/or explosion potential recognised and controlled?

- Was there uneven, slippery, sloped ground or floor surface?
- If outside, was the wind, rain, or sun seen as issues?
- Were ground conditions secure?
- Was the equipment/tool/material used or stored in the appropriate location?
- What was the relative positioning of the people, equipment/tools and other structures?
- Was there adequate space/clearance for the task?
- Was the level of housekeeping appropriate (i.e., clean and uncluttered area)?
- Was the equipment/tool/material located or presented at a comfortable height?

Procedural factors (job/system factors)

What procedure factors were involved in the incident (e.g., permit systems, isolation, standard operating procedures, maintenance procedures, pre-use checks, etc.)? Examples of questions that you might ask when considering procedure factors are:

- Were standard operating procedures not written, not used or incorrectly used?
- Was a system in place to ensure standard operating procedures are current?
- Is there a standard (if relevant) and if so, is it adequate and complied with?
- Was a permit-to-work system not used or incorrectly used?
- Were isolation procedures not used or incorrectly used?
- Were inspections conducted by responsible personnel to established standards?
- Were actions arising from inspections completed?
- Did the inspection system detect and correct deficiencies?
- Were pre-use checks in place and used correctly?
- Were personnel trained to competencies required for job/task?
- Was a system in place and used for reporting of hazards?
- Were actions taken arising from hazard reports?
- Was a system in place to ensure PPE was available, issued, correctly stored and maintained?
- Did purchasing systems allow review of new equipment/substances, etc. prior to purchase?
- Were designs of new plant, equipment modifications, etc. reviewed for safety and health considerations prior to plan sign off?
- Were there procedures to check that any construction, commissioning work, etc. was completed as per design plans?
- Were there procedures to ensure modifications to plant/equipment were not made until a thorough review process had occurred?
- Was maintenance scheduled and conducted for plant/equipment, etc.?
- Was there current information on hazards, etc. available, disseminated and applied?
- Were there emergency response procedures in place?
- Were there procedures to ensure appropriate storage and disposal of hazardous substances/equipment/tools/etc.?

Organisational factors

- What are the factual, existing culture and beliefs of the work group?
- How are things normally handled?
- What is the usual accepted practice?

4.5 Investigation report

The lead investigator is to compile the incident investigation record in MYOSH. The record must include all of the mandatory field details and attachments of all associated photos and documents gathered. The timeline for finalising standard incident investigations in MYOSH is ideally **2 weeks** from the date the incident was reported. Additional time may be required for major investigations.

The investigation team, in liaison with the supervisor, workers, department manager, and health and safety representative must establish remedial actions and assign responsibility and timeframes for same. Investigations are to be linked to the department risk registers before it is closed. All actions will be logged within the MYOSH incident record and subsequently tracked to completion in the MYOSH Actions module.

For notifiable incidents, the incident investigation report will be forwarded as formally requested to the Regulator.

4.6 Communicating outcomes and lessons learned

Outcomes and learnings from incident investigations (such as safety alerts or lessons learned safety alerts) will be communicated to workers via the intranet and safety and wellness noticeboards. Alerts will also be tabled as part of the HSR committee meeting agenda and are to be discussed in toolbox meetings.

The timeframe for lessons learned alerts should be compiled and distributed within 1 additional week from the date the incident investigation report is finalised.

The department manager responsible for the area where the incident occurred must review and approve lessons learned alerts within the specified timeframe above.

4.7 Investigation training and competency

Investigation leads must be adequately trained and skilled in the process of facilitating the level of investigation (this can be either formal or informal training). Training and/or mentoring in incident investigation may form part of a worker's learning and development plan.

4.8 Legal professional privilege

If an incident has been subjected to legal privilege at the discretion of the CEO and Manager safety & wellness, governance legal advice and instructions are to be strictly adhered to.

5.0 Responsibilities

All workers shall, if involved (or indirectly involved) in any council workplace incident:

- Ensure the incident reporting procedure has been correctly followed.
- Provide only factual information regarding the incident investigation and to not falsify information or evidence.

Supervisors shall ensure:

- All incidents are logged into MYOSH **within 24hrs** of occurrence.
- The correct level of investigation has been achieved in MYOSH by the timeframe specified.
- Define any corrective actions and suitable timeframes in order to prevent a recurrence.

Managers shall ensure:

- The department has the resources available in order to achieve the correct level of investigation and corrective action measures and timely outcomes.
- Review incident investigation findings and provide input.
- Timely review of lessons learned safety alerts for any incidents which have occurred within their department prior to its distribution to all workers.

Safety & wellness team shall ensure:

- The Regulator has received the required information as formally requested throughout the investigation process.
- Training in this procedure is made available to employees.
- Ensure that incident investigations are finalised within **2 weeks** from the date the incident was reported (unless otherwise advised).
- Ensure lessons learned alerts have been drafted and approved by the department Manager prior to distribution within **1 week** of the investigation being finalised.

6.0 Procedure review

This procedure will be reviewed no later than five years from its adoption or when any of the following occurs:

- Relevant legislation, regulations, codes or practice, standards or associated policies are amended and/or replaced
- As a result of corrective actions associated with the outcome of an incident investigation or risk register review
- At the direction of the CEO / Executive Team / Manager Safety and Wellness
- Health and safety representative/s or workers have identified the need for a review
- New hazards have been identified and additions control measures are required
- After an incident and/or near miss.

7.0 Associated documents

- [Incident reporting procedure \(ECM #893735\)](#)
- [Plant & equipment incident report form \(ECM #812696\)](#)
- [Public incident report form \(ECM #1212839\)](#)
- [Incident report form \(ECM #893728\)](#)
- [MYOSH Viking incident reporting user guide \(ECM #1563373\)](#)