WHSMP17: Incident Management, Reporting and Investigation

Section 1 - Purpose and Scope

(1) The purpose of this procedure is to ensure reporting of Workplace Health and Safety (WHS) events at Southern Cross University (SCU) is appropriately managed and controlled.

(2) The purpose of this procedure is to ensure Southern Cross University's management, employees, contractors, students, visitors and others are aware of the standardised approach across the University so that workplace health and safety (WHS) events are correctly reported, investigated, classified, and actions assigned to manage and prevent future unplanned events from occurring.

(3) All employees, students and others, including both independent contractors and contractors under SCU control are to be made aware of and follow this procedure.

(4) This Procedure applies to all SCU Work Units and sites. The procedure aligns with WHS legislation in the relevant jurisdictions SCU operates in.

Section 2 - Definitions

AS/NZS	Australian Standard/New Zealand Standard.
RiskWare	Electronic database for the reporting of all incidents and near misses. Includes investigation of incidents against root cause, the assignment of corrective actions, and regulatory and performance reporting.
Causal Factor	A factor that affects an event's outcome but is not a root cause.
Competent Person	A competent person is a person who has acquired, through training, qualification or experience, the knowledge and skills to carry out the task.
Consultation	Seeking views before deciding.
Contributing Factor	Outcomes that have contributed to the root cause(s) of an incident but have not been determined to be a root cause in themselves.
Critical Incident	A critical incident is a traumatic event, or the threat of such, which has the potential to harm life or well-being and causes extreme stress, fear or injury to the person(s) experiencing or witnessing the event.
Duty of care	The WHS Act imposes a general duty of care that requires everything reasonably practicable to be done to protect the health and safety of others in the workplace. This duty is placed on all employers, employees and any others who have an influence on hazards in the workplace.
EAP	Employee Assistance Program.
First Aid Injury	Immediate treatment or care is given to a person suffering from an injury or illness until more advanced care is provided or the person recovers e.g. applying bandages, use of ice packs, wound management, imaging for diagnostic purposes, GP appointments, pain relief medication, use of a defibrillator, attending an Emergency Department.

Hazard	Source with a potential to cause injury, ill health, death, damage to or loss of a system, equipment, property, or damage to the environment.
Hierarchy of Controls	The hierarchy of controls is a set of ranked risk control measures ranging from most to least effective. These include elimination (most effective), substitution, isolation, engineering, administrative and the use of personal protective equipment (least effective).
High Risk Work (HRW)	High risk work (HRW) refers to work that requires a person to have a licence to perform that work such as but not limited to dogging (DG), crane or hoist operation (C0) and forklift operation (LF/LO).
Incident cause analysis method (ICAM)	A formal root cause analysis process to identify root causes and contributory factors
Illness Event	A result of a medical condition not work-related incident. An incident is an unplanned event or chain of events, which has, or could have caused a workplace injury or disease and/or damage to people, the environment, assets or reputation.
Investigation Owner	The investigation owner is the most senior role with accountability for the work where the incident occurred This role is designated as per the incident classification: • SIRS 1 – Vice President • SIRS 2 – One Operational level lower than Vice President • SIRS 3 – Work Unit Manager • SIRS 4 - One Operational level lower than Work Unit
Interested party	Synonymous with stakeholder
Lead Investigator	The Lead Investigator is the person nominated by the Investigation Owner to lead the investigation team. The Lead Investigator must: • Determine the scope of the investigation with the investigation owner. • Coordinate and select the investigation team in consultation with the investigation owner. • Ensure resources are available to support an effective investigation. • Coordinate and direct the investigation. • Provide regular updates to the investigation owner. • Work with the team to finalise a report and present the findings to the investigation owner. Leaders will be supported at all times by the investigation owner.
Lost Time Injury (LTI)	A Lost Time Injury (LTI) is an injury which results in an employee missing at least one (1) shift/day as a result of the injury following an incident at work, where confirmed as work related on a medical certificate.
Medical Treatment Injury (MTI)	An occupational injury or illness, which has not been classified as a Lost Time Injury, which requires treatment beyond first aid. The treatment is provided by a registered physician or under the direction of same, e.g. injury resulting in loss of consciousness, surgery including stitches, admission to hospital for observation for more than 12 hours, removal of foreign bodies from the eye, fractures, use of casts and splints.
Near Miss	A Near Miss is an incident that occurred at the place of work, which, although it did not result in personal injury/disease or damage to people, property or the environment, had the potential to do so.
Notifiable Incident	A notifiable incident is a definition used by regulatory authorities and can vary across jurisdictions. Notifiable incidents include events such as death, serious injury and a dangerous occurrence or incident at a workplace, that are required to be reported to the relevant regulatory authority.
Occupational Health Event	These are incidents that, due to exposure/s over a period of time, have the effect of work has impacted an individual's health.
Personal injury accident	These are acute incidents that result in harm to an individual, either accidentally or intentionally
Plant / Property Damage Event	These are incidents that result in financial expenditure to repair, replace or substitute.
SCU Incident Reporting Scale (SIRS)	The SCU Incident Reporting Scale (SIRS) is used across SCU to classify the severity of incidents. The SIRS ratings classify incidents from 1-4, with 1 being the most severe.
Stakeholder	Person or organisation that can affect, or be affected by, or perceive itself to be affected by a decision or activity.

