ThinkSafe Event Reporting Guidelines

Purpose:
To define the process for reporting health and safety events, including requirements for reporting High Potential Incidents.

Scope:
All sites, all personnel.

Definitions:

Event: An unplanned or uncontrolled outcome of a business operation or activity that has or could have, contributed to an injury or physical damage or environmental damage. Events include incidents and near misses.

First Aid Case (FAC): Cases which are not sufficiently serious to be reported as medical treatment or more serious cases, but nevertheless require minor first aid treatment, e.g. dressing on a minor cut, removal of a splinter from a finger.

Medical Treatment Injury (MTI): Cases that are not severe enough to be reported as fatalities or lost workday cases or restricted workday cases, but are more severe than requiring simple first aid treatment.

Restricted Workday Case (RWC): Any work-related injury other than a fatality or lost workday case which results in a person being unfit for full performance of the regular job on any day after the occupational injury.

Lost Time Injury (LTI): Any work-related injury or illness, other than a fatal injury, which results in a person being unfit for work on any day after the day of occurrence of the occupational injury.

Fatality (FAT): Loss of life.

Permanent Total Disability (PTD): Any work-related injury that permanently incapacitates an employee and results in termination of employment.

High Potential Incident (HPI): Could have realistically resulted in one or more fatalities.

Near Miss: An unplanned or uncontrolled event or chain of events, that has not resulted in injury or physical damage but had the potential to do so in other circumstances.

Potential Consequence: A reasonably foreseeable, but unrealised, consequence associated with an event. Potential outcomes must be based on the basis of realistic worst-case scenario considering, whether a similar event could re-occur with higher consequences (i.e., in a different environment).

Table 1
Use the Matrix below to determine if a full investigation is required (AA), or if identifying the immediate cause is sufficient (CC).

	Actual Severity					
Potential Risk	HPI	FAT	LTI (PTD)	LTI (other) RWC MTI	FAC	Near Miss
Very High	AA	AA	AA	AA	CC	CC
High	AA	AA	AA	AA	CC	CC
Moderate	AA	AA	AA	CC	CC	CC
Low	AA	AA	AA	CC	CC	CC

WorkSafe Notifications need to occur as soon as possible for events which reach certain thresholds. Details can be found on the following link https://www.worksafe.govt.nz/notifications/notifiable-event/what-is-a-notifiable-event/#lf-doc-39637

Immediate Cause Identification (CC)

Use the '5 Why' techniques to identify the immediate cause

The primary goal of the technique is to determine the root cause of a defect or problem by repeating the question "Why?". Each answer forms the basis of the next question. The "five" in the name derives from an anecdotal observation on the number of times the question needs to be asked to resolve the problem.

Not all problems have a single root cause. If one wishes to uncover multiple root causes, the method must be repeated asking a different sequence of questions each time.

Example:

The Event: A worker slips and falls and suffers an injury.
1st Why: There was a puddle of oil on the plant floor.
2nd Why: Oil spilled from a compressor.
3rd Why: An oil leak from the compressor was not detected.
4th Why: The compressor was not inspected on a regular basis and repaired (if required).
5th Why and the Root Cause: The compressor was not in the maintenance system.

Event Guidelines
It is recommended that you do the following as soon as possible, following an event occurring.

- Take appropriate action to make the area safe and prevent escalation of the situation
- Implement appropriate Emergency Response Procedures
- Determine whether the event justifies standing down all operations
- Notify relevant authorities as required (WorkSafe, Client etc.)
- Classify the incident as per ***Table 1.***

If a Full Investigation (AA) of Work Safe notification is required, complete the following:

- Preserve the scene to retain valuable information
- Conduct substance abuse testing as appropriate
- Statement from Injured Person obtained
- Witness Statements (those present at scene, first aider, first on scene etc.) obtained
- Photos taken of incident scene as soon as possible after the incident and/or items directly related to the incident
- Describe the details in the order of what happened before, during, and after the incident
- Create a chronological timeline of events/details leading up to the incident. How far back in time? As far as required to gather the relevant and useful data (Jim started at 0700, attended toolbox meeting…etc.)

Take notes on the following:

- Exact time and location of the incident
- Weather conditions at time (if applicable)
- Working conditions at location and time of the incident (poor lighting, extreme temperature, time pressure, confined space etc.)
- List all people who were present in the area
- List all plant, equipment or substances that were involved

Contact ThinkSafe on support@thinksafe.co.nz. We will send you an ***Incident Details*** form. Complete this form, return to us for review and we will make recommendations on the next steps to take.

Full Investigation Report (AA) Guidelines

1. Appoint an Investigation Team (highly recommend Leadership / Management involvement for serious events)
2. Organise meeting to define the terms of reference (investigation objective / what will be investigated?)
3. Define investigation schedule
4. Agree on action plan
5. Collect relevant evidence needed for investigation
6. Determine sequence of events leading up to and immediately after incident
7. Identify causal factors
8. Identify root cause
9. Identify corrective actions, responsibilities for follow up and target dates
10. Identify lessons learned
11. Write Investigation Report which should consist of the following information:
    - Executive summary
    - Events leading up to the incident
    - Full incident description
    - Results of the investigation
    - Significant findings and factors
    - Conclusion
    - Corrective actions
    - Appendices
12. Review Report
13. Distribute report to appropriate levels of management / within organisation
14. Communicate lessons learned within organisation and with various stakeholders