Incident Investigation Procedure

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TABLE OF CONTENTS

1. Purpose

Valued Lives is committed to the health and safety of all people at the workplace. The purpose of this procedure is to provide the requirements and instruction regarding the process of Incident Investigation. This procedure extends to ensure that corrective actions are effectively investigated and actioned to prevent a reoccurrence and to minimise harm.

2. Scope

This procedure is to be followed for investigation of workplace incidents. This procedure sets out the process to be followed in the investigation of hazards and incidents.

3. Definitions

Term	Description
Hazard	A hazard is a source or situation with a potential for harm in terms of injury or ill-health, damage to property, damage to the environment, or a combination of these.
Incident	An incident is defined as any unplanned event resulting in injury, ill-health, damage or other.
Home and Environment Checklist	A risk assessment approach that requires Network Advisors and Support Workers to assess their surroundings and workplace as part of participant onboarding and/or when major changes occur.

4. Roles and Responsibilities

Position Title	Key Responsibilities Within Process
Executive Management	Ensure all required incidents are investigated, reviewed and closed out within appropriate timeframes.
Responsible Person	Employee nominated for the responsibility of ensuring the preventative or corrective actions are being actioned, tracking the progress of implementation and completion or resolution of the issue. Close out of investigation where required.
Team Leaders / Managers	To lead or participate in the investigation processes. Liaise with any injured parties and key stakeholders to ensure their wellbeing is appropriately managed. Participate in the analysis of events leading up to the incident and assist in compiling the investigation report. Participate in the debriefing of personnel identifying: • Timeline of events leading up to the incident

Position Title	Key Responsibilities Within Process
	• Timeline of events after the incident • Assigning, implementing and monitoring appropriate corrective and/or preventative actions in a timely manner. • Ensure the analysis outcomes and actions are recorded within the Participant Management System.
Lead Investigator	Facilitate or participate in investigations and provide advice and expertise where required. Ensure the correct level of investigation is conducted. Assist in compiling the investigation report. Liaise with any injured parties and key stakeholders to ensure their wellbeing is appropriately managed. Ensure the investigation analysis outcomes and actions are recorded within the Participant Management System. Ensure the completed incident investigation is sent to the appropriate Manager for final review and sign off.
Operational Manager	Where applicable as per State reporting protocols, advise the relevant Regulatory Authority via phone and follow up with a written report within the designated time frame.
Employees / Contractors	Shall assist management and the lead investigator to conduct an investigation if requested to do so.

5. Procedure

All incidents that are within the scope of this document follow the steps listed below. Hazard reports and incident reports require immediate corrective actions to be assigned by the responsible Network Advisor or Manager.

5.1. Incident Response

Once an incident has occurred, it shall be entered into the Participant Management System as soon as practicable. All incidents must be reported as soon as practicable to the appropriate line manager. The purpose of this is to ensure that the incident is communicated and recorded without delay. An appropriate person (e.g., Supervisor/Manager) should take immediate action to assume control of the incident.

5.1.1. Assessment and Classification

Incidents are to be assessed against Valued Lives' Risk Management Matrix. There are five levels of consequence: Trivial, Minor, Moderate, Major and Extreme.

	Consequence				
Likelihood	Trivial	Minor	Moderate	Major	Extreme
Frequent	5	10	15	20	25
Occasional	4	8	12	16	20
Unlikely	3	6	9	12	15
Remote	2	4	6	8	10
Rare	1	2	3	4	5

The incident manager shall review the incident and assess the actual severity. The actual severity is based on the actual outcome of the incident, regardless of what could have eventuated. Potential severity is based on the potential outcome of the incident, or the worst-case scenario.

The assessment and classification of an incident will assist with determining the level of investigation and its level of documentation required.

5.1.2. Level of Investigation

Depending upon the outcome of an incident, an investigation will be conducted. The following is a guideline on the level of investigation required for an incident.

Please note this is a guideline only and Investigation levels may vary depending on the incident.

