

BSBWHS505

Investigate WHS incidents



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ASSESSMENT FOR BSBWHS505

Student name	RYAN CHUA WEI HUI
Date of assessment submission	23/08/2015

Trainer/Assessor's name	
Date of assessment marking	Click here to enter a date.
Outcome for unit	☐ Competent ☐ Not Yet Competent

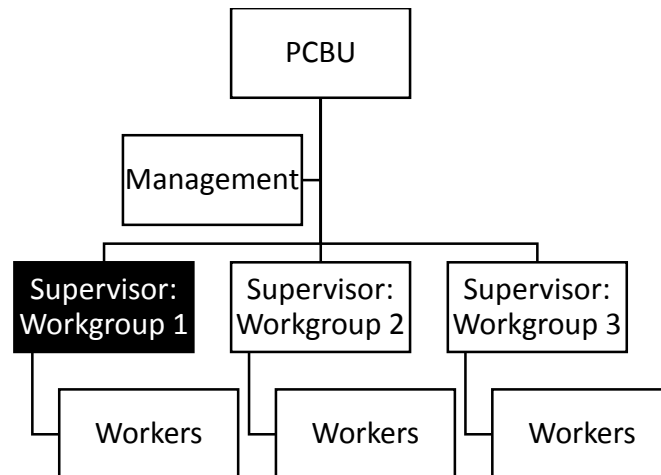
TASK INSTRUCTIONS

- The assessment for this unit of competency consists of the following:
 - **A series of activities:** Some of these activities will require you to provide a response within this document, others will require you to gather evidence to demonstrate your knowledge and skills (overview below)
 - **Quiz:** You will be required to complete a series of questions to demonstrate your knowledge and skills.
 - **Practical task:** You will be required to have an observer attest to your knowledge and skills and sign a report to this effect.
- At times, you will be provided with a specific business context to which you must respond, otherwise it is anticipated that you will use a workplace of your choosing (your own, or hypothetical) to provide the context to the task.
- At all times, the responses in your assessment must reference **Australian** (Queensland or Federal) documentation, including legislation, regulations, codes of practice, standards and guidance publications.

ACTIVITY OVERVIEW	REQUIRED FOR SUBMISSION
1. Initial responses to incidents	• Workbook response (below)
2. Planning the investigation	• Workbook response (below)
3. Collecting and analysing information and data	• Workbook response (below)
4. Completing investigation report	• Workbook response (below)

ACTIVITIES

For the following activities, you will assume the role of a workgroup supervisor in a workplace of your choosing (see example organisational chart below).



Name a workplace and workgroup that you are (or hypothetically are) the supervisor for. Also, identify a likely incident to occur within this workplace which requires investigation. It may have actually happened or could hypothetically happen.

Name of workplace	Singatac Fabrication Yard
Workgroup	Fitter
Describe incident	A fitter was cutting a dog plate which attached to the pad eye at underneath the jacking beam. The fitter turned off the cutting torch and placed it on the nearby welding machine rack. The fitter then went to the jacking beam to do alignment and continue tag welding at the upper pad eye. When the fitter was performing tag welding, the flying spark from welding activity ignited the cutting torch which is not in used and causing the minor fire. A helper was in the vicinity quickly extinguish the fire with water. No property damaged and injury reported

ACTIVITY 1

Consider the initial responses to the incident, in preparation for an investigation:

- a) How would you ensure the incident site is safe and secure?
 - Describe how you would address the immediate needs of those involved in the incident
- b) Outline the WHS legislative requirements for your workplace regarding incident response (i.e. duty holders, notification/reporting, preserving incident sites) as outlined in:
 - WHS Acts
 - WHS Regulations
- c) Outline the your workplace's requirements regarding incident response as outlined in:
 - Policies
 - Processes
 - Procedures
 - Systems

Ensuring safety and security of site

First the incident area are barricaded and signed do not entry. Take photo of the equipment, area, location of work for evidence. After that, the fitter who performed the job, witness and supervisor called out for incident statement immediately, and organize an incident investigation meeting.

