Australian Forest Products Association

INDUSTRY GUIDELINE

FORESTRY OPERATIONS AHEAD

Date issued: 01 June 22

Guideline #: G22-02

Completing an effective incident investigation

The primary purpose of an incident investigation is to identify any unsafe conditions, acts, or procedures that may have contributed to the injury or near miss incident and prevents others from being injured in the same manner.

AN EFFECTIVE INVESTIGATION PROCESS INVOLVES:

1. Gathering Information (physical observation and witness statements)
2. Establish and review the facts (if possible, establish the timeline of events that resulted in the incident occurring)
3. Work backwards through the sequence of events to identify all possible contributing factors
4. Finding the Root Cause (s) - **G22-03 Root Cause Analysis** available for further assistance
5. Consider and implement short and long term corrective actions

Being on-site as soon as possible after the event allows you to observe the conditions as they were at the time of the incident, take photos, gather any relevant evidence, and speak with witnesses to fully understand the chain of events that led to the incident occurring.

DO:

- ✓ Be curious and approach the investigation process with an open mind
- ✓ Investigate all incidents even when the root cause seems obvious
- ✓ Investigate programs, not behaviours
- ✓ Focus on identifying root cause, not on establishing fault
- ✓ Preserve the scene and notify WorkSafe if required to do so
- ✓ Commence investigations as soon as possible while the facts are still fresh in peoples minds

DO NOT:

- × Make assumptions
- × Focus on finding fault or blame
- × Rush the process. It takes as long as it takes.
- × Interrogate witnesses. This is an investigation, not a courtroom
- × Get caught up in what 'might have happened'. Stick to the facts
- × Hide or tamper with evidence
- × Be afraid to ask for help. If you require assistance your manager, safety professional, machine manufacturer or client (if you are a contractor, your forest manager) will be able to assist

DOES THE INCIDENT INVESTIGATION ACHIEVE THE DESIRED RESULTS?

All incidents—regardless of size or impact—should be investigated.

At the completion of the investigation, ask yourself, can you answer these five (5) important questions?

- ☐ **WHAT** happened?
- ☐ **HOW** did it happen?
- ☐ **WHY** did it happen?
- ☐ **WHAT** can we learn?
- ☐ **WHAT** needs to change?

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1. FIRST THINGS FIRST...

1. Preserve the scene—try to stop people clearing up before you have an opportunity to record all the details
2. Take photos (if possible)
3. Sketch the scene—include measurements (distance, height, lengths etc..) and identify landmarks or permanent features of the site as reference points
4. Note down the names of the people involved, the equipment involved and the names of any witnesses.

It is important to get a brief statement from the employee and any witnesses directly involved in the incident as soon as possible as details quickly get forgotten.

Workers will understandably be nervous and perhaps reluctant to talk openly about the incident, particularly if they think they, or someone else will get in trouble. Try to put them at ease and remind them that the facts will be used to ensure the same incident doesn't happen again.

2. TAKING STATEMENTS

Discovering what happed can involve a bit of detective work. Facts may conflict. This is completely normal as different people will have a different perspective.

It is often better to talk one on one with those involved to avoid a group response. If the interviewee is nervous, they may prefer to have a support person present, however this person should not speak or involve themselves in the investigation.

The statement should:

- Include name, date, occupation and address of the witness
- Be written in short paragraphs
- Refer to all relevant events, people, places and dates in a logical way
- Include factual statements of what the witness saw, heard and did
- Be written in the workers own words
- Be signed by the witness as a true and accurate account

When conducting an interview, remember:

- There is no right or wrong answer
- There are no "magic questions" to ask when interviewing someone. But you will never fail if you ask the "who, what, where, when, why and how" questions.
- Ask mainly open ended questions. Avoid close-ended questions (unless seeking clarification). This type of question typically results in a yes / no answer or a brief statement at most.
- Ask simple, straightforward questions.
- Ask one question at a time, and allow the worker to finish before asking another
- Don't correct or imply what may or may not have happened. Simply record the facts, in their own words.
- Reflect back to the interviewee the factual information and correct any inconsistencies
- Ask individuals what they think could have prevented the incident, focusing on the conditions and events preceding the incident

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3. GET THE FACTS

1. Examine the scene of the incident and look for things that will help you to understand what happened.
2. Collect any other information that might be useful, including:
   - Equipment manual and maintenance records / logs
   - relevant legislation, codes of practice and/or industry standards or guidelines
   - Safety Data Sheets (If chemicals were involved)
   - Company policies or procedures
   - Training records, toolbox talk records
   - Audit and follow-up reports
   - Any previous corrective action recommendations

4. ANALYSE AND DETERMINE THE CONTRIBUTIONG FACTORS

Once the facts are gathered, the information should be analysed. This involves examining all the facts; ultimately to establish what factors (the 'Why') led the incident to occur.

Contributing factors can be grouped into 4 main categories:

ENVIRONMENTAL FACTORS: includes noise, light, heat, vapours, fumes, dust and site layout / design, or poor housekeeping

EQUIPMENT / MATERIAL FACTORS: includes inadequate maintenance, inadequate guarding, equipment failure, plant equipment not fit for purpose

SYSTEM FACTORS: includes inadequate training / supervision, no or inadequate SOP, no or inadequate controls in place, hazard previously not reported (not in risk register), no scheduled inspection program for equipment

HUMAN BEHAVIOUR FACTORS: Fatigue, drugs / alcohol, distraction, personal issues, stress, production pressures, procedure not followed, lack of communication

All the detailed information gathered should be closely examined to identify what information is relevant and if any information is missing. Sometimes during the analysis process, further information will be required. The process of gathering information and analysis should continue until you are satisfied you have all the answers.

For simple investigations, sometimes the root cause will be obvious and no further formal

For more serious incidents requiring a more complex investigation, root cause analysis is required.

Refer to **Industry Guideline G22-03 Root Cause Analysis** for further information.

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QUICK REFERNECE GUIDE FOR SAFETY INVESTIGATIONS

The following is not intended as a checklist and it is not expected that you will be able to answer all the questions, for every investigation, simply a prompt to help guide your enquiry.

As you gather information about the incident, ask yourself , do you know.....

WHAT?

- What was the incident / injury?
- What activity was being undertaken at the time?
- What tools / equipment was involved?
- What protective equipment was / should have been used?
- What did the employee / witness see?
- What did the employee / witnesses do immediately following the incident?

WHERE?

- Where did the incident occur?
- Where was the employee standing / working at the time?
- Where was the supervisor?
- Where were other workers?
- Where were the witnesses when incident occurred?

WHO?

- Who was injured?
- Who witnessed the incident?
- Who was working with the employee?
- Who instructed / assigned the employee the task?

WHEN?

- When did the incident occur?
- When did the employee start on that site?
- When was the employee trained / re-trained?
- When was the equipment involved serviced?

WHY?

- Why was the employee injured?
- Why and what did the employee do?
- Was protective equipment used– why not?
- Why was the employee using that tool or that machine?
- Why wasn't the supervisor there at the time?

HOW?

- How did the employee get injured?
- How could the employee have avoided it?
- How could fellow workers have avoided it?
- How could supervisors have prevented it—could it be prevented?

As you begin to analyse the information you are gathering, ask yourself if you have.....

- Identified the immediate and all underlying root causes?
- Identified risk control measures that are needed / recommended to prevent further incident?
- Identified which risk assessments / safe work procedures need to be reviewed?