Unplanned event	Incident or non-conformance that was not expected to occur. Synonymous with incident, near miss, or non-conformance.

Section 3 - General Principles

(5) This procedure aims to assist SCU employees through the steps associated with incident management for WHS events. The procedure provides details on:

a. Classification of incidents and determining severity levels.
b. Event reporting and investigation.
c. Notification to both internal and external relevant interested parties of events.
d. Outline of the investigation process, timeframes and required party's involvement.
e. Managing unplanned events and investigations.
f. Event review and approval requirements.
g. Communication of events and lessons learnt.

(6) This Procedure does not provide details on injury management and workers compensation requirements.

Incident or non-conformance definition

(7) An incident is defined as an unplanned event that did, or could result in:

a. An injury or illness sustained at the workplace because of work.
b. Near miss.
c. Occupational health and/or hygiene concern or exceedance.
d. Non-compliance with the regulator requirements.
e. Enforcement notices, improvement notices and certifications should also be recorded in RiskWare within the relevant event report to formally record breaches and actions developed to correct non-conformances and those developed to prevent reoccurrence.

Event management

Immediate Action

(8) Whenever an event transpires, immediate action should be taken to prevent or, where not possible to prevent, control and minimise further impact where it is safe to do so. Where it is not safe to take action to control or correct the event, emergency services should be contacted to render assistance as per WHSMP05: First Aid, Emergency Preparedness and Response.

(9) The initial response should consider the following elements:

a. Ceasing of work activity.
b. Adequately control hazards or minimise the risk of further damage or injury to persons.
c. Rendering first aid and securing casualties where safe to do so if applicable to the event.
d. Notify emergency services when and if required in line with WHSMP05: First Aid, Emergency Preparedness and Response.
e. Make the area safe and preserve the incident scene and any potential evidence.
f. Notify relevant stakeholders.

Employee Assistance Program (EAP)

(10) The University shall provide adequate support to assist person(s) who have been affected by an incident. This may include:

a. Immediate support from a manager where possible.
b. Where appropriate, support via the Employee Assistance Program (EAP).
c. Workplace rehabilitation.
d. Change in work duties.

Event Classification

(11) Incidents and non-conformances must be classified using the Event Classification Matrix (see Table 1 below). Incidents shall be assigned one or more classifications depending on the outcomes of the event. These impacts may include safety, health and wellbeing. All incidents will be assigned:

a. An "actual consequence"; and
b. A "maximum reasonable outcome (MRO)". The MRO is determined from the maximum reasonable consequence and the maximum reasonable likelihood, had the circumstances been slightly different.

Table 1: Event Classification Matrix

Incident Type	SIRS1	SIRS2	SIRS3	SIRS4	No treatment/Near Miss
Personal Injury Accident / Occupational Health	Fatality Permanent alteration to an individual's future Notifiable event	Lost Time Injury (LTI)	Medical Treatment Injury (MTI)	First Aid Injury (FAI)	An event that transpires but does not result in injury, or property damage but has the potential to do so under the same or similar circumstances. An energy source must be released, or an event must occur for a near-miss classification to be made. Near misses should be attributed to what the most reasonable outcome should have been determined by the relevant Work Unit in consultation with the WHS Manager.
Property Damage	$100,000 plus damage to plant /equipment and/or property	$100,000 to $20,000 damage to plant /equipment and/or property	$20,000 to $5,000 damage to plant /equipment and/or property	Less than $5,000 damage to plant /equipment and/or property	

(12) Classification of event outcomes matrix (Appendix 1) below, outlines the base determination on what constitutes a First Aid Injury (FAI), Medical Treatment Injury (MTI), Lost Time Injuries (LTIs), and permanent alteration to an individual's future. Where uncertainty exists around the correct incident classification to use, you should seek advice from SCU WHS or the Work Unit Manager.

