

Safety Investigation Reporting Schedule

1 Purpose

To outline the purpose, content, terminology and terms of reference for safety investigations and reports.

2 Scope

This schedule is subordinate to, and must be read in conjunction with, the Incident and Hazard Reporting and Investigation Procedure.

3 Schedule

3.1 Purpose of safety investigations

The People Portfolio is responsible for investigating safety related incidents and hazards in accordance with the Incident and Hazard Reporting and Investigation Procedure.

The object of a safety investigation is to identify and reduce safety-related risk. The People Portfolio investigations determine and communicate the safety factors related to the safety matter being investigated.

It is not a function of the People Portfolio safety investigation to apportion blame or determine liability. At the same time, an investigation report must include factual material of sufficient weight to support the analysis and findings. At all times the People Portfolio endeavours to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

The methodology used for investigation is primarily based on the work of Professor James Reason which is also used as the basis for other investigation models and systems such as ICAM, Bowtie Method and Tripod Beta. The Reason Model provides a framework for analysing safety and investigating incidents and accidents in modern technical and often complex systems. The basic factors of the model are also very useful when analysing 'simple' incidents. The model can be applied both proactively, by operational managers, and reactively, by accident investigators. The Reason Model concentrates on the human factors involved, as the primary purpose of a safety investigation is to prevent a recurrence and to ensure similar deficiencies or issues are identified elsewhere in the organisation. The investigation studies absent and failed defences, unsafe acts or active failures made by the operator and other key personnel, local Workplace factors and environmental conditions, and organisational and systemic issues.

Although it is not a function of the University's safety investigations to apportion blame, during the analysis of the human factors involved it may be necessary to report findings of routine and exceptional violations. In some circumstances an exceptional violation may show a deliberate action on the part of an individual and this finding may initiate punitive or disciplinary action by the University albeit by other means than the safety report.

3.2 Developing safety actions in detailed and short investigations by the People Portfolio

Central to the People Portfolio investigation of safety matters is the early identification of safety issues. The People Portfolio will encourage the relevant department to initiate proactive safety action that addresses safety issues. Nevertheless, the People Portfolio may make a formal safety recommendation either during, or at the end of, an investigation, depending on the level of risk associated with a safety issue and the extent of corrective action undertaken by the relevant department.

When safety recommendations are issued, they focus on clearly describing the safety issue of concern, rather than providing instructions or opinions on a preferred method of corrective action.

When the People Portfolio issues a safety recommendation to a person or department they are requested to provide a written response and indicate whether they accept the recommendation, any reasons for not accepting part or all of the recommendation, and details of any proposed safety action to give effect to the recommendation.

3.3 Content and organisation of investigation reports

Detailed Investigation Reports	Short Investigation Reports
<p>Safety summary</p> <p>Provides an upfront, one-page summary of</p> <ul style="list-style-type: none"> • what happened; • what the investigation found; • what has been done as a result; and • any broader safety message. 	N/A
<p>The occurrence</p> <p>The occurrence provides a description of the occurrence, sequence of events and, if</p>	<p>The occurrence</p> <p>The occurrence section of a short report provides a description of the occurrence,</p>

<p>relevant, the consequences of the occurrence in terms of injuries and damage. It is an expanded version of the 'What Happened' section of the safety summary.</p>	<p>sequence of events and, if relevant, the consequences of the occurrence in terms of injuries and damage. It contains more detail than the 'What Happened' section in a safety summary.</p>
<p>Context</p> <p>The context provides additional Information necessary to help the reader understand the safety analysis, and to some extent The occurrence. The Information is intended to be relevant to the occurrence, rather than included just because it was collected.</p>	<p>Context</p> <p>The context provides additional Information necessary to help the reader understand the safety analysis, and to some extent the occurrence. The Information is intended to be relevant to the occurrence, rather than included just because it was collected.</p>
<p>Safety analysis</p> <p>The safety analysis provides a detailed discussion of the safety factors identified during the investigation. It provides the evidence and argument required to support the contributing factors and other factors that increase risk, and it is an expanded version of the 'What the investigation found' section of the safety summary. It should also outline the basis for the 'safety message' section of the safety summary.</p>	<p>Safety analysis</p> <p>The safety analysis provides a discussion of the safety factors identified during the investigation. It summarises the evidence and argument required to support the contributing factors and other factors that increase risk. It is an expanded version of the 'What the investigation found' section of a detailed report safety summary.</p>
<p>Findings</p> <p>Based on the analysis of the safety factors identified during the investigation, the findings presents three categories of findings: contributing factors, other factors that increase risk, and other findings.</p>	<p>Findings</p> <p>Based on the analysis of the safety factors identified during the investigation, the findings are presented in simple language and clearly detail the main issues.</p>
<p>Safety issues and actions</p> <p>This section summarises all the 'safety issues', or system problems that were identified during the investigation and details what safety action has been taken, or is planned to be taken by relevant parties to address those issues.</p>	<p>Safety actions</p> <p>This section summarises what safety action has been taken, or is planned to be taken by relevant parties to address those issues. It may also include recommendations on other actions required.</p>
<p>Appendices</p> <p>Contains additional Information that supports the report, for example, specialist reports on materials failure or plant serviceability.</p>	<p>Appendices</p> <p>Contains additional Information that supports the report, for example, specialist reports on materials failure or plant serviceability.</p>

Note: Not all parts described above will be applicable in all circumstances. Reports of less complex investigations, for example, may not include safety action or appendices.

