GUIDELINE AND PROCEDURE

INCIDENT, NEAR MISS AND HARM REPORTING AND INVESTIGATION

Purpose

The purpose of this document is to ensure the correct reporting and investigation of all workplace incidents causing, or near misses having the potential to cause, illness or injury to our people and others affected by our work.

Correct investigation will give us information that provides a more comprehensive understanding of the risks associated with WorkSafe's work activities and helps prevent future incidents and near misses that have the potential to cause illness or injury.

This procedure is informed by the related policy statement (see Appendix 1).

Scope

This document applies to all workers on a WorkSafe site or carrying out Worksafe business. This includes WorkSafe employees, contractors, consultants and casual or volunteer workers.

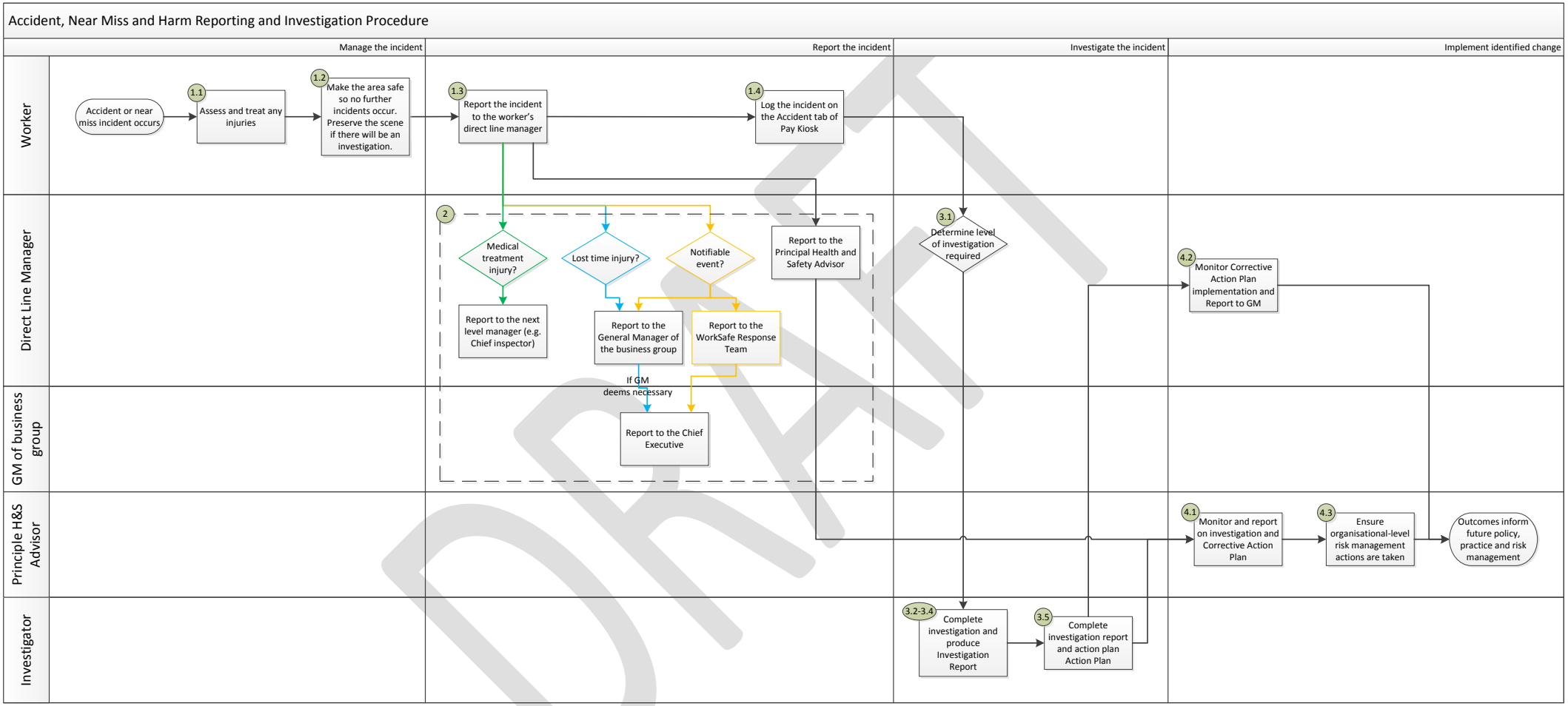
Quality expectations

WorkSafe workers are expected to adhere to the following procedure in order to:

- Ensure incidents, near misses and harm incidents are reported to the correct people at the correct time
- Ensure events are investigated in a consistent way
- Provide better understanding of the risks associated with our work activities so incidents and near misses can be prevented in the future.
- Ensure WorkSafe is exemplifying best-practice health and safety reporting.