(13) All investigations will be undertaken based on the MRO or Potential consequence level in line with the requirements set out in this document. Where more than one event category is identified during the incident classification, the level of investigation will be determined by the highest severity level.

Event Reporting and Notifications

Internal Event Reporting

(14) All events, including near misses, shall be recorded to allow effective management, investigation, and communication of implemented actions. Lessons learnt will also be recorded to assist in the prevention of similar events occurring in the future. Internal reporting of incidents and escalation shall be completed following Table 2,

unless the incident is deemed to warrant a more urgent notification or wider distribution than indicated. Where an injury or illness triggers the injury management and/or workers' compensation process, the process outlined in the Injury Management Procedure shall be followed to ensure correct reporting and engagement of relevant parties.

Table 2. SCU Internal Event Reporting Matrix

	SIR 1	SIR 2	SIR 3	SIR 4
Internal Notification Requirements	University Council, Vice Chancellor, Vice Chancellor's Group, Head of Work Unit, SCU Governance, Work Unit Supervisor, WHS Manager (Verbally within 1 hour, same shift in writing)	Head of Work Unit, Work Unit Supervisor, WHS Manager (Verbally within 4 hours, same shift in writing)	Head of Work Unit, Supervisor, Manager & WHS Business Partner (Same shift)	Supervisor & WHS Business Partner (Same shift)
Insurance Provider	As per Workers' Compensation legislation.			
Logged into RiskWare	Within 24 hours of the event occurring			

Internal SIRS 1 & 2

(15) Reporting Supervisors must inform the WHS Manager of a potential SIRS 1&2 event immediately. Once received the WHS Manager needs to inform the Vice Chancellor and other relevant stakeholders as per Table 2. Applicable timeframes are within 1 hour for SIRS1 incidents and 4 hours for SIRS2 events. SIRS 1&2 WHS Alert (WHSMP17 – FOR – 05 SIRS 1 & 2 Initial Notification Form) is to be completed and submitted through the WHS Partner to the Vice Chancellor, University Council (SIRS1 only), Head of Work Unit and WHS Manager within the day for review and dissemination to the wider business where applicable.

(16) Exact details and information reported shall be concise, and factual, and only provide a summary of the event. The Manager with the support of the WHS Partner are to ensure the injured employee is provided with the appropriate medical care and early return to work intervention in line with the Injury Management Procedure. The following information is to be conveyed as part of the initial notification for SIR1&2 events via phone call:

a. the occurrence of the SIRS1 & 2 events.
b. details of any injuries/damage and the current status.
c. any arrangements made to ensure employee/s have been provided with assistance.
d. preliminary investigation findings.
e. any interim controls that have been determined to make the area safe or to remedy the cause of the incident/injury.
f. proposed plan of action to manage the incident and expected time frames to notify outcomes of the investigation.

(17) For SIRS 1 incidents, the Vice Chancellor shall seek advice from SCU Legal on whether to establish legal professional privilege of the event and subsequent advice. If the incident is considered a crisis, then the Vice Chancellor will determine if the Critical Incident Team (CIT) needs to be activated. The process to be followed is outlined in detail in the SCU Emergency Management Plan.

External Notifications

(18) The SCU internal reporting requirements do not remove the responsibility for other reporting requirements, such as to regulatory authorities under statutory or regulatory requirements. SCU report all notifiable incidents arising from the conduct of the business to the relevant authorities as required under relevant acts and regulations.

Notifiable Safety Incidents

(19) Where it is a requirement to notify the Regulator, the Head of Work Unit shall discuss the event with the WHS Manager in consultation with SCU Legal as to whether the incident should be treated as Legal Privilege. Where it is determined that Legal Professional Privilege will be applied, WHS shall report to the relevant regulator. When reporting events to the regulator, details shall be factual and concise, providing only a summary of what is known.

(20) A record of the notification and subsequent correspondence with the regulator should be documented and logged in RiskWare as part of the incident recording. Failure to notify authorities of a notifiable incident may lead to significant fines for each offence. WHS shall predetermine applicable areas of jurisdiction and identify reporting Regulators and Authorities so that in the unfortunate event of a notifiable incident the correct reporting can be undertaken within set timeframes. The definition of a notifiable incident and its associated reporting requirements vary across jurisdictions and should be known by WHS to ensure accurate reporting. WHSMP03: Legal Obligations and Other Requirements refers to the relevant state regulatory authority and reporting requirements.