WHS Acts

Under WHS Act 2011, person who conducts a business or undertaking must ensure that the regulator is notified immediately after becoming aware that a notifiable incident arising out of the conduct of the business or undertaking has occurred. The notice must be given as required under this section and by the fastest possible means. The notice must be given by telephone; or in writing. The person with management or control of a workplace at which a notifiable incident has occurred must ensure so far as is reasonably practicable, that the site where the incident occurred is not disturbed until an inspector arrives at the site or any earlier time that an inspector directs

WHS Regulations

Under WHS Act 2011, As soon as practicable after a major incident occurs, the operator of the major hazard facility must take all reasonable steps to provide the persons, with information about the major incident, including:

- (a) a general description of the major incident; and
- (b) a description of the actions the operator has taken and proposes to take to prevent any recurrence of the major incident or the occurrence of a similar major incident; and
- (c) recommended actions that the local authority and members of the local community should take to eliminate or minimise risks to health and safety.

If a notifiable incident occurs in connection with the construction project to which the statement relates, the person must keep the WHS management plan for at least 2 years after the incident occurs.

Policies

In Technip HSE policy, it is encourage people to stop the job and intervene for safety. Nonetheless, the management also committed to ensure continual improvement of HSE management system and performance, whereby if incident occurs, the root cause shall be identified and communicated within the organization and preventive and improvement action shall be to ensure no reoccurrence.

Processes

In case of incident occur, the first witness shall activate the emergency alarm and notify to their supervisor. Then HSE personnel will receive the information to report to the respective HSE manager in charge. The incident area is then need to be barricaded or isolated to ensure the evidence is not destroyed. Incident investigation is immediately arranged to identify the root cause. After that, carry out the improvement and preventive action to avoid the reoccurrence.

Procedures

Incident notification and investigation procedure has been published and communicated widely within the organization. In the procedure, it stated the category of incident, classification of injury and also the process of incident notification until investigation close out.

Systems

All incident shall report to Technip in house incident system called Synergi. The incident shall be registered in the system within 24 hours. Then, preventive action or corrective action shall be carried out, and update in the synergi with valid evidence to close the incident case.

Outcome for Activity 1

- ☐ Satisfactory
☐ Not satisfactory

Trainer/Assessor comments

ACTIVITY 2

You are required to develop an investigation plan to address the incident:

- a) Define the scope and purpose/objectives of the investigation
 - Ensure this reflects the scope and nature of the incident
 - Explain which individuals/parties you would consult with in planning the investigation, including deciding between options (e.g. internally, external advisors)
- b) Outline the requirements of the investigation in the form of an action plan
 - Identify resourcing requirements, and allocate roles and responsibilities
 - Prioritise tasks and specify timelines for the investigation
 - Identify how the outcomes of the investigation will be documented
- c) Identify factors that may impact on the investigation and how they might be addressed. Consider the impact of:
 - Workers with specific needs and limitations (e.g. cultural background and diversity, low language, literacy and numeracy levels)
 - Structure and organisation of the workforce (i.e. part time vs casual vs contract workers; shift rosters; geographical location)
 - Workplace culture relating to gender

Ensure that the requirements from Activity 1 are met through your responses to Activity 2.

Scope and purpose/objectives of the investigation

The purpose of the incident investigation is to identify the root cause of the fire incident for improvement and to prevent reoccurring of the unwanted event. Therefore, it is very important to consult the worker who had involved in the incident such as fitter and also the witnesses, the helper. Nonetheless, the investigation shall be also facilitate by qualified and competent investigator to ensure the effective investigation is carried out.