3.4 Terminology used in University safety investigation reports

Investigation report term	Description
Occurrence	Accident or incident.
Safety factor	An event or condition that increases safety risk. In other words, it is something that, if it occurred in the future, would increase the likelihood of an occurrence, and/or the severity of the adverse consequences associated with an occurrence. Safety factors include the occurrence events (e.g. chemical spill, vehicle collision, fall from height), individual actions (e.g. errors and violations), local conditions, current risk controls and organisational influences.
Contributing factor	A safety factor that, had it not occurred or existed at the time of an occurrence, then either: <ul style="list-style-type: none"> • the occurrence would probably not have occurred; or • the adverse consequences associated with the occurrence would probably not have occurred or have been as serious; or • another contributing safety factor would probably not have occurred or existed.
Other factors that increase risk	A safety factor identified during an incident investigation which did not meet the definition of contributing safety factor but was still considered to be important to communicate in an investigation report in the interests of improved safety.
Safety issue	A safety factor that: <ul style="list-style-type: none"> • can reasonably be regarded as having the potential to adversely affect the safety of future operations; and

	<ul style="list-style-type: none"> • is a characteristic of an organisation or a system, rather than a characteristic of a specific individual, or characteristic of an operational environment at a specific point in time.
Other finding	Any finding, other than that associated with safety factors, considered important to include in an investigation report. Such findings may resolve ambiguity or controversy, describe possible scenarios or safety factors when firm safety factor findings were not able to be made, or note events or conditions which 'saved the day' or played an important role in reducing the risk associated with an occurrence.
Safety action	The steps taken or proposed to be taken by a person, department or the University in response to a safety issue.

3.5 Standard Terms of Reference (TOR) for detailed reports

When directed to conduct a detailed investigation by the Chief People Officer, investigators from the University Safety team are authorised to conduct the investigation in accordance with these standard Terms of Reference (TOR) unless directed otherwise by specific TOR or other instruction.

3.5.1 Background

The investigation is to determine the factors that contributed to the incident and provide detailed analysis of those factors, including:

- supplying copies of relevant documentation;
- providing details of any similar incidents in this University, previous similar incidents in other Australian universities or research establishments; and
- describing any actions taken to prevent a recurrence so far.

3.5.2 Scope of the investigation

The investigation will include any, and all, contributing factors that led to the incident, and will address the emergency response (if any).

3.5.3 Reporting requirements

A written report must be provided to the Chief People Officer. The Chief People Officer will distribute the report as deemed appropriate.

During the investigation progress reports will be made regularly to the appointing authority.

3.5.4 Requirements of the investigator

The investigator will take statements and reach findings of fact as well as make recommendations either specific to the events, or more generally.

3.5.5 Investigator's authority

The investigator may contact and interview any University Employee they deem appropriate for the investigation and may access files necessary for the discovery of contributing factors.

3.5.6 Investigator's obligations

The investigator will:

- act fairly, without bias (including disclosing any perceived, potential or actual Conflicts of Interest);
- allow people who are involved in the investigation a full opportunity to participate and provide any Information to the investigation;
- make all reasonable enquiries to gather evidence before making a finding; and
- complete the Workplace investigation in a timely manner.

4 References

Reason, J.T. (1997) *Managing the Risks of Organizational Accidents*.

5 Schedule Information

Accountable Officer	Chief People Officer
Responsible Officer	Executive Director (Facilities Management)
Policy Type	University Procedure
Policy Suite	Work Health and Safety Policy

Approved Date	31/1/2024
Effective Date	31/1/2024
Review Date	3/4/2024
Relevant Legislation	Work Health and Safety Act 2011 (Qld) Work Health and Safety Regulation 2011 (Qld)
Policy Exceptions	Policy Exceptions Register
Related Policies	
Related Procedures	Incident and Hazard Reporting and Investigation Procedure
Related forms, publications and websites	Laboratory and Workshop Safety Manual
Definitions	<p>Terms defined in the Definitions Dictionary</p> <p>Employee</p> <p>A person employed by the University and whose conditions of employment are covered by the Enterprise Agreement and includes persons employed on a continuing, fixed term or casual basis. Employees also include senior Employees whose conditions of employment are covered by a written agreement or contract with the University.</p> <p>Information</p> <p>Any collection of data that is processed, analysed, interpreted, organised, classified or communicated in order to serve a useful purpose, present facts or represent knowledge in any medium or form. This includes presentation in electronic (digital), print, audio, video, image, graphical, cartographic, physical sample, textual or numerical form.</p> <p>Procedure</p> <p>An operational instruction that sets out the process to operationalise a Policy.</p> <p>University</p> <p>The term 'University' or 'UniSQ' means the University of Southern Queensland.</p> <p>Definitions that relate to this schedule only</p>

	<p>Contractor</p> <p>An entity or individual who contracts to perform work for another person or organisation, but is not employed by that person or organisation.</p> <p>Visitor</p> <p>Includes those volunteers, trainees, Researchers and other persons who are engaged in unpaid activities on a University Site or Workplace.</p> <p>Workplace</p> <p>A place where work is carried out for the University and includes any place where a Worker goes, or is likely to be, while at work.</p>
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