PROCEDURE

Procedure Map



<table>
<tr><td colspan="3">1. Manage the event</td></tr>
<tr><td>1.1</td><td>Treat any injuries</td><td>1. Assess the situation and the level of seriousness of injury
2. If the seriousness of the injury warrants it, call an ambulance
3. Take any immediate steps to treat injuries and provide comfort to injured or harmed people</td></tr>
<tr><td>1.2</td><td>Make the area safe</td><td>1. Control any immediate risks to the injured person or others.
2. If the illness or injury constitutes notification under the HSWA, preserve the scene.
➲ The only interference that should occur in a notifiable event is to:
• Save life
• Prevent harm to or relieve the suffering of any person
• Maintain access of the general public to a central service or utility
• Prevent serious damage to, or serious loss of, property.
3. Record witness names and other key details in preparation for an investigation</td></tr>
<tr><td>1.3</td><td>Report the incident to management</td><td>1. Notify the injured worker’s direct line manager of the event immediately or as soon as practical depending on the seriousness of the incident. If possible before the injured person seeks minor medical treatment. This allows the manager to support the person appropriately.
2. For sensitive incidents (see Definitions), discuss reporting options with the Principal Health and Safety Advisor as it may not be appropriate to report to or be investigated by the individual’s direct manager. The reporting and investigation may be undertaken by the manager’s manager, Principal Health and Safety Advisor, Human Resource Consultant or an independent person.
3. If the incident occurs at a PCBU site, report to the PCBU as well as through WorkSafe internal processes as there may be overlapping duties.</td></tr>
<tr><td>1.4</td><td>Log the incident in Pay Kiosk</td><td>1. If the injured person is able, they must report the incident in the Report Incident tab of the Pay Kiosk as soon as possible. Incidents must be reported within 48 hours of occurrence. See Appendix 2 for instructions on how to do this.
2. Where the reporting tool is not adequate to fully record the incident and investigation a manual form Incident Investigation Form must be completed and recorded as an action as part of the online reporting tool. Manual Forms must be sent to internalhealthandsafety@worksafe.govt.nz.
3. Where a worker does not have access to Pay Kiosk (e.g. a contractor), their manager is accountable for reporting incidents on their behalf.
➲ If the worker attends a traumatic serious injury or a fatality, they must debrief with their manager, however it is not mandatory to report an incident in Pay Kiosk unless they feel adversely affected by the incident either at the time or at any time afterwards.</td></tr>
<tr><td colspan="3">2. Escalating the report of an event</td></tr>
<tr><td>2.1</td><td>Determine event type</td><td>1. The injured/ill worker, responder or direct line manager determines whether the incident is a notifiable event, lost time injury or medical treatment injury.
➲ The WorkSafe website has guidance on what is a notifiable event. Also see Appendix 5 – Definitions, in this document.</td></tr>
<tr><td>2.2</td><td>Notify relevant roles</td><td>1. The direct line manager will report the event as follows as soon as practicable:
<table>
<tr><th>Event type</th><th>Report to</th><th>Escalate to</th></tr>
<tr><td>Notifiable event as soon as it is identified as notifiable</td><td>1. The WorkSafe Response Team (using the Notify WorkSafe tool on the WorkSafe website https://worksafe.govt.nz/notify-worksafe or phone 0800 030 040)
2. GM of the applicable business group</td><td>Chief Executive</td></tr>
</table></td></tr>
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			Lost Time Injury *or* Medical Treatment Injury	GM of the applicable business group or Chief Inspector (if relevant)	Chief Executive