Action plan

Preventive action shall be recorded down in the investigation report. It is to ensure the prevention action is being agreed to execute. Example of the preventive action is, adequate fire blanket and fire watcher, and leak test on the cutting torch is carry out prior begin the activity. Also, the duration of the preventive action to execute and responsibility of the preventive action shall be also identified and allocated. For example, this action shall be carry out by the fitter but supervisor in charge must double check and ensure the inspection report is filled and submitted.

Impacting factors

The only factor that impacting the investigation process is language used in the investigation process. This is due to the worker are from low education background, so it is hard to communicate in English. As a result, a spokesman/translator has been identified to do translating and explanation throughout the investigation process.

Outcome for Activity 2

- ☐ Satisfactory
☐ Not satisfactory

Trainer/Assessor comments

ACTIVITY 3

Consider the collection and analysis of information and data:

- a) Explain why and how you will inspect the incident site.
- b) Explain why and how you will inspect the equipment used at the time of the incident.
- c) Identify other evidence you would gather regarding the incident.
- d) Outline how you would gather information and data in ways that ensure objectivity, confidentiality, validity and accuracy.
- e) What reasoning would you give to the investigation team to justify using the conceptual basis for the analysis, namely:
 - Adopting an open-minded and objective approach
 - Analysing policies, procedures, processes and systems in place at the time of the incident
 - Focussing on the 'how', 'what' and 'why' of the incident
 - Not focussing on individual behaviour or fault
 - Using applicable models of causation and occurrence

Inspecting the incident site

The reason of inspecting the incident site is to understand the incident scenario and identify the unsafe act and condition. All areas of the incident must be visited such as position of the worker carry out the job and any findings identified during the visiting must capture down by camera as evidence. Other than that, it is also can request the victim to illustrate how the incident occur, and also can do a mock up to understand the incident scenario.

Inspecting equipment

All the equipment used shall be physically checked including its function. It has to bring over lab for calibration if necessary. For example, if the fire incident is due to leaking from the equipment, the equipment can put in the water to see if there is bubble coming out. If yes, meaning that the equipment is not tighten enough or malfunction which cause the leaking and fire incident eventually

Other evidence

Other evidence can be taken from the CCTV nearby, equipment purchasing certificate, worker's training record, worker's health record, worker's HSE violation record, work process, and other similar incident investigation report.

Process for gathering information and data

Information and data can be collected from interview, physical survey such as inspection of the equipment, observation of the working position and unsafe condition. Nonetheless, the information should be able also from document review of any documents which relevant to the incident.

Briefing the investigation team

The objective of the investigation team using the named conceptual basis for analysis is to ensure a quality of investigation is carry out. It is to make sure the root cause is identified properly and achieving a fair and balance investigation report.

Outcome for Activity 3	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	

ACTIVITY 4

Complete an investigation report of the identified incident for your PCBU in the following structure:

1.0 INTRODUCTION

- Outline the background of your company, its role and purpose
- Briefly describe the incident that has taken place
- Define the scope and purpose of the investigation

2.0 INVESTIGATION FINDINGS

- Construct a timeline of events leading up to the incident (e.g. who was involved, what happened, initial responses to meet legislative/organisational requirements)
- Describe the scope of the investigation (e.g. identify investigation team, sources of information and data, site/equipment inspections that took place, other evidence gathered, experts consulted)
- Outline how information and data was gathered using objective, confidential, valid and accurate methods.
- Highlight the root causes of the incident:
 - Note the key events, conditions and/or circumstances that together resulted in the incident
 - Consider the effectiveness of workplace policies, procedures, processes and systems

3.0 RECOMMENDED PREVENTION MEASURES

- Highlight points at which the incident could have been prevented
- Outline actions, interventions and practical measures that would prevent reoccurrence of the incident, which address the root causes identified
 - Evaluate between alternative strategies to identify the best option(s) for the workplace, identifying the criteria used for this decision
 - Identify resourcing requirements, and allocation roles and responsibilities
 - Prioritise tasks and specify timelines for implementation
 - Outline how the effectiveness of these solutions will be measured and evaluated

4.0 CONCLUSION

- Explain the importance of WHS to your company, and the value of addressing and avoiding incidents

TIPS:

- Use the report template (below) and elaborate on the points above.
- Write in simple English. Remember that people from a range of backgrounds and abilities would be reading this document.
- Be sure to reference evidence to back up your conclusions and recommendations, providing sufficient detail so that the reader can look into it further.

