



(Reference document: [HS307 Hazard & Incident Reporting Procedure](#) , [HS338 HS Issue Resolution Procedure](#))

This guide is to be used for investigating health and safety incidents/issues in the following circumstances:

- (a) A serious incident has been reported, which may need to be reported to the state Regulator (eg.in NSW this is Workcover NSW).
- (b) An incident/issue has been accepted as a Workers Compensation claim;
- (c) An issue that has been previously raised with the worker's supervisor or their work group's Health & Safety representative (HSR), and still remains unresolved.

This incident/issue investigation guide is intended to be used as a prompt for a health & safety incident/issue investigation and subsequent report. Some of the parts may not be applicable in all circumstances and discretion should be used when including any information in an investigation report.

All notes, documents, drawings, statements etc that you collect in the investigation process become part of the records and should be included in the Trim File related to the incident/issue.

Investigation:

The purpose of an incident/issue investigation is to identify any appropriate corrective actions or possible measures to resolve HS issues. It is not intended to assign blame to any party or make assumptions about the actions that may have led to an incident/issue. When a serious incident/issue occurs, there are often many factors which lead to the incident/issue happening, it is the job of the investigation team to determine as many of these individual factors as possible and recommend appropriate corrective actions.

1. If there are any witnesses or persons that were involved in the incident/issue you should attempt to interview them about the incident/issue. Some useful things to remember in interviews are:
 - a. Avoid asking leading questions or prompting the witness (example; Open: Where were you at the time? Leading: You were in the kitchen at the time were you?)
 - b. Document only the facts: what the interviewee said, did or saw
2. The investigation team should inspect the area and/or equipment related to the incident/issue.
3. Photos should be taken wherever possible; these are particularly beneficial to those who may not be familiar with the area.
4. Any test equipment (e.g. air monitor) used must be properly calibrated and within service date.
5. Get copies of risk management forms (SWP's, training records, induction records etc) related to the incident/issue.
6. Narrow down the causes of the incident/issue by a process of elimination. Determine the influence of the following factors on the incident/issue:
 - a. Environment
 - b. People
 - c. Plant/Materials/Substances
 - d. Actions taken
7. Identify any corrective actions to prevent the incident from happening again, or suggested measures to help resolve the health & safety issue.

The investigation report:

The investigation report should be structured according to nature of the incident/issue and the evidence collected in the report. A suggested format for an investigation report is included below:

1. The beginning should include
 - a. a title such as, "Investigation into xyz incident/issue dated xx/xx/xxxx". This should be the same title as the Trim File created for the incident/issue
 - b. the name and position title of the author of the report
 - c. names and positions of the investigation team
 - d. reference to the on-line reporting system details

2. If the investigation team have interviewed or spoken to any witnesses then a summary of their testimony may be included as an appendix/attachment to the incident/issue report.

3. Examine any other evidence collected.

4. Once this is complete the investigation team must assess all the information and evidence and identify the causal factors which may have led to the incident/issue. Immediate causes should be considered first (e.g. equipment failed), however it is important to identify underlying causes (e.g. if there was no maintenance for equipment, why not, is there enough resources available to pay for maintenance?). Addressing immediate causes will help prevent a similar incident/issue from happening again. Addressing underlying causes may help prevent many different incident/issues.

5. Causal factors should only be based on the evidence and where possible should not include assumptions. If assumptions do need to be made then they should be clearly identified as such

6. After these contributing factors have been identified it may be useful for the investigation team to provide some recommendations for improvement or possible measures to help resolve the health & safety issue. It is not always necessary to provide recommendations and this section should only be included if the lead investigator determines it is necessary. This section may simply be entitled "Corrective actions to be considered" or "Possible Measures to resolve issue".

<h2 style="margin: 0;">Incident/Issue Investigation Report</h2>	 <b style="font-size: 2em; margin-left: 10px;">UNSW <small>THE UNIVERSITY OF NEW SOUTH WALES</small>
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Title: Investigation into incident/issue no. XXXXX on xx/xx/xxx
 TRIM File Number: *Same as title*

Investigation report prepared by: [INSERT NAME]
 Investigation team: [INSERT NAMES]

Date: [INSERT DATE REPORT MADE]

Details of the incident/issue:

H ₂ O issue #:	
H ₂ O hazard description:	
Area where incident/issue occurred:	
Date of incident/issue:	Time of incident/issue:
Name of person who reported incident/issue:	Date of report:
Name of injured person (if relevant):	Injury sustained (if relevant):
Workers Compensation Claim accepted:	Yes/No
Reportable to WorkCover:	Yes/No
If yes, reported by:	On: Reference:

Witness details (add extra lines if more witnesses)

Name	Job title	Z-ID
Name	Job title	Z-ID

Full description of events

Briefly describe what happened including the sequence of events, investigate scene of incident/issue; who was involved e.g. worker, visitor; conditions present at time of incident/issue; what was involved, what activity (if any) was taking place prior and at time of incident/issue. What hazards was the person exposed to? What hazards may have contributed to the incident/issue occurring?

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Immediate cause(s) of the incident/issue: e.g. the environmental conditions at the time, action taken by the person/others, equipment failed

Underlying cause(s) of the incident/issue: e.g. lack of or poor: training, induction, SWP, risk management, resources, building/grounds design, management commitment etc

Corrective actions to be considered / Possible measures to resolve issue:		
Corrective action (s) /Measures # *	By who?	Date due:

List any corrective actions that have already been implemented

*All corrective actions must be added to and monitored on the on-line reporting system

Checklist

Witness statement included
Induction records included
Risk management forms included
Records of testing

Photos included
 Training records included
 SWPs included
 Other
