Guideline to conducting an investigation into a health and safety incident
Introduction

The Department of Education (the department) has a duty under the Work Health and Safety Act 2011 (Qld) to ensure where reasonably practicable, the health and safety of employees, students and other persons by identifying hazards, assessing risks that may result because of the hazards, and deciding on appropriate control measures to prevent or minimise the levels of risk. To fulfil this duty the department is committed to investigating health and safety incidents.

When a health and safety incident occurs within a workplace, a thorough investigation assists in determining the cause of the incident and allows for corrective action or solutions to be implemented. This is to prevent the recurrence of the incident and to minimise or eliminate any current or future risk.

It is important to remember that health and safety investigations are never conducted, under any circumstances, to apportion blame or liability for what occurred. A health and safety investigation must be a ‘no blame investigation’.

The scope and complexity of any health and safety investigation should mirror the actual or potential seriousness of the incident. To assist employees in determining the seriousness of an incident the department has established the following four classes to assist in the classification of a health and safety incident.

<table>
<thead>
<tr>
<th>Class A</th>
<th>Class B</th>
<th>Class C</th>
<th>Class D</th>
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<tbody>
<tr>
<td>• Serious injury</td>
<td>• Injury</td>
<td>• Minor injury or incident</td>
<td>• Psychological-related injury</td>
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<td>• Dangerous incident</td>
<td>• Near miss or potential event</td>
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<td>• Work-caused illness</td>
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<td>• Serious electrical incident</td>
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Refer to the Health and Safety Incident Investigation procedure for further class definitions.

While every endeavour should be made to attend the incident scene as soon as possible in order to commence the investigation (or immediately as in the case of a Class A incident), it is understandable that in some regional circumstances this may not always be practicable.

In circumstances where the appointed health and safety investigator is unable to immediately attend the scene of a Class A incident, it may be necessary to contact the officer in charge of the workplace and request arrangements for photographs to be taken and witnesses identified.
Investigation process
The investigation process consists of seven steps:

1. Immediate action
2. Plan the investigation
3. Collect information
4. Organise information
5. Analyse information
6. Recommend solutions
7. Report outcomes

**Step 1: immediate action**
When appointed by a supervisor to undertake the investigation of a health and safety incident, dependent on the severity of the incident, it may be necessary to take some immediate action. If the incident has just occurred it is important to go immediately to the incident scene to consider the following requirements:

- **Does anyone require medical attention?** If so, make sure the appropriate medical attention is being, or has been arranged.

- **How can the incident scene be secured and taken control of?** This may involve erecting barricades, turning power off, evacuating people, etc.

- **Are there any hazards, that pose a danger to yourself or other persons that need removing?** Make sure you document or photograph the location of the hazard prior to its removal for future reference.

- **Was any equipment involved in the incident?** If so, tag it as ‘out of order’.

- **Were any departmental vehicles involved in the incident?** For example, a school tractor or ride-on mower. If so, impound them.

- **Does any individual (e.g. principal, regional health and safety consultant) or organisation (e.g. Workplace Health and Safety Queensland (WHSQ) need to be informed of the incident?)**
Step 2: plan the investigation

Start the investigation by preparing a simple investigation plan outlining what steps are to be taken to successfully conduct the investigation. Use a diary or notebook to record what actions are undertaken. Consider:

- What is the time frame for the investigation?
- Who do I need to speak to? Write down the actual names of the people you need to speak to. Writing ‘witnesses’ is not enough because by tomorrow you might not recall who the ‘witnesses’ were.
- Does anything need to be photographed? If items require photographing, either take the photographs immediately and make a note in your investigation plan that you have done so, or make a note of what needs to be photographed so that you remember to come back and do it.
- Do you need to draw a sketch plan of the incident scene? If you take photographs, it is a good idea to draw a simple sketch plan showing where you took the photographs.
- What other documents need to be collected or sighted? For example, risk assessments, hazard registers, and procedures.
- Who do I report the investigation findings to?

Having a simple plan or checklist helps to ensure nothing is overlooked.

As an investigator, always be objective and keep an open mind. In particular, do not assume; outcomes must be based on information which is known to be accurate and complete.