1.0 INTRODUCTION

Technip Asia Pacific (APAC) is the leading engineering technology solutions and turnkey contracting provider in Asia Pacific for the design and construction of hydrocarbon field development, oil refining, gas processing, petrochemicals and selected non-hydrocarbon projects. Technip APAC consists of country from Singapore, Vietnam, China, Brunei, Malaysia, Thailand, and Myanmar. And activities cover 3 business segments i.e. Subsea, Offshore and Onshore. Incorporated in 1982, the company participates in business activities internationally with Kuala Lumpur in Malaysia as the main operational centre.

However, a fire incident occurred on 20th May 2016 in one of the project under controlling of Kuala Lumpur Management. A fitter was cutting a dog plate which attached to the pad eye at underneath the jacking beam. The fitter turned off the cutting torch and placed it on the nearby welding machine rack. The fitter then went to the jacking beam to do alignment and continue tag welding at the upper pad eye. When the fitter was performing tag welding, the flying spark from welding activity ignited the cutting torch which is not in used and causing the minor fire. A helper was in the vicinity quickly extinguish the fire with water. No property damaged and injury reported

2.0 INVESTIGATION FINDINGS

As usual working day, the fitter attended the daily toolbox talk which conducted by his safety personnel. Then we has assigned by the supervisor to do fit up activity on the pad eye to jacking beam. Fitter is then carry out the leak test, placed fire blanket around the working area and began the work. However, there is a gap between the walking platform where he placed the fire blanket and the fit up area which he has no intention to cover the gap by fire blanket to prevent the flying spark dropped to the ground. Fitter started to do the job and a helper observed the fire incident and quickly extinguish the fire with water. Investigation was formed immediately to identify the root cause of the incident. All relevant document was reviewed, relevant workers involved are also interviewed and site survey conducted.

During the investigation, document such as toolbox talk attendance list, leak test report, cutting torch inspection record and fitter training record was reviewed. Site survey was also conducted and found the gap of the working area was not covered by fire blanket properly and the cutting torch was placed or left unattended without disconnected. The cutting torch was then send to workshop to calibrate the tighten test and found the switch was not in good function which allowing the gas leaking.

3.0 RECOMMENDED PREVENTION MEASURES

As result of the investigation, It is recommended the workers to carry out the leak test not only at the hoses connection, but also on the hot work equipment and tool for example, cutting torch. Other than that, the fire watcher need to ensure the gap is properly covered up. Assumption has to be eliminated in HSE implementation. The incident was then shared in all project progress meeting, HSE committee meeting and in weekly toolbox talk. This is to ensure all project personnel understand the hazards and to avoid the reoccurrence again.

4.0 CONCLUSION

Technip is priority in HSE and wanted Technip to be a reference company in HSE, therefore Technip has zero tolerance in HSE. It is also because Technip value the importance of HSE which able to help in getting more project from oil and gas client like shell, chevron and subsea 7. Technip also value the life of the workers are precious and can't be replaced. Therefore, HSE is priority and important in project implementation