(21) The site of the notifiable incident shall be preserved and not be disturbed without the approval of the regulatory authority. Exemptions to the above include the need to:

a. protect the health and safety of a person(s).
b. aid an injured person(s) involved in the incident.
c. take essential action to make the site safe or to prevent any re-occurrence of an incident.

(22) Release of scene correspondence from the regulator shall be documented and evidence uploaded to RiskWare as part of the investigation.

Reporting in RiskWare

(23) All events are to be reported in RiskWare within 24 hours of transpiring.

(24) Where there is no access to RiskWare, Section 1 of WHSMP17 - FOR - 04 - Basic Investigation Report is to be completed following the initial notifications following Table 1 to document all relevant information about the event. A copy of the completed and signed form is to be uploaded to RiskWare when access is available.

Incident Investigation Process

(25) The sole objective of the investigation of an incident or non-conformance shall be operational learning, the prevention of future incidents and corrective actions of systemic contributory factors or non-conformances. It is not the purpose of this activity to apportion blame or liability. The level of investigation required is determined by the classification of the event. The event classification is based on the maximum severity level of the actual and maximum reasonable outcome (potential) severity of the event. The below table, Table 3 outlines the level of investigation and required outputs for each event classification.

(26) All SIRS 1-2 classified events are to undergo detailed investigations using the incident cause method analysis (ICAM) and documented in the ICAM investigation template (WHSMP17-FOR-01). SIRS 3, 4, and near-miss events shall be required to have basic investigations undertaken using RiskWare. All incidents must be investigated within nominated timeframes as per below Table 3.

Table 3: Incident Investigation Levels and Time Frames

Incident Investigation Level and Time Frames				
Unplanned Event Document	SIR 1	SIR 2	SIR 3	SIR 4
RiskWare Entry	24 hours	24 hours	24 hours	24 hours

Investigation Report	28 Days	28 Days	14 Days	7 Days
Lessons Learnt Generated	28 Days	28 Days	Not Required	Not Required

(27) On receipt of advice of an incident, SCU must immediately investigate the circumstances of the event and determine follow-up action to be taken. This shall include immediate actions, such as:

a. Notification to relevant stakeholders.
b. Advising the authorities of a notifiable or reportable incident, where applicable.
c. Ensuring employees on-site and other stakeholders, where applicable are aware that an incident has occurred and securing the scene, until cleared by the relevant statutory authorities.
d. Ascertaining further facts about the event, via interviews, gathering information about the reasons for the incident (immediate cause).
e. Implementing actions to reduce the risk of further injuries and/or damage to the environment.

Resourcing of Investigation Team

(28) The Investigation Owner is the most senior role with accountability for the work where the incident occurred. This role is designated as per the table below. The appointment of the Lead Investigator shall also be undertaken in accordance with the details in Table 4 by the Investigation Owner.

(29) Lead investigators must meet the below competency levels per the SIRS classification of the Incident. Investigations may also be undertaken by a specialist third party or regulator where deemed necessary. Approval will be gained from the WHS Manager or equivalent Council member before engaging any external party/regulator in an investigation.

Table 4: Lead Investigator Criteria Matrix

Classification	Investigation Owner / Lead Investigator appointed by	Required Credentials
SIR 1	Executive Member of the Work Unit in consultation with WHS and SCU Governance	WHS Team presence. Incident investigation knowledge. Understanding of SCU incident investigation requirements.
SIR 2	Head of Work Unit in consultation with WHS	WHS Team presence. Incident investigation knowledge. Understanding of SCU incident investigation requirements.
SIR 3	Team member supervisor in consultation with WHS	WHS Team presence. Incident investigation knowledge. Understanding of SCU incident investigation requirements.
SIR 4	Team member supervisor in consultation with WHS	WHS Team presence. Incident investigation knowledge. Understanding of SCU incident investigation requirements.

(30) The investigation team shall:

a. Collect all relevant data relating or potentially relating to the event through observations, interviews and available documents.
b. Analyse the evidence to determine the sequence of events and decisions made.
c. Determine relevant findings relating to contributory and systemic causes.
d. Establish the contributory and systemic causes of the incident and the impact, or potential impact, of the threat.
e. Develop an action plan that restores business as usual and notifies external third parties (such as the police and regulators).

f. Develop an action plan that mitigates the risk presented by the incident. The plan developed, where appropriate, may initially focus on a temporary workaround solution and risk containment, followed by additional work to resolve the incident and mitigate the threat. This action must be logged on the relevant reporting system.
g. Engage appropriate resources where specialist support is needed or SCU is at high risk of further compromise.
h. Communicate findings and lessons learnt for distribution to the wider organisation.