2. In all cases, notify the Principal Health and Safety Advisor.

3. Investigate an incident and develop Action Plan		
3.1	**Determine level of investigation required**	1. The direct line manager determines the level of investigation required by considering: • The actual or potential **consequences** of an incident or near miss and the **likelihood** of it recurring, • The injury or illness suffered • The potential for learning lessons from the investigation and/or gaining greater insight into the risks associated with the work being undertaken. • If there have been a number of similar incidents or near misses an in-depth investigation may be appropriate, even if the potential consequences don't warrant it. ➲ *The matrix in Appendix 3 will assist in determining the appropriate level of investigation.*
3.2	**Complete Level 1 investigation**	1. The direct line manager undertakes a short investigation or review, commencing within five days of notification. ➲ *Appendix four – The Investigation Process provides guidance on how to complete an investigation* 2. Determine the circumstances and the immediate, underlying and root causes of the incident. 3. Complete the investigation section of the kiosk reporting process. If more information is available or required complete a Level 1 Incident, Near Miss Investigation Report 4. Submit the report to the Principal Health and Safety Advisor via internalhealthandsafety@worksafe.govt.nz.
3.3	**Complete Level 2 investigation**	1. The direct line manager leads an investigation team comprising a health and safety representative and (where relevant) other employee/management representatives. ➲ *Appendix four – The Investigation Process provides guidance on how to complete an investigation* 2. The investigation team will undertake a more detailed review, looking for immediate, underlying and root causes 3. The review must be completed within one month of incident date. This can be extended by agreement with the relevant General Manager. 4. Complete the Level 2/3 Incident, Near Miss Investigation Report. 5. A detailed corrective action plan will be identified from the Level Two investigation. 6. Submit the report to: o The General Manager responsible for the area of the business where the incident occurred o The Principal Health and Safety Advisor via internalhealthandsafety@worksafe.govt.nz

3.4	**Complete Level 3 investigation**	1. The relevant General Manager appoints an investigation team within five working days of the incident. 2. The team will include manager/s, health and safety representatives, and employee representatives. Availability and geographic location of team members must be considered. 3. The team may include specialist expertise from within, or external to, WorkSafe. 4. The investigation will be carried out under the supervision of a senior manager. ➲ *Appendix four – The Investigation Process provides guidance on how to complete an investigation* 5. The investigation team will undertake a more detailed review, looking for immediate, underlying and root causes 6. The review will ideally be completed within one month of the incident date. This can be extended by agreement with the relevant General Manager but should not exceed 3 months. 7. Complete the Level 2/3 Incident, Near Miss Investigation Report. 8. A detailed corrective action plan will be identified from the Level 3 investigation.
3.5	**Submit Investigation report**	1. Submit the investigation report to: • The General Manager responsible for the area of the business where the incident occurred • The Principal Health and Safety Advisor via internalhealthandsafety@worksafe.govt.nz
4. Outcomes of the investigation		
4.1	**Local or group Change**	1. The direct line manager is accountable for implementing and monitoring any local change identified in the action plan.
4.2	**Organisational Change**	1. The Relevant General Manager is accountable for implementing and monitoring any business or organisation-wide national change identified in the action plan.
4.3	**Review report**	1. The Principal Health and Safety Advisor reviews the report to identify key trends, lessons and information on how to improve WorkSafe's safety culture, and to inform future policy, practice and risk management.

ACCOUNTABILITIES AND RESPONSIBILITIES

Workers

Responsibilities:

- Report all incidents and near misses that cause, or have the potential to cause, workplace illness or injury.
- Participate fully in any incident or near miss investigation.
- Participate fully in any corrective actions that result from incidents or near miss investigations

Direct Line Managers

Accountabilities:

- Ensure all incidents or near misses that occur within a workplace or involve a worker they are responsible for, and all incidents or near misses they become aware of, are reported.
- Ensure all reported incidents or near misses that occur within a workplace or involving a worker they are responsible for, are investigated.

Responsibilities:

- Undertake incident and near miss investigations in accordance with this procedure.
- Monitor the completion of corrective action plans arising from incident and near miss investigations they are responsible for undertaking and/or those that occur within the workplace(s), or involve the worker(s), they are responsible for.

- Complete, within required timeframes, corrective actions assigned to them through incident and near miss investigations.

General Managers

Responsibilities:

- Oversee all incident and near miss investigations within their area of responsibility.
- Monitor the completion of incident and near miss investigation action plans within their area of responsibility.
- Ensure all incident and near miss investigation actions are completed within required timeframes.
- Report to SLT on incident and near misses, investigation outcomes, and action plan implementation progress within their area of responsibility.