Outcome for Activity 4	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	

QUIZ

QUESTIONS	CORRECT
1. Which of the following matters are considered as initial responses to an incident? Select all that apply. ☒ First aid ☐ Evaluation of response ☒ Preserving the incident site ☒ Evacuation	☐
2. Under Part 3 of the <i>Work Health and Safety Act 2011</i> (Qld), a PCBU must notify Work Health and Safety Queensland about all incidents that occur in the workplace, even if there is no injury or damage caused. ☐ True ☒ False	☐
3. Which of the following should be considered when developing an investigation plan? Select all that apply. ☒ WHS legislation ☒ Workplace policies, procedures, processes and systems ☒ Appropriate selection of a team for the scope of the investigation ☒ Consultation and participation of individuals/parties with planning ☒ Obtaining necessary resources for investigation, including expert advice	☐
4. Under Part 9 of the <i>Work Health and Safety Act 2011</i> (Qld), which of the following rights and powers does a WHS inspector possess? Select all that apply. ☒ To provide information and advice about WHS compliance ☒ To assist in resolving WHS issues in the workplace ☒ To inspect a workplace, including investigation of WHS incidents ☒ Enter a workplace with or without the PCBU's permission	☐
5. Which of the following factors would be considered barriers to an incident investigation? Select all that apply. ☒ Availability of witnesses due to organisational structure (e.g. casual employees, shift work) ☒ Differences in understanding due to diversity (e.g. cultural background, low language, literacy and numeracy levels) ☒ Attitudes of investigators (e.g. negative views of opposite gender) ☒ An extended time passing since the incident occurred	☐

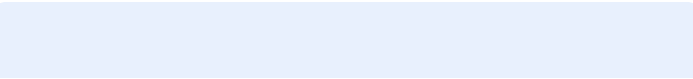
6. Under Part 10 of the <i>Work Health and Safety Act 2011</i> (Qld), which of the following types of notices may be issued by a WHS inspector? Select all that apply. ☒ Improvement notices ☐ Non-disturbance notices ☒ Prohibition notices ☐ Time out notice	☐
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Outcome for Quiz	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	

PRACTICAL TASK

You are required to have a suitable observer verify your ability to complete the following tasks. These tasks may be simulated or real.

TASKS	VERIFIED
A. Work with others to carry out initial responses to a notifiable incident: • Ensure incident site is safe and secured, addressing the immediate needs of those involved • Ensure workplace policies, procedures, processes and systems are followed (e.g. evacuation procedures, providing support, requesting information from those involved) • Ensure WHS regulator is notified	☒
B. Take a leadership role when consulting with others to develop and document an investigation plan: • Determine scope and purpose of investigation, including timelines • Form an appropriate investigation team and assign responsibilities and roles • Identify and evaluate alternative strategies and resources for investigation process • Obtain necessary resources for investigation • Ensure requirements of WHS legislation and workplace policies, procedures, processes and systems are met by the plan	☒
C. Work in investigation team to collect information and data: • Inspect incident site, equipment and other evidence (e.g. witnesses) • Extract mathematical information, as required • Gather information and data in ways that ensure objectivity, confidentiality, validity and accuracy • Electronically document outcome of inspection	☒
D. Work with others to analyse information and data: • Construct a timeline of events leading up to the incident • Analyse numerical data, key events, conditions and/or circumstances • Demonstrate an open-minded and objective approach • Analyse policies, procedures, processes and systems in place at the time of the incident • Focus on the 'how', 'what' and 'why' of the incident, using models of causation and occurrence rather than focussing on individual behaviour or fault	☒
E. Consult with others to determine prevention measures: • Develop and detail actions, interventions and practical measures to address root causes and prevent the reoccurrence of the incident • Identify how solutions will be measured and evaluated to determine effectiveness	☒
F. Prepare and verbally present an electronic investigation report to relevant parties (e.g. PCBU, Trainer/Assessor): • Identify the events leading up to the incident, immediate and underlying causes and points at which the incident could have been prevented • Explain recommendations arising from the investigation • Cite evidence and basis for conclusions and recommendations • Develop appropriate report for audience and use objective language	☒

Name of observer	Phan Nguyen
Role of observer (Confirm their suitability to sign)	☐ Trainer/Assessor ☒ Other (specify): HSE Head of Department
Phone number of observer	+84917810114
Email address of observer	pdnguyen@technip.com
Signature of observer	
Date	25/04/2016
Comments	

Outcome for Practical Task	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	