Risk Level	Requirement	Investigation Level and Participants
Negligible	Incident report only and system-based investigation	**Level 1** 1. Lead investigator (e.g., Supervisor) 2. Involved person 3. Safety/Employee Representative
Low	ICAM optional	
Intermediate	ICAM recommended	**Level 2** 1. Lead investigator (e.g., Manager) 2. Line Manager 3. Operational Manager 4. Safety/Employee Representative 5. Department Manager **Please note, investigation participants must not be involved in the incident directly*
High	ICAM mandatory	**Level 3** 1. Lead investigator (e.g., Manager) 2. As per intermediate risk participants 3. ICAM skilled analyst 4. Experts/technical/other 5. Legal, Human Resources, Independent Executive Manager**

Risk Level	Requirement	Investigation Level and Participants
		*** As appropriate*
Extreme		**Level 4** 1. Independent executive manager as team leader. 2. As per High-risk participants

5.2. Investigation Planning

An investigation plan shall be initiated outlining the steps which are to be taken to successfully conduct the investigation.

The relevant person(s) including the appropriate Line Manager, Operational Manager and Safety/Employee Representative shall conduct an investigation at the earliest possible time, and shall:

- Assume responsibility for the co-ordination of the investigation;
- Ensure the site is assessed (where applicable) and gather all relevant information;
- Ensure key personnel are kept abreast of the incident; and
- Where required, ensure external and statutory authorities are notified including Work Cover WA, etc.

The objectives of an investigation shall include:

- Identification and analysis of all circumstances and factors that caused and/or are contributing factors to the incident (casual factors).
- Establishment as to whether existing policies, procedures and practices were in place and applied, if they were not applied to identify reasons for non-compliance.
- To establish if existing policies, procedures and practices were adequate, and if system failures are identified, recommend alterations or additions.
- To identify if all personnel involved had appropriate levels of training and competency to perform the tasks involved.
- To identify actions and responsibilities for these actions to prevent occurrence of similar incidents.
- To communicate the findings of the investigation to promote learning opportunities and to provide greater awareness.

Ensure your investigation plan includes plans to collect information from the following categories:

- People
- Environment
- Equipment
- Procedures
- Organisation

The investigation shall only commence once the wellbeing of any injured parties is established and the site has been assessed and investigated to gather required evidence and information.

5.3. Data Collection

The data collection process aims to collect sufficient information for use during the investigation. The information gathered should highlight failed defences that have led to the occurrence of the incident.

Once all relevant data has been collated, the information shall be analysed to identify the underlying causes and/or contributing factors of the event. This should be conducted amongst the investigation team, key stakeholders and business experts.

An event timeline should be developed as soon as possible after the incident and documented in the incident report.

5.4. Workplace Inspection

It is important that evidence can be gained from observations made at the scene of the incident. The investigation team should look at the following site conditions:

- Where person was injured (if applicable)
- Lighting, visibility and audibility
- Weather and environmental conditions
- Equipment failures and condition of equipment
- Force and manual handling
- General housekeeping
- Home and environment checklist review

*Please note this list is a guideline only. Other conditions may be observed and should be noted.

5.4.1. Records

Photography is one of the most useful tools to the investigation team. It can document the situation as it exists now and as it changes. Video footage and drawings can also be used to assist with recording the scene. Consideration must also be given to personal privacy when collecting evidence to ensure that permission is sought when required.

5.4.2. Documentation

A review of documents may also uncover contributing factors and should include:

- Applicable regulations.
- Training, medical and work history records.
- Organisational policies and procedures.
- Incident reports, audit reports.
- Safety Data Sheets and Home and Workplace Checklists.

5.4.3. Interviews and Statements

The gathering and evaluation of evidence is essential for the investigation to be successful. Interviews must be conducted as soon as practicable after the incident occurring. This includes talking to witnesses, the injured/involved person, Line Managers and others involved in the incident.

Interviews should include the following individuals:

- Individuals directly involved in the incident
- Line Managers
- Person(s) at the scene
- Management
- Emergency Services personnel (if applicable)
- Safety personnel
- Subject matter experts

Those being interviewed are allowed to have a representative present for the interview if requested.

5.4.4. Final Considerations

Once all the data has been collected for the incident, the following should be considered:

- Ensure all options for gathering information have been exhausted;
- Ensure that other concurrent investigations are not affected and are not affected your investigation;
- Communication of any residual hazards by the Lead Investigator; and
- Communication of findings from the initial assessment of data to the appropriate Advisors/Managers to ensure relevant action is taken to prevent similar occurrences.