Health and Safety Representatives

Responsibilities:

- Support and encourage the full and timely reporting of incidents and near misses that do or may cause harm
- Participate in the incident and near miss investigation process where required to do so, including the implementation of corrective actions resulting from incident and near miss investigations
- Share learnings from incident and near miss investigations with other health and safety representatives, and workers and managers

Principal Health and Safety Advisor

Responsibilities:

- Monitor, analyse and report on incidents and near misses, including investigation outcomes, to the Senior Leadership Team and the WorkSafe NZ Board
- Monitoring the completion of incident and near miss investigations, and resulting corrective action plans
- Identify key trends and learnings that provide information on how to improve our safety culture, and ensure our workplaces remain free from harm.
- Communicating key findings and trends from incident and near miss investigations that have national implications
- Identifying and acting on improvements to risk management and mitigation through analysis of incidents and near miss reports and investigations

RELATED DOCUMENTS

Health and Safety at Work Act

Health, Safety and Wellbeing Policy

APPENDIX 1 – INCIDENTS, NEAR MISS AND HARM REPORTING AND INVESTIGATION – POLICY STATEMENT

When an incident occurs on a WorkSafe site or while carrying out WorkSafe business, we are committed to investigating it and taking steps to ensure that we reduce or minimise the risk of harm to our people.

We want to ensure that all incidents and near misses that cause, or have the potential to cause, harm (workplace illness or injury) are reported as soon as possible and must be within 48 hours of occurring and investigated to provide a more comprehensive understanding of the risks associated with our work activities and prevent future workplace accidents and near misses that have the potential to cause illness or injury.

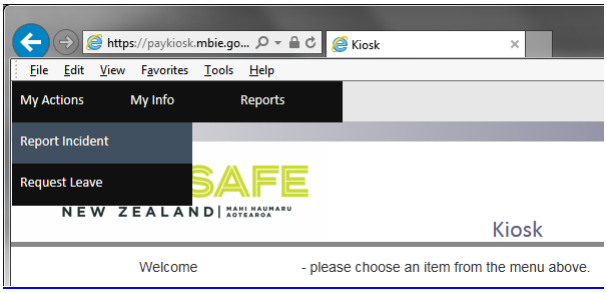
Incidents requiring medical treatment or lost time (>1 day off work) must be proactively managed, ensuring medical providers know that alternative duties may be available and early return to work programmes are the norm in WorkSafe. All medical treatment and lost time injuries must be reported to the General Manager and any lost time injury must be reported to the Chief Executive.

Where an incident results in a notifiable event, the incident must be reported immediately to the Chief Executive, the relevant senior manager and the Principal Health and Safety Advisor.