Step 3: collect information

If you attend an incident scene shortly after the incident has occurred, or if the incident scene has been preserved, spend a few moments observing the scene. This can provide you with valuable information. Consider the following issues:

- the date, time and location of the incident
- the people involved
- any known events leading up to the incident
- what was happening at the time of the incident
- weather conditions.

Depending on the incident, you may be required to collect information relating to one or all of the following areas:
You should record all of your activities, interviews and notes in the same diary or notebook as your investigation plan.

Conducting interviews
Make sure you conduct your interviews as soon as possible after the incident. This will include talking to witnesses, the injured person/s, others involved in the incident, supervisors and persons in control of the workplace.

- Make it clear that your purpose for investigating the incident is to find out why it happened in order to prevent similar incidents from happening in the future.
- If any witnesses are reluctant to speak to you, assure them that your investigation is not attempting to apportion blame or liability.
- If possible, speak to witnesses at the scene. Research shows that a person’s recall diminishes as time goes on.
• **Speak to people separately.** Make sure, where possible, that witnesses can discuss the incident with you in relative privacy. Allow support persons to be present, but remember that a support person should not be a witness or directly linked to the incident and should not participate in the discussion about what occurred.
• **Always use simple language and avoid acronyms.** After speaking to a person, repeat what they said to ensure you have correctly recorded their version of events.
• **Most importantly, close each interview on a positive note.**

In your interviews, you want to obtain all the facts – **who, what, where, when, why** and **how**. Don’t assume anything – get clear and concise answers. To do this, you will need to ask open questions to get initial information and then use closed questions to clarify ambiguity. Avoid asking leading and multiple questions.

**Open questions**
Use open questions to encourage the person to say what’s on their mind. This will help you to obtain their personal opinion of what happened, without any unintended influence from the question. Asking open questions means that you will only receive information about what the respondent actually saw or knew – other types of question can put ideas into people’s minds. Open questions generally start with **who, what, when where why** and **how**. For example:

- What did you see?
- Who else was there?
- When did it happen?

**Closed questions**
Only use closed questions after a person has told you their story. This type of question is useful to clarify information, but tends to restrict the person from articulating themselves. A closed question usually elicits a yes or no answer. For example:

- Was the teacher carrying a box when you saw her walking down the stairs?

**Leading questions**
Under no circumstances should you ask leading questions because they can:

- cloud the information you are collecting
- put words in the mouth of the person you are speaking to
- suggest an answer or range of answers.

For example: Did you see the tread break when Ms. Bird was walking down the staircase carrying the box?

By asking this question you are putting words in your witness’s mouth – they might not have known that the tread broke or that the teacher was walking down the staircase or carrying a box.
Multiple questions
A multiple question is a question that contains two or more questions, but is phrased as one question. For example, ‘Did you see the staircase tread break and the teacher walking down the staircase carrying a box?’ In one question we have asked:

- Did you see the staircase tread break?
- Did you see the teacher walking down the staircase?
- Did you see the teacher carrying a box?

Research indicates most people will only answer the last question of a multiple question, therefore the information gathered cannot be considered reliable.

Recording statements
The oral information people provide needs to be recorded in some sort of written document. This is commonly known within investigation circles as ‘taking a statement’. Because there is no blame in a health and safety investigation, and no punitive action or liability is attached to the investigation outcome, the information you gather will not be presented as evidence in a court of law.

As you know, the health and safety investigation is a no-blame and no-liability investigation. Therefore, the way in which you record oral information is not of such importance as long as:

- the person knows why you are speaking to them
- what is recorded is a true reflection of what the person has to say
- it is recorded in a manner that the person is comfortable with.

The following are all appropriate for a health and safety investigation.

Email responses  
Notes in a diary, pad or notebook
At times you may be required to collect information in circumstances that are not conducive to conducting an investigation. There may be multiple witnesses at the incident scene. You may not have the time or capacity to take formal statements. The witness might tell you they are urgently needed somewhere else and that they will send you an email of what they saw.