Evidence Collection

(31) The collection of evidence enables the incident to be fully described and the causes to be determined. Key considerations to be determined when collecting evidence include the who, what, when, where, why and how. Examples of key methods for evidence collection include direct observations, document review, and interview/witness statements as outlined in the sub-sections below.

(32) Incident scenes shall remain undisturbed pending the collection of evidence for investigation purposes. If movement of evidence becomes necessary to make people or the scene safe, the location and situation of items to be moved shall be made to allow memory recall as accurately as possible. When collecting the data investigators should identify all conditions, actions, or deficiencies that may have contributed to the event using the five known categories from the incident cause analysis method (ICAM) data collection: people, environment, equipment, procedures, and organisation.

(33) All evidence collected as part of the investigation should be uploaded into RiskWare as part of the record-keeping process.

Direct observations

(34) This is pertinent to the understanding of the circumstances and the events leading to the incident. A variety of information sources will be used to collect the necessary data for the reconstruction of the event. To ensure the continued availability of such data for safety improvement, information sources need to be protected.

(35) Although the investigation should primarily focus on the factors that are most likely to have influenced action, the dividing line between relevance and irrelevance is often blurred. Data that initially may seem to be unrelated could later prove to be relevant once the relationship between the different elements of an occurrence is better understood.

(36) Direct observations can take the form of:

a. Physical examination of the equipment or assets used during the incident. This may include examining the field or lab equipment used, its components, and the workstations and equipment used by supporting employees.
b. Recordings – CCTV, Security Camera’s, etc. These may provide useful information for determining the sequence of events.
c. Direct observation of actions performed by operating employees in their work environment. This can reveal information about potential unsafe conditions. However, the persons being observed must be aware of the purpose of the observations.

Documents

(37) Documentation spanning a broad spectrum of the operation can assist in establishing what has transpired coupled with providing evidence of prior risk assessments, inspections, and training records. For example:

a. Maintenance records and logs.
b. Contractors work records.

c. Employee records, qualifications/proficiency, training records.
d. Work schedules and rest periods, work hours, hours of sleep.
e. Certificates and licences.
f. Operator’s manuals and Procedures.
g. Training manuals and syllabi.
h. Manufacturers’ data and manuals.
i. Weather forecasts, records and briefing material.
j. Safety databases - useful supporting information may come from RiskWare and previous events.

Interview and Witness statements

(38) Interviews conducted with individuals directly or indirectly involved in the incident can provide a principal source of information for any investigation. In the absence of measurable data, interviews may be the only source of information. More importantly, interviews are often the only way to answer the important ‘how’ question, which in turn will facilitate the establishment of appropriate and effective safety improvement recommendations.

(39) Witness statements can also provide an opportunity to check back on any issues arising from the examination of the physical and documented evidence. Interviews should not only include those who were directly involved in the event but also witnesses, line managers, and subject matter experts. They must realise personal limitations as investigators cannot be experts in every field related to the operational environment. When necessary, they must be willing to consult with other professionals during an investigation.

(40) When collecting witness statements, they must be documented in the persons' own words, using WHSMP17-FOR-03 Witness Record Form or document containing the same elements to ensure a factual account of events is recorded. All witness statements collected are to be uploaded into the RiskWare for future review where required. Witness statement should be collected for all incidents where possible.

Analysis of the information

(41) Once the data has been collected it is important that it is organised into a logical and sequential order to build up a picture of the incident and its causes. This is often an interactive process, between evidence gathering and the development of causes, which should include the creation of an event timeline, cross-linked to the various pieces of evidence.

(42) The lead investigator should also:

a. Ensure the investigation goes far enough into the historical period before the incident so that all contributory factors are covered.
b. Cross-check evidence at hand to find any time gaps, missing evidence, or areas of inconsistency.
c. Re-interview or re-check evidence where there is significant disagreement or inconsistency occurs.

(43) The analysis shall provide systematic reasoning about how the incident happened and enable the drawing of conclusions and identification of actions to eliminate or mitigate the risk.

Drawing conclusions

(44) The output of the data analysis phase should be a set of events that agrees with recorded information, and which unifies the views of the various persons who were involved in these events immediately before and after the occurrence.