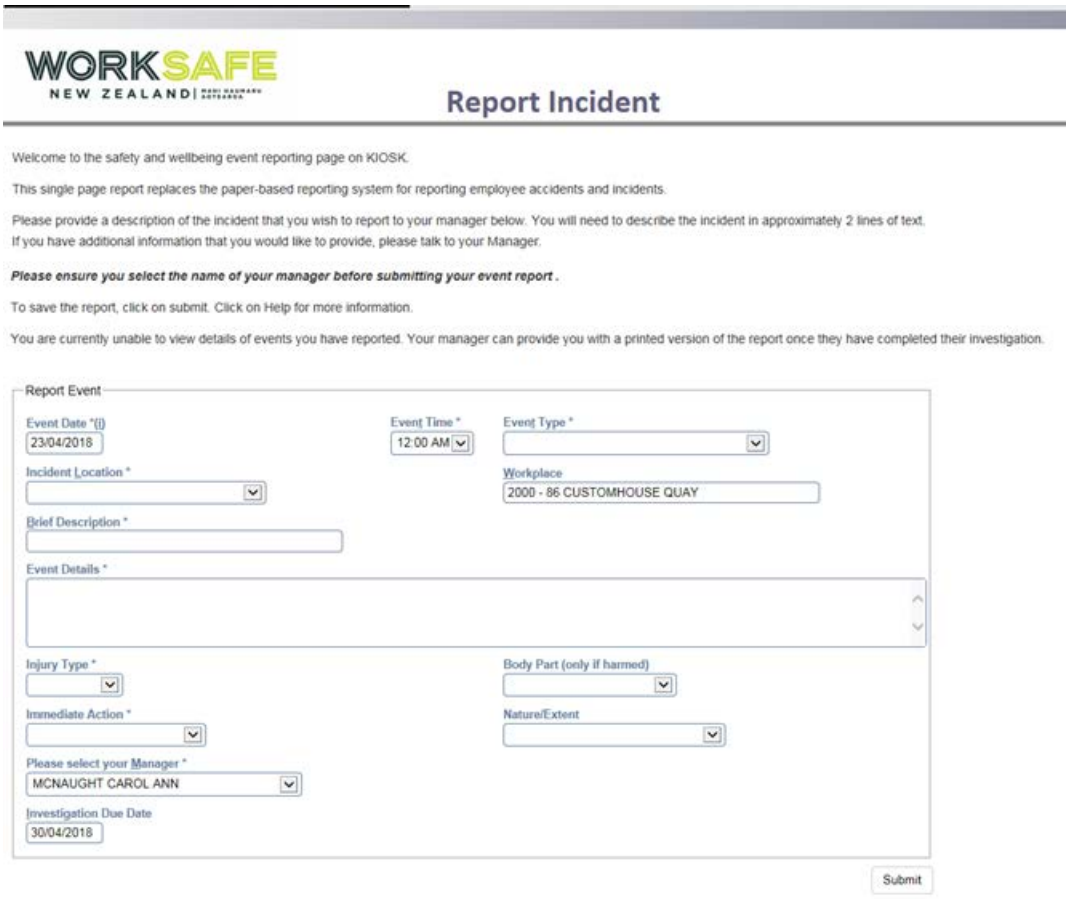
APPENDIX 2 - REPORTING AN INCIDENT IN PAYROLL KIOSK

Access the Incident Reporting tool in the payroll kiosk.

- Log in to the payroll kiosk. Select the My Actions tab, then Action Incident Report from the dropdown menu.



- Complete all required details, including the direct line manager, and then submit.



Where a worker does not have access to the pay kiosk (e.g. a contractor), their manager is accountable for reporting incidents on their behalf.

APPENDIX 3 – DETERMINING THE LEVEL OF INVESTIGATION REQUIRED

Use the matrix below to determine the appropriate level of investigation required, taking into account the worst possible consequences.

The matrix indication should be used as a guide, and discretion exists for the responsible manager to elevate the level of investigation required based on other factors such as the number of similar near misses that have occurred in the past.

	Likelihood of Recurrence (L)				
Potential Worst Possible Consequences (C)	Rare	Unlikely	Possible	Likely	Certain
Fatal	Level 3	Level 3	Level 3	Level 3	Level 3
Major	Level 2	Level 2	Level 3	Level 3	Level 3
Serious	Level 2	Level 2	Level 2	Level 2	Level 2
Minor	Level 1	Level 1	Level 1	Level 2	Level 2

Medical Treatment and Lost Time Injuries are to be investigated at level 2 or 3 as requiring medical treatment or lost time (>1 day) away from work constitute a serious incident.

If the incident involves one of WorkSafe's critical risks, this is to be considered when determining the level of investigation required. The crtical risks are:

1. Driving vehicles while working,
2. Aggressive and Threatening behaviour,
3. Psychosocial harm from Trauma
4. Psychosocial harm from work related stress

APPENDIX 4 – THE INVESTIGATION PROCESS

There are four key steps in the investigation process:

Step One: Gather Information

Step Two: Analyse the Information

Step Three: Identifying suitable risk control measures

Step Four: Develop and implement the Action Plan

The appropriate Investigation Report template should be used to record the information gathered, the analysis and the conclusions:

- Level 1 Incident or Near Miss Investigation Report
- Level 2 or 3 Incident or Near Miss Investigation Report

Step One: Gather Information

Talk to witnesses and observe the scene to find out what happened and what factors contributed to the incident or near miss event. This initial information gathering should start as soon as possible after the event occurred as the sooner the information is collected the more accurate it is likely to be.

The amount of time and effort spent gathering information should be proportionate to the level of investigation being undertaken.

At the end of this step you should be able to answer "where, when and who" in relation to the event with as much certainty as possible i.e. Where and when did it happen? Who was (or was potentially) injured/suffered ill health? What did others see, hear, observe prior to, or at the time?