5.5. Data Organisation and Analysis

After the collection of data and analysis, it should be possible to organise the data to provide the sequence of events leading up to the incident, the incident itself and events post incident until control was regained. The sequence of events process shall be used to determine the root cause and contributing factors of the incident being investigated.

5.5.1. Root Cause Analysis

Incidents whether they are informally or formally investigated should have a root cause analysis completed. In many cases, where a formal investigation is not required, the root cause analysis provides an adequate assessment of causes which may assist in directing efforts towards selecting and planning corrective actions.

A root cause is the most direct reason for an incident which if it were corrected would prevent a reoccurrence of the incident. The 5 Whys Technique is a successful method of establishing the root cause of an incident.

Once a timeline has been developed the 5 Whys are then applied to the key events identified. The 5 Whys process is:

1. Ask why an incident has happened or why a condition is present.
2. Continue asking why until the question can no longer be answered.
3. When why can no longer be answered you have reached:
    a. A control point (organisational factor)
    b. A point that is beyond organisational control
    c. A point where more data needs to be collected to answer why
4. 5 Whys helps identify the Organisational Factors.

**The 5 Why Technique is outlined in the SafetyWise Incident Investigation Reference Guide.*

5.6. Investigation Summary

The interim investigation summary is an accurate and objective record of the incident and provides preliminary details of:

- The investigation team's investigation process;
- Facts pertaining to the incident, covering the categories of:
    - People
    - Environment
    - Equipment
    - Procedures
    - Organisation
- Analytical methods used and their results; and
- Preliminary casual factors of the incident.

The summary should be sufficiently detailed for a reader to understand the incident and the basis of any proposed improvements. Based on the initial findings it will be determined if there is any requirement for additional investigation – this is to be determined by the Operational Manager.

5.6.1. Incident Investigation Report

A formal report shall be prepared within 30 days of the incident using the Incident Investigation Report Template and forwarded to the appropriate management for review and sign off as appropriate. Once the approval of recommendations has been made by management, the actions will then be managed through the corrective and preventative action plan process.

5.6.2. Corrective and Preventative Actions

The investigation should identify system failures, corrective and preventative actions and recommendations in order to raise awareness and reduce the recurrence of the incident and minimise the likelihood of harm.

An action plan shall be developed detailing the particular corrective and preventative actions to be undertaken, how they will be implemented, by whom and to what timeline.

All actions implemented shall be monitored for effectiveness by the action implementer. Actions will be entered into the Participant Management System and the person assigned to the action will be responsible for tracking and updating the status of their corrective and preventative actions.

5.6.3. Communication

Email communications and other means are distributed to employees and contractors for their information and to alert them to specific events that have occurred. They may include directives as to actions that must be undertaken as well as advisory information relating to the minimisation of the likelihood of occurrences.

5.7. Final Review and Close Out

When the investigation is complete and actions have been assigned, the incident shall be reviewed a final time, then signed off. The delegated Manager can send the incident investigation for sign off. Investigations can only be signed off by nominated executive management representatives.

6. Investigation by Statutory Authorities

The relevant Work Cover Authority and/or other regulating bodies, have specific responsibility for enforcing health and safety and may be involved in the Valued Lives incident investigation or conduct an independent investigation of their own.

Any requests for information from the Work Cover Authorities or other Regulators must be referred to the Operational Manager immediately so that any appropriate action regarding resolution, compliance or appeals etc., can be taken within the timeframes which apply.

7. Continuous Improvement

Valued Lives is committed to planning and managing the processes necessary for the continual improvement of its supports and services delivered. It will do this through:

- The development of safety and health related policies and procedures;
- The setting of objectives/KPI’s;
- Undertaking audits/inspections and analysing the data from those audits/inspections;
- Identification and analysis of innovations and initiatives;
- Implementing and monitoring corrective and preventative actions; and
- Undertaking management review.

8. Review

This procedure must be reviewed annually or as required with key legislative changes.

9. References

Supporting Documents

Risk Management Policy

Risk Management Procedure

Risk Matrix

ICAM Investigation Template

Incident Report Form

Incident Statement Form

Reference Documents

Occupational Safety and Health Act 1984 (WA)

National Standards for Disability Services

NDIS Quality and Safeguarding Practice Standards

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Chief Executive Officer

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