(45) Any drawing of conclusions shall be based on collected and analysed information, generally presented by the following categories:

a. Main (direct) cause(s) and contributing factors leading to the occurrence.
b. Findings that identify additional hazards that have risk potential but have not played a direct role in the occurrence.
c. Other findings that have the potential to improve the safety of operations or to resolve ambiguity or controversy issues contributed to the circumstances surrounding the occurrence.

(46) Identifying the lessons to be learned from a safety occurrence requires an understanding of not just what happened, but how and why it happened. Therefore, the investigation should look beyond the obvious causes and aim to identify all the contributory factors, some of which may be related to weaknesses in the system's defences or other organisational issues.

Incident investigation Reports

(47) All incident investigations undertaken for SCU events should follow the standard SCU methodology (in RiskWare and outlined in this document). As outlined earlier in Table 3, the level of detail and documents required to be undertaken will vary based on the severity and risk to the University.

(48) SIRS 1 and 2 events are to be recorded using the WHSMP17-FOR-01 - ICAM Investigation Template or RiskWare investigation tool. Lower severity events (SIR 3/4) investigations will be documented using the WHSMP17-FOR-04 - Basic Investigation Template or RiskWare investigation tool.

(49) The Lead Investigator shall use the resources at their disposal to ensure a thorough and accurate investigation is undertaken. The Lead Investigator is responsible for producing a report detailing the investigation's findings and recommendations. All investigations shall be reviewed and approved in accordance with Table 5 Investigation review and approval matrix.

Development of Corrective and Preventative Actions

(50) When developing corrective and preventative actions, key stakeholders, Health & Safety Representatives (HSRs) or other groups/agencies involved in the incident, must be consulted to ensure the threat or impact from the incident has been removed or reduced to an acceptable level. Recommendations not implemented as actions should be noted in the final report for consideration by the Incident Owner.

(51) The Lead Investigator must propose recommendations to the investigation owner (as part of the final report) that will be designed to eliminate the hazard or reduce the risk of event re-occurrence. When developing actions, preference shall be given to physical controls rather than administrative controls, following the 'Hierarchy of Controls'. Corrective and preventative actions shall be identified for all SIR events and recorded in RiskWare.

(52) Corrective or preventive actions must be assigned a due date and be the responsibility of a specific person to oversee the implementation. The incident owner is responsible for the monitoring of effectiveness and close-out of actions. Actions shall be tracked using RiskWare. Where actions cannot be closed on time request for extension should be sought from the relevant WHS person responsible for sign-off of the incident.

(53) Evidence of implementation and completion of actions should be uploaded to RiskWare as part of the action close-out to provide evidence of completion and effectiveness.

Investigation Review and Approval

Incident sign-off and approval

(54) Upon completion, investigations, recommendations, final report, and lessons learnt shall be presented to the investigation owner for sign-off. Once the investigation has been signed off, it is then passed to the relevant person as per Table 5 for their review and approval. The review is to ascertain that a thorough investigation has been completed

and that relevant actions to correct and prevent reoccurrence have been developed.

Table 5: Investigation Review and Approval Matrix

Investigation Review and Approval Matrix				
Classification	Outputs for Review	Investigation Owner Sign Off	Investigation Reviewer:	Investigation Approver:
SIRS 1	ICAM/RiskWare Report Lessons Learnt Corrective / Preventative actions	Executive Member	WHS Manager	Vice Chancellor
SIRS 2	ICAM/RiskWare Report Lessons Learnt Corrective / Preventative actions	Head of Work Unit	WHS Business Partner	Executive Member
SIRS 3	Basic Incident Report Form/RiskWare	Team Supervisor	WHS Business Partner	Head of Work Unit
SIRS 4	RiskWare Incident Report/RiskWare	Team Supervisor	WHS Business Partner	Senior Team Supervisor

(55) These reviews shall consider the following:

a. Investigation quality.
b. Confirmation of systemic causes and contributing factors.
c. Effectiveness of actions – in line with the hierarchy of controls.
d. Evidence of actions being implemented.
e. Lessons learned document developed from the investigation findings.
f. Reviews are to be undertaken in accordance with the time frames stipulated in Table 3: Incident Investigation Levels and Time Frames.

Just Culture

(56) Post investigation completion and approval, a Just Culture review shall be conducted by the applicable Event Owner for SIR 1 & 2 classified events where it was identified with sufficient documented evidence that a destructive act, wilful violation or gross negligence may have been one of the contributing factors. SCU is committed to promoting a balance between the accountabilities of both the organisation and our leaders and team members in relation to the ownership of incident lessons learnt.

(57) Embedded in the Just Culture Guideline is a process for the facilitation of a review of behavioural, process and systems aspects of an incident, which will guide the leader to a course of action and recommendations that are fair and consistent, and promote a culture of trust, openness and accountability.