Once the initial details have been clarified, the focus should move to discovering what happened. This can involve quite a level of investigative work. At the end of this stage these questions should be answered with as much certainty as possible:

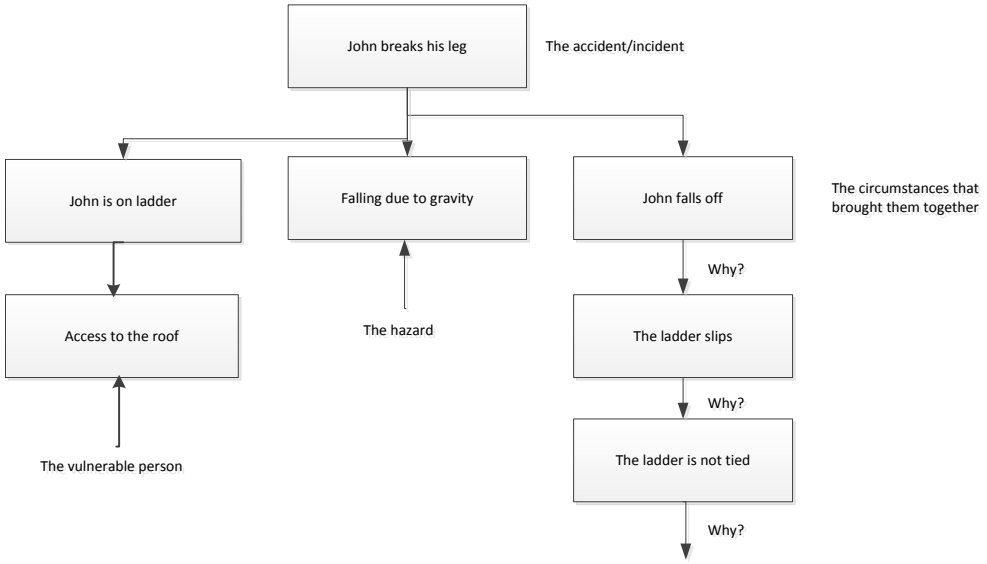
- How did the incident or near miss happen?
- What plant and equipment was involved in the incident or near miss?
- What activities were being carried out at the time?
- Was there anything unusual or different about the working conditions?
- Were there adequate safe working procedures and were they followed?
- What injuries or ill health effects, if any, were caused?
- If there was an injury, how did it occur and what caused it?
- What injuries or ill health effects could have been caused?
- Was the risk known? If so, what controls, if any, were in place, and how effectively did they work? If controls were either not in place or not working, why was this case?
- Did the organisation and arrangement of the work influence the event?
- What other factors relating to equipment and materials contributed to the event e.g. maintenance, materials, plant, equipment?
- Was the safety equipment sufficient?
- What other factors not already identified may have, or did influence the event?

Step Two: Analyse the Information

The purpose of this step in the investigation is to understand why the incident or near miss occurred and identify the immediate, underlying and root causes that led to the incident or near miss occurring:

- The immediate causes are the most obvious reasons why an incident or near miss occurs.
- The underlying causes are initiating events or failings from which all other causes or failings result.
- The root causes are the less obvious 'system' or 'organisational' reasons for an incident or near miss happening.

The first stage in understanding what happened is to use the technique of asking "why" over and over until the answer is no longer meaningful. Start from the point of the incident or near miss itself.



Once you have done this the focus turns to determining the immediate, underlying and root causes. Continue to ask "why" in your analysis of the event to ensure that you have identified not just the immediate cause (in the example above, the ladder not being tied) but all of the influences that contributed to that immediate cause.

If your investigation concludes that errors or violations contributed to the adverse event, thought will need to be given on how to handle this information. Not addressing the "human" factors will greatly reduce the value of the investigation. Laying all of the blame on one or more individuals is counter-productive and could potentially undermine our safety culture. There will often be deeper underlying reasons why an error or violation occurred that links back to the organisation's safety culture. Your investigation needs to uncover these in order to prevent similar recurrences.

Step Three: Identifying suitable risk control measures

The analysis undertaken in step two will likely have identified a number of risk control measures that failed, were not implemented effectively, or were not in place that could have prevented the incident or near miss from occurring.

Evaluate and make recommendations on risk control measures that should be implemented or addressed, and prioritise these controls.

