

Procedure

Incident Investigation

Document number: PRO-00793

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Rev	Description	Process Owne	r		Approved	for issue		
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Purpose

Seqwater is committed to the health and safety of all people at the workplace. The purpose of this procedure is to provide instruction regarding the process of Work Health and Safety (WHS) incident investigation with the aim of ensuring:

- All incidents and system failures are investigated, to the extent necessary, to determine the root causes and contributing factors and to identify actions which will:
 - eliminate or minimise identified hazards or risks as far as reasonably practicable
 - prevent recurrence or further incidents or injury
 - improve overall system performance
 - improve Seqwater's WHS culture.
- Investigations are conducted in a manner that provides a consistent approach, with assurance that the outcome is reliable and evidential requirements are not compromised.

This procedure supports the requirements of Element 13 – Incident investigation, corrective and preventive action as detailed in Seqwater's Work Health and Safety Management System Framework (MAN-00211).

This procedure adopts and is consistent with the requirements outlined in the:

- Work Health and Safety Regulation 2011 (Qld)
- Electrical Safety Regulation 2013 (Qld)
- Bulk Authority Emergency Response Plan (ERP-00001)
- AS/NZS 4801:2001 Occupational Health & Safety Systems- Specifications with guidance for use.

2. Scope

This procedure applies to all Sequater workers, business groups and work activities.

This procedure is limited to the investigation aspects of WHS incidents only. For other aspects of WHS incident management and reporting refer to the following:

- Injury Management Procedure (PRO-00792)
- First Aid Management Procedure (PRO-00903)
- WHS Emergency Preparedness and Response Procedure (ERP-00079)
- WHS Incident Notification Procedure (PRO-00338).



3. Roles and responsibilities

Term	Definition
Managers	 Promote a positive safety culture in by ensuring investigations are conducted in a manner which views human errors as an opportunity to learn.
	 Use incident investigations to actively challenge work processes to identify systemic issues and seek continual improvement.
	 Ensure implementation of procedures to investigate incidents.
	 Communicate and consult with workers regarding the incident investigation process out outcomes, including key lessons learnt through incident investigations.
	 Ensure appropriate resources are provided to adequately investigate all incidents within designated timeframes.
	 Ensure effective control measures are implemented for hazards and risks identified in the incident investigation process.
	 Check and approve investigation report findings within their area of responsibility.
	 Review, approve and verify the completion of corrective actions within their area of responsibility.
Site Supervisors/Project Managers	 Ensure appropriate and immediate action is undertaken to secure the scene and prevent reoccurrence following an incident.
	 Ensure communication, consultation, training and supervision is provided to workers in relation to factors found through the incident investigation to contribute to incidents at the relevant project or operational site and relevant corrective and preventive actions.
	 Following an incident direct workers involved to be tested for alcohol and other drugs if required, in accordance with Managing Alcohol and Other Drugs Procedure (PRO- 01105).
	 Participate in an incident investigation as required by any appointed role in the investigation team.
	Secure evidence as appropriate.
Manager, WHS	 Appoint an appropriately qualified incident investigation team in consultation with the relevant manager.
	 Ensure maintenance of a database of incident investigation outcomes enabling analysis of incidents, root causes, corrective actions and effective risk analysis.
	 Ensure appropriate legal advice is sought in consultation with Seqwater's legal services team prior to commencing, and at any necessary stage of the investigation.
	 Ensure the appropriate personnel are competent in incident investigation methodology and Seqwater's incident investigation requirements.

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Term	Definition
	 Report investigation findings to the relevant manager and responsible general manager.
	 Report incident investigation outcomes to Seqwater's WHS Steering Committee, Executive Team, Board and other agencies as required.
	Monitor and verify the close-out of corrective actions.
WHS Coordinator and Advisors	 Conduct incident investigations in accordance with the requirements of this procedure and any appointed role in an incident investigation team.
	 Ensure investigation outcomes are reported to the Manager, WHS within the allocated timeframe.
	 Immediately report any identified non-conformances or hazards with the potential to cause Incidents or injury in accordance with WHS Hazard Identification & Risk Management Procedure (<u>PRO-00657</u>).
	 Administer and maintain incident investigation data in the electronic database.
	Report incident investigation outcomes to Seqwater's relevant Regional WHS Improvement Committee
	 Verify the close-out of approved corrective actions.
Seqwater Legal Services	 Provide advice in relation to the provision of information to, or investigations by, Workplace Health and Safety Queensland (WHSQ), the Electrical Safety Office (ES) or any other regulator.
Lead investigator	 Conduct the investigation in accordance with this procedure.
	 Lead the investigation to determine the immediate and underlying causes.
	 Ensure the investigation report is submitted within the allocated timeframe.
	 Recommend corrective actions. Confirm actions and schedule are acceptable to assigned supervisor and relevant managers.
	 Document the investigation and file in Seqwater's document management system.
	Report findings to the Manager, WHS.
Workers	Proactively identify and report incidents.
	Participate in incident investigations.
	 Participate in testing for alcohol and other drugs in accordance with the Managing Alcohol and Other Drugs Procedure (PRO-01105).