Communication and Consultation of Investigation Findings

(58) Consultation with non-managerial workers should be undertaken during the investigation of incidents and non-conformities, and in determining corrective actions. They should form members of investigation teams and be consulted and communicated with throughout the entire investigation process, where applicable.

(59) The sharing of lessons learnt from unplanned events is critical to assist in the prevention of similar events across Work Units and the University. The communication of investigation outcomes following the review and approval of incidents shall be undertaken by the relevant person as per Table 5. At no time is it permissible to distribute the names of persons injured or killed or the extent of injuries identified for public release.

(60) As a minimum, incident outcomes shall be communicated to the workforce via team and safety meetings, notice boards, information meetings and safety bulletins. The WHSMP17-FOR-02 Lessons Learnt Template outlines the elements required to be communicated however alternate document may be used provided the below elements are contained within:

a. Title of event.
b. Event summary.
c. Findings from event.
d. Systemic causes and contributing factors.
e. Actions determined to assist in preventing reoccurrence.
f. Lessons learnt that can be transferred to other disciplines.

Recording Events

(61) All Investigation Reports and evidence shall be securely stored within RiskWare. All event investigation records and supporting evidence shall be maintained for a minimum of 7 years after the last action unless otherwise requested by external parties. Work Units shall ensure that all incident-related records are maintained in accordance with regulatory requirements, and WHSMP08: Document Control and Records Management .

(62) The permanent disposal of hard copy records at the end of the mandatory period should be risk assessed for the potential future need. Verification that all documents have been correctly scanned and saved should be undertaken before the commencement of disposal.

Investigation Records Management

(63) All evidence collected during an investigation (e.g. interview statements, field notes, photos, maintenance records etc.) shall be scanned and uploaded into RiskWare. Incident notifications, investigation reports and corrective actions for all events are also to be entered in RiskWare. Unless required by legislation, a copy of the investigation report shall only be made available to the regulatory authority when a request is made in writing.

(64) The privacy of injured or ill individuals or involved persons must be respected during the investigation process and when recording the investigation details into RiskWare. Information should be captured in a way including in the final report that does not personally identify those involved. Medical records must not be disclosed without written authorisation and medical details must remain confidential amongst the incident investigation team. All medical records are to be maintained in a secure online HR system.

(65) All WHS incidents shall be recorded and managed through the SCU-mandated RiskWare system. Events classified as legal privilege will be only visible to the Governance team and those with approved permission settings in RiskWare. Where there are multiple outcomes from a single event (i.e. personal injury and environmental damage), outcomes will be entered into RiskWare separately and the individual events linked.

Injury Record Management

(66) All personal injury events are to be logged in the RiskWare. All work-related injuries are to be recorded and managed in accordance with reference to the Injury Management Procedure. A copy of the completed incident report must be made available to the injured person if requested.

Training

(67) All employees and other relevant interested parties shall be trained in the requirement to report any incident or near-miss event to their immediate supervisor. All leaders shall be trained in the application of this Procedure, reporting events with those responsible for incident entry into RiskWare.

(68) The below table outlines the training and competency requirements for employees with the potential to be involved in or manage incidents and investigations.

Role	Competency Required	Training
Employees	Incident Reporting Awareness module	Staff induction and mandatory SCOUT training
Students	Incident Reporting Awareness module	SCOUT training
Subcontractors	Incident Reporting Awareness module	Contractor induction
Leaders and managers	Incident Reporting Awareness module	Staff induction and mandatory SCOUT training
	Incident Management Reporting and Investigation Procedure	Mandatory SCOUT training

Monitoring and Review

(69) Ongoing monitoring and reviews through inspections and audits should be undertaken to ensure the effectiveness of any actions taken including corrective actions. When events occur, other subsequent Work Units should review their work to ensure that a similar event won't transpire in a separate area of the University.

(70) The ongoing application and effectiveness of this procedure shall be monitored through the review of incident investigations by the WHS Team. Unless otherwise triggered via an incident, process change, or other event, this procedure shall be reviewed at least every two years.

Section 4 - Roles and Responsibilities

(71) Refer to WHSMP13: Responsibility and Accountability Statement

Section 5 - Records of Documentation

(72) All relevant documentation will be recorded and kept in accordance with WHS Legislation and other legislative obligations including:

a. Incident reports
b. Incident investigation reports
c. Training

Section 6 - Revision and approval history

(73) This procedure will be reviewed as per nominated review dates or because of other events, such as:

a. Internal and external audit outcomes.
b. Legislative changes.
c. Outcomes from management reviews.
d. Incidents.