You also need to consider whether similar risks exist elsewhere and make recommendations on steps that could be taken to address those risks.

Finally, determine whether similar incidents or near misses have occurred previously and consider why they have occurred again. This analysis also needs to be considered in identifying and recommending risk control measures and other actions that should be taken as a result of your investigation.

Step Four: Develop and implement the Action Plan

The final, critical step in the investigation process is the implementation of the action plan. All investigation reports and action plans must be submitted to the Principal Health and Safety Advisor and the relevant General Manager who is accountable for monitoring and report on progress of the action plan.

For Level 1 and Level 2 investigations, the direct line manager is accountable for implementing the action plan within an agreed timeframe. This does not mean that the line manager has to personally undertake all of the actions, but they must ensure they occur. If required, the line manager can seek the support of their General Manager in implementing the action plan.

The Principal Health and Safety Advisor is also accountable for actions that need to be implemented at a national level, rather than a site or functional level.

APPENDIX 5 – DEFINITIONS

Direct line manager	The line manager directly responsible for an injured/ill worker or the site where the incident or near miss occurred.
Event	An incident or situation, which occurs in a particular place during a particular interval of time (AS/NZS 4360:1999).
Near miss	An event that, while not causing harm, has the potential to cause injury or ill health.
Immediate cause	The most obvious reason why an incident or near miss occurs.
Incident	Any unplanned event resulting in, or having a potential for injury, ill health, damage or other loss.
Injury	Tissue damage resulting from either the acute transfer to individuals of one of the five forms of physical energy (kinetic or mechanical, thermal, chemical, electrical or radiant) or the sudden interruption of normal energy patterns to maintain life processes.
Illness	A departure from a state of health. A disease or sickness.
Investigator	A person who carries out a health and safety investigation, a direct line manager or someone else assigned by the GM.
Notifiable event	• The death of a person • A notifiable injury or illness • A notifiable incident.
Notifiable Incident (HSWA)	An unplanned or uncontrolled events in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health and safety arising from an immediate or imminent exposure to one of a categories of events: • Escape, spillage, or leakage of a substance • Implosion, explosion or fire • Escape of gas or steam • Escape of a pressurised substance • Electric shock • Fall or release from a height of any plant, substance or height • Collapse, overturning, failure, or malfunction of, or damage to ,any plant that is required to be authorised for use in accordance with regulations • Collapse or partial collapse of a structure • Collapse or failure of an excavation or any shoring supporting an excavation • Inrush of water, mud, or gas in workings underground excavation or tunnel • Collision between 2 vessels, a vessel capsize, or in inrush of water into a vessel • Any other incident prescribed declared by regulations to be a notifiable incident for this section
Notifiable Injury or Illness (HSWA)	One of the injuries or illnesses listed below, where it requires immediate treatment (other than first aid): • The amputation of any part of his or her body • A serious head injury • A serious eye injury • A serious burn • The separation of skin from underlying tissue (such as de-gloving or scalping) • A spinal injury • A loss of bodily function • Serious lacerations • An injury or illness that requires, or would usually require, the person to be admitted to a hospital for immediate treatment • An injury or illness that requires, or would usually require, the person to have medical treatment within 48 hours of exposure to a substance • Any serious infection (including occupational zoonoses) to which the carrying out of work is a significant contributing factor, including any infection that is attributable to carrying out work: o with micro-organisms; or o that involves providing treatment or care to a person; or o that involves contact with human blood or bodily substances; o or that involves handling or contact with animals, animal hides, animal skins, animal wool or hair, animal carcasses, or animal waste products; or o that involves handling or contact with fish or marine mammals • Any other injury or illness declared by regulations to be a notifiable injury or

	illness under section 23 of HSWA.
Root cause	An initiating event or failing from which all other causes or failings result.
Senior Manager	A person who is a manager of managers.
Sensitive Incident	An incident or near miss where it is workplace factors adversely affecting an individual's health and safety e.g. work-related stress, work place relationship issues which result in the worker feeling they are negatively impacted at the time.
Underlying cause	The less obvious 'system' or 'organisational' reason for an incident or near miss happening.
Worker	Anyone who carries out work for WorkSafe including: employees, contractors and sub-contractors and their employees, a person gaining work experience or work trial or a volunteer.