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4. Procedure

The preferred Incident investigation methodology utilised by Seqwater is Incident Cause Analysis Method (ICAM).

4.1 Investigation response

The site supervisor must:

- ensure any immediate reporting or notification requirements have been completed
- if required, ensure any workers involved in the incident are directed to be tested for substance use in accordance with the Managing Alcohol and Other Drugs Procedure (<u>PRO-01105</u>) and are offered Employee Assistance Program (EAP) support
- ensure appropriate resources are available to commence an incident investigation
- document any emergency response taken to control the incident
- perform a preliminary incident risk assessment to determine immediate controls.

4.1.1 Secure the incident scene

In the case of a notifiable incident, workers and the site supervisor must ensure equipment, plant, machinery or other associated plant connected with the incident are not disturbed without the permission of the relevant statutory authority. This does not prevent any action:

- to assist an injured person
- to allow an authorised person to remove a deceased person
- to make the site safe or to minimise the risk of a further notifiable incident
- that is associated with a police investigation
- for which an inspector or the regulator has given permission.

Work may be stopped until the risk of another or further incident is determined and hazards and risks are managed to as low as reasonably practicable and in accordance with relevant activity approvals detailed in the WHS Risk Assessment Guide (GDE-00044).

4.2 Investigation planning

4.2.1 Appoint the investigation team

For incidents with an actual or potential consequence rating of moderate or above (refer to Appendix B for incident level definitions), the Manager, WHS shall appoint an investigation team and lead investigator in consultation with the relevant general manager. As a minimum, the lead investigator must have completed ICAM Lead Investigator Training.

If the incident is a notifiable incident, the Manager, WHS must ensure Seqwater's Legal Services team is informed to ensure that any requirement to maintain legal

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professional privilege is identified and considered, and other relevant advice is provided before the investigation commences.

For an incident with a WHS consequence of minor or insignificant (refer to Appendix B for incident level definitions), the WHS Coordinator, in consultation with the relevant manager, will appoint an investigation team and team leader. As a minimum the team leader must have completed ICAM Basic Investigator Training.

The team should be assembled as early as practical after an incident. Line supervisors are to ensure all members of the team are given the appropriate resources and time to complete the investigation.

4.2.2 Investigation planning

The objectives of planning are to establish the scope, means and timeframe of the investigation, identify the resources required for investigation and to assess and control the risks associated with the investigation activities.

The investigation team will develop an action plan for relevant incidents, which includes plans to collect information from within the following categories:

- People information relating to witnesses and personnel associated with the incident.
- Environment information relating to weather, workplace and incident scene.
- Equipment information relating to vehicles, plant, tools, infrastructure etc.
- Procedures information relating to documents, reports, charts, maps etc.
- Organisation information relating to training, communication, resources, organisational culture and management etc.

The lead investigator in consultation with the relevant line manager and supervisor will decide when the incident scene inspection will take place, considering the safety of the scene and available resources.

4.3 Data collection

An incident sequence timeline should be developed as soon as possible after the incident and documented in the incident report.

4.3.1 Inspection of the incident site

An inspection of the site should be undertaken as soon as practicable after the incident. Prior to conducting the inspection, the investigation team will complete a Real Time Hazard Assessment (RTHA) for each work area and each type of activity to assess and manage the hazards and risks in gathering evidence.

All conditions shall be assessed during the inspection including:

- position of equipment, instrumentation and control switches
- illumination, visibility and audibility
- gouges, scratches, smears, discolouration, burn marks, spills
- the effects or condition of the weather
- presence or absence of signage
- excessive force used

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- equipment failures
- loss of any containment
- condition of the equipment.

4.3.2 Records

Video cameras, still photography cameras and sketches may be used to assist with recording the scene. When taking photos or video footage the time and location must be documented. The Incident Investigation Photograph Log (FRM-00479) may be used for this purpose. Consideration must also be given to personal privacy when collecting evidence, with permission sought to collect, store and use private information including images. In addition, individuals should be advised of the reason and scope of use of the private information.

4.3.3 Documentation

The investigation team should review the relevant documents or parts of documents and reference their use. Record appropriate dates and times associated with the incident on the documents reviewed.

4.3.4 Interviews and statements

Any written statements from witnesses involved must be recorded using the Incident Witness Statement Form (FRM-00480).

Any interviews must be conducted so that:

- confidentiality of any personal information obtained is maintained and any limits to confidentiality are explained
- the interviewee is not pressured into providing a statement or information
- the interviewee may invite other persons to attend the interview such as a work colleague, union representative or safety representative
- the location of the interview is suitable and free of interruptions
- leading questions are not asked and the interviewee is not prompted for answers
- objectivity is maintained
- vague generalisations are avoided and information discussed is specific to what was witnessed.

4.3.5 Evidence collection and storage

The investigation team shall coordinate the collection, labelling, and preservation of physical evidence. All evidence must be documented and stored together in a secure location to allow for retrieval. The Incident Investigation Evidence Log (FRM-00481) may be used for this purpose.

The relevant line manager or site supervisor must establish a quarantine area for any failed equipment or components and ensure all failed equipment or components are clearly tagged and labelled as 'out of service' as per the Energy Tag and Lock Out Procedure (PRO-00014).

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4.3.6 Final considerations

Once all the data is collected from the incident scene and before the scene is released back to the relevant owner, the following should be considered:

- Ensure all options for gathering information have been exhausted
- Ensure that other concurrent investigations are not affected
- Communication of any residual hazards should occur via the lead investigator
- After an assessment of the initial data, a summary of incidents and an initial
 assessment of causes and contributing factors may be communicated to the
 relevant general manager and then all internal stakeholders. This should prompt
 an immediate review of current practices on similar tasks to prevent similar
 occurrences.

4.4 Data organisation and analysis

4.4.1 Assess for consistency

The investigation team must review and verify the data to ensure accuracy and objectivity. The initial information obtained should then be organised into the following categories:

- People information relating to witnesses and personnel associated with the incident.
- Environment information relating to weather, workplace and incident scene.
- Equipment information relating to vehicles, plant, tools, infrastructure etc.
- Procedures information relating to documents, reports, charts, maps etc.
- Organisation information relating to training, communication, resources, organisational culture and management etc.

4.4.2 Information analysis techniques – determining chain of events

The sequence of events process shall be used to determine the root cause and contributing factors of the incident under investigation.

For incidents of level catastrophic and major it may be helpful to use the '5 whys' technique (refer to Incident Investigation Guide) in determining the contributing factors as outlined in the Investigation Toolbox Kit.

For detailed investigations, the ICAM process should be followed to determine the contributing factors categorised as: absent or failed defences, individual or team actions, task or environmental conditions and organisational factors.

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4.4.3 Analysis of contributing factors and root causes

A root cause is the most basic reason for an incident, which if corrected would prevent a reoccurrence of the incident. A root cause is associated with the underlying system or organisational factors and should be determined using the ICAM methodology and chart templates in the Investigation Report Template (<u>TEM-00025</u>).

4.5 Prevention and learning

4.5.1 Interim investigation summary

The interim investigation summary constitutes an accurate and objective record of the incident and provides preliminary details of:

- the investigation team's investigation process
- facts pertaining to the incident, covering the categories of:
 - people
 - environment
 - equipment
 - procedures
 - organisation
- analytical methods used and their results
- preliminary casual factors of the incident.

The summary should be sufficiently detailed for a reader to understand the incident and the basis of any initial proposed improvements.

Based on the initial findings, the Manager, WHS or WHS Coordinator will determine any requirement for additional investigation.

Depending on the actual or potential severity, the summary will be:

- detailed for catastrophic and major incidents. Refer to investigation report template (<u>TEM-00025</u>) which is to be completed by the lead investigator
- utilising the minimum requirements defined in the Incident Investigation Form (FRM-00094) for all other incidents.

4.5.2 Identifying corrective and preventive actions

All recommendations for corrective actions shall be documented in the investigation report. The investigation team will provide recommendations for corrective and preventive actions to address absent or failed defences, individual or team actions, task or environmental conditions and organisational factors. These will include corrective or preventive actions required to prevent a reoccurrence of the event. These actions must address each of the root causes and contributing factors identified, which will give effective long and short-term control measures.

In determining recommendations for risk controls and corrective and preventive actions, the hierarchy of controls must be applied in accordance with the Hazard and Risk Management Procedure (<u>PRO-00657</u>). The investigation team should consider recommendations that are:

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- specific to the incident
- have implications for the site
- have implications for other areas
- do not introduce any new hazards.

The timeframe and person(s) responsible for these actions should be identified, agreed upon by that person and documented. Timing and priority will be based on the risk of exposure if it is not implemented. Workers should be consulted in determining the recommended actions and solutions where required.

The relevant asset owner must be consulted and endorse any proposed asset improvements.

4.5.3 Incident investigation report

The incident investigation report constitutes an accurate and objective record of the Incident and provides complete and accurate details and explicit statements of:

- the investigation team's investigation process
- facts pertaining to the Incident
- analytical methods used and their results
- conclusions of the investigation team, including the causal factors of the incident
- preventative and corrective actions to prevent recurrence of the incident.

Depending on the actual or potential severity, the incident investigation report will be:

- detailed for catastrophic and major incidents. Refer to investigation report template (<u>TEM-00025</u>) which is to be completed by the lead investigator
- utilising the minimum requirements defined in the Incident Investigation Form (<u>FRM-00094</u>) for all other incidents.

The Manager, WHS or WHS Coordinator may determine the report detail and format as required.

The incident investigation report will be presented to the relevant members of the WHS team as a draft for a peer review. Following peer review, the incident investigation report will be provided to the Manager, WHS and the relevant stakeholders, including the level 3 manager, for analysis and debrief, with details of the recommended corrective actions documented as accepted, rejected or modified.

Following debrief, final approval of the incident investigation report will be requested from the delegated person in accordance with Appendix B.

The WHS Steering Committee shall review details of the incident investigation outcomes and agreed corrective actions.

Refer to Appendix B for timeframes to complete an incident investigation report.

4.5.4 Data recording

The WHS team will input incident levels, root causes, mechanisms of incident/injury, hazard category, risk assessment, related hazards/risks, contributing factors and actions into an electronic database for recording and analysis. Injury data will be entered into the electronic database by the Rehabilitation and Return to Work

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Coordinator in accordance with AS1885.1 - Workplace injury and disease recording standard.

5. Training requirements

Training will be provided in accordance with the WHS Training, Competency and Behaviour Management Procedure (<u>PRO-01574</u>). Minimum training requirements are:

- lead investigators must complete an ICAM Lead Investigator Course.
- members of an investigation team must complete an ICAM Basic Investigators Course. This training will also allow these people to undertake the role of team leader for investigations of minor or insignificant incidents. Each business group will identify roles within their area to attend this training.

The Manager, WHS will ensure there is an adequate number of trained WHS lead incident investigators within Seqwater. These investigators must undertake appropriate training in the application of the ICAM incident investigation methodology.

In addition, each business group will identify roles that are required to undertake All workers will be made aware of the requirements for incident investigation through toolbox talks.

Record keeping

All records relating to Incidents and injuries are to be forwarded to the safety@seqwater.com.au mailbox, or as otherwise advised by Legal Services. All injury records will be treated confidentially and securely stored as per the Injury Management Procedure (PRO-00792).

All records are to be retained, archived and disposed of in accordance with the Queensland State Archives General Retention and Disposal Schedule for Administrative Records.

7. Monitoring and audit

The requirements of this procedure will be audited in accordance with the WHS Internal Audit Schedule and the Internal Audit Procedure (PRO-00002).

Reporting to management will be conducted in accordance with the WHS Monitoring and Reporting Procedure (PRO-01334).

Incident management performance including trending of contributing factors and root causes will be reviewed by Regional WHS Improvement Committees and the WHS Steering Committee at regular intervals and during the management review in accordance with the Management Review and Audit Management Procedure (PRO-00002). Analysis of investigation outcomes will be undertaken using the incident management database and reviewed at regular intervals in conjunction with the risk register and risk profile reviews.

This procedure will be reviewed biennially, unless determined by risk assessment or as a recommended corrective action of an audit, incident or hazard report.

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8. References

8.1 Legislation and other requirements

Description	Status	Location
Electrical Safety Act 2002 (Qld)	Active	www.legislation.qld.gov.au
Electrical Safety Regulation 2013 (Qld)	Active	www.legislation.qld.gov.au
Seqwater Compliance Register – 1.3 WHS Legislation	Active	TRIM Ref: D13/18237
Work Health and Safety Act 2011 (Qld)	Active	www.legislation.qld.gov.au
Work Health and Safety Regulation 2011 (Qld)	Active	www.legislation.qld.gov.au

8.2 Supporting procedures

Description	Status	Location
ERP-00001 - Bulk Authority Emergency Response Plan	Active	Q-Pulse
ERP-00079 – WHS Emergency Preparedness and Response Procedure	Active	TRIM Ref: D13/64184
MAN-00211 - Corporate Safety – WHS Management System Framework	Draft	TRIM Ref: D13/43216
PRO-00002 – Internal Audit Procedure	Active	TRIM Ref: D13/915
PRO-00388 - WHS Incident Notification Procedure	Active	TRIM Ref: D13/62376
PRO-00657 – Hazard Identification and Risk Management	Active	TRIM Ref: D13/61507
PRO-00792 - Injury Management Procedure	Active	TRIM Ref: D13/61350
PRO-00903 - First Aid Management Procedure	Active	TRIM Ref: D13/64183
PRO-01105 - Managing Alcohol and Other Drugs Procedure	Active	TRIM Ref: D13/64233
PRO-01574 – WHS Training, Competency & Behaviour Management Procedure	Active	TRIM Ref: D13/70676

8.3 Supporting documents, forms and templates

Description	Status	Location
Incident Investigation Evidence Log	Active	TRIM Ref: D13/68993

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Description	Status	Location
(<u>FRM-00481)</u>		
Incident Investigation Form (FRM-00094)	Active	TRIM Ref: D13/68985
Incident Investigation Photograph Log (FRM-00479)	Active	TRIM Ref: D13/68994
Incident Investigation Report (TEM-00025)	Active	TRIM Ref: D13/68986
Incident Witness Statement Form (FRM-00480)	Active	TRIM Ref: D13/68984
Real Time Hazard Assessment (RTHA) Booklet (<u>RSK-00222</u>)	Active	TRIM Ref: D13/61877
WHS Risk Assessment Guide (GDE-00044)	Active	TRIM Ref: D13/43229

9. Definitions

Term	Definition
Absent or failed defences	The situations, systems, conditions, equipment, measures or human factors that normally prevent this type of incident from happening.
Dangerous electrical event	A dangerous electrical event includes:
	 when a person, for any reason, is electrically unsafe around high voltage electrical equipment, even if the person doesn't receive an electric shock or injury
	 significant property damage caused by electricity or something originating from electricity e.g. electrical fire
	unlicensed electrical work
	unsafe electrical work
	 unsafe electrical equipment or electrical equipment that is does not have electrical equipment safety system (EESS) approval markings.
	Note: high voltage means a voltage above 1000 V AC or 1500 V ripple-free DC.
Dangerous incident	An incident in relation to a workplace that exposes a worker or any other person to a serious risk to a person's health or safety emanating from an immediate or imminent exposure to:
	 an uncontrolled escape, spillage or leakage of a substance
	an uncontrolled implosion, explosion or fire
	an uncontrolled escape of gas or steam
	an uncontrolled escape of a pressurised substance
	electric shock
	the fall or release from a height of any plant, substance or thing
	the collapse, overturning, failure or malfunction of, or

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	damage to, any plant that is required to be authorised for use in accordance with the regulations
	the collapse or partial collapse of a structure
	 the collapse or failure of an excavation or of any shoring supporting an excavation
	 the inrush of water, mud or gas in workings, in an underground excavation or tunnel
	 the interruption of the main system of ventilation in an underground excavation or tunnel.
Effective control	The meaning of an effective control includes fit for purpose, being suitable for the nature and duration of the work and installed, set up and used correctly.
Emergency	An event that happens as a consequence of an incident and demands immediate action. It is the broader coordination to manage incidents including mitigation and public and stakeholder outcomes.
First aid injury	Any once-off treatment and/or subsequent observation of minor scratches, cuts, burns, splinters, etc, which do not require professional medical treatment (however, in some instances, a medical practitioner or registered professional, may administer the first aid.
Hazard	A situation that has the potential to harm a person and/or the environment and/or damage property.
Hierarchy of controls	Identify the risk control actions and responsibilities by identifying controls in the following specific order:
	Eliminate the hazard.
	If elimination of the hazard is not reasonably practicable, minimise the risk so far as reasonably practicable by:
	 substituting (wholly or partly) the hazard giving rise to the risk with something that gives rise to a lesser risk
	 isolating the hazard from any person exposed to it
	implementing engineering controls.
	If a risk then remains, then minimise the remaining risk, so far as is reasonably practicable, by implementing administrative controls.
	If a risk then remains, then minimise the remaining risk, so far as is reasonably practicable, by ensuring the provision and use of suitable Personal Protective Equipment (PPE).
Incident	An event or circumstance that could have or did lead to unintended and/or unnecessary harm to a person