Section 7 - References

Work Health and Safety Act (in the applicable jurisdiction that SCU operates)
Work Health and Safety Regulation (in the applicable jurisdiction that SCU operates)

Section 8 - Related Documents

WHSMP17 - FOR - 01 - ICAM Investigation Template
WHSMP17 – FOR-02 - Lessons Learnt
WHSMP17 - FOR - 03 - Witness Record Form
WHSMP17 - FOR - 04 - Basic Investigation Form
WHSMP17 - FOR - 05 - SIRS1 & 2 Notification form
WHSMP17 – GUI – 01 Event Classification One Pager
WHSMP03: Legal Obligations and Other Requirements
WHSMP05: First Aid, Emergency Preparedness and Response
WHSMP13: Responsibility and Accountability Statement

Section 9 - Appendix 1. Classification of Event Outcomes

Event Outcome	Interpretation of criteria
Fatality	A death of any person caused (or thought likely to have been caused) by a workplace safety incident. Any death of an employee caused or thought likely to have been caused by a workplace safety incident, through natural causes, whilst travelling on business. A death from self-harm by any person. A death due to any cause (other than a workplace safety issue or self-harm) of an employee when they are at work.
Permanent Alteration to an individual	An injury to any person caused by a workplace safety incident or during commuting to and from work that is: • Life threatening • Likely to result in permanent loss of substantial physical or neurological capacity • Amputation • Loss of sight in one or both eyes or deterioration of sight • Occupational disease, such as OO,S where an employee is unable to return to their current role • Change in wellbeing resulting in workers unable to return to their current role • Disabling Injury (Quadriplegic, paraplegic) • Disfigurement
Lost Time Incident	A work-related injury resulting in a fatality, permanent disability or time lost from work of one day/shift or more subsequent to the shift on which the injury occurred.

Event Outcome	Interpretation of criteria
Serious injury or illness	An injury or illness requiring the person to have immediate treatment as an in-patient in a hospital. Immediate treatment for the amputation of any part of his or her body. • A serious head injury. • A serious eye injury. • A serious burn • The separation of his or her skin from an underlying tissue (such as degloving or scalping) • A spinal injury. • The loss of a bodily function. • Serious lacerations OR • Medical treatment (treatment by a doctor) within 48 hours of exposure to a substance. • 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. OR • that involves providing treatment or care to a person, OR •that involves contact with human blood, OR • body substances, OR • that involves handling or contact with animals, animal hides, skins, wool or hair, animal carcasses or animal waste products, The following occupational zoonoses are 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
Major Injury/Event Dangerous Incident	A 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 an uncontrolled implosion. • Explosion or fire an uncontrolled escape of gas or steam. • An uncontrolled escape of a pressurised substance. • Electric shock. • The fall or release from a height of any plant, substance or thing • 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. • The collapse or partial collapse of a structure. • The collapse or failure of an excavation or of any shoring supporting an excavation. • The inrush of water, mud or gas in workings, in an underground excavation or tunnel. • The interruption of the main system of ventilation in an underground excavation or tunnel.
Medical Treatment Injury	An occupational injury or illness, which has not been classified as a Lost Time Injury, which requires treatment beyond first aid. The treatment is provided by a registered physician or under the direction of same e.g. injury resulting in loss of consciousness, surgery including stitches, admission to hospital for observation for more than 12 hours, removal of foreign bodies from the eye, fractures, use of casts and splints.
First Aid Injury	Immediate treatment or care given to a person suffering from an injury or illness until more advanced care is provided or the person recovers e.g. applying bandages, use of ice packs, wound management, imaging for diagnostic purposes, GP appointments, pain relief medication, use of defibrillator, attending an Emergency Department.
Near Miss	An event that occurs that did not result in injury, environmental harm or damage but had the potential to do so under the same or similar circumstances. An energy source must be released, or event must occur for a near miss classification to be made. An unsafe condition or an environmental risk is not a near miss; it should be classified as a hazard.

Status and Details

Status	Current
Effective Date	9th December 2024
Review Date	9th December 2027
Approval Authority	Vice President (People and Culture)
Approval Date	9th December 2024
Expiry Date	Not Applicable
Responsible Executive	Kim Franks Vice President (People and Culture)
Head of Work Unit	Brendan Pearce Director, Workplace Relations
Enquiries Contact	Shaun Brown Manager, Workplace Health and Safety