Recording the scene
As Napoleon Bonaparte has been credited with saying, ‘a picture is worth a thousand words’ and this is true for health and safety investigations. Photographs are one of the most useful investigation tools, but are often overlooked. Taking photographs can eliminate the need to write descriptions. If you don’t have a camera handy, you can always use a mobile phone with a camera. Always try and include a scale to give perspective to close-up photographs, for example a ruler or a coin.

Photographs assist the investigation by providing a permanent record of:

- the original scene and as things change
- any scratches, dents and perishable evidence (e.g. tyre marks, bruises)
- before and after views e.g. scene, equipment. They also enable:
  - comparison between damaged and undamaged equipment
  - a ‘first-person’ view of an incident e.g. a photograph of the scene from where the injured person was standing.

Note: If taking a photograph to represent the ‘first-person’ view ensure you do not put yourself at risk of sustaining the same injury you are investigating.
Drawing a scene plan may also assist the investigation. This can be anything from a rough sketch to a detailed drawing. It can be a good idea to note on the scene plan where you took your photographs from. Take measurements, if necessary, and note them on the scene plan.

Gathering existing documentation
Collecting information also includes gathering other relevant documentation, such as procedures, training records and guidelines. Your workplace may have a hazards register showing identified hazards and their outcome.

Step 4: organise information
Once you have collected all the information relevant to the investigation, it is important to put it into some sort of order so you can understand what happened and analyse the events. The best way of doing this is to construct a timeline chart which shows the key events relating to the incident. Timeline charts are easy to construct and are an excellent way of depicting complex events in a logical manner. A timeline chart can be in a number of ways, for example, drawn in your diary or on a whiteboard or created using large Post-it® notes stuck on the wall of a room or a computer program. The events should be arranged progressing from left to right on the timeline.

If more than one sequence of events occurred, draw separate timelines on the timeline chart, showing where the events converged to create the incident. At this stage, do not speculate on possible causes. Speculation could lead to inappropriate conclusions.
Step 5: analyse information
To determine the cause of the incident, the events on the timeline need to be analysed or examined. To do this, you need to ask ‘why’ an event occurred and keep asking ‘why’ until you know why the event occurred.

The analysed timeline chart might look something like this:

![Timeline Chart]

The possible causes of the event are identified by the answers.

Step 6: recommend solutions
Once you have identified the possible causes, you need to identify which are within the control of the workplace. Only the possible causes that are within the control of the workplace can have solutions. You cannot apply a solution to a possible cause if it is outside the control of the workplace.

Sometimes it is easier to look for solutions by using a table or columns. In one column, list the possible causes you found during your analysis of the timeline. In the next column, indicate whether the possible causes are within the control of the workplace. In the third column, write all the possible solutions that could eliminate or reduce the risks posed by the possible cause, if the possible cause is within the control of the workplace. This is a brainstorming activity. Not all solutions will be workable or cost efficient or become a recommended control.
Hierarchy of controls

Once you have a list of possible solutions, you need to rank them according to the ‘hierarchy of controls’. Elimination, substitution and isolation are the preferred controls because they remove the risk, which means that the other controls are not required.

- Elimination – complete elimination of the risk.
- Substitution – replace the risk with a less dangerous one.
- Isolation – isolate the risk by enclosure, guarding or barriers.
- Engineering – redesign the work process or equipment.
- Administration – provide training and/or procedures.
- Personal protective equipment – use personal protective equipment.

Not all causes can be completely eliminated and some may only be eliminated at a prohibitive cost or excessive time. Rank your solutions, making notes where appropriate. Remember, some solutions may be unworkable.

Solutions are also referred to by a number of other names, including recommended corrective actions, remedial actions or simply actions.

Solutions should never be band-aid or one-off solutions.

Step 7: report outcomes

You will need to use the Health and Safety Investigation Report template to report investigation findings. This template is an interactive PDF document and can be located on OnePortal and the Creating Healthier Workplaces website.

Inclusion of the information you collected and your analysis charts and tables will help your supervisor to understand the causes of the incident. You should include an executive summary of the incident, your analysis and the recommended corrective action, and then submit the report to your supervisor so key learnings can be passed on to the appropriate persons and committees.

Remember, to have an incident in the workplace is regrettable but to have an incident and not learn from it is unforgivable so if you are aware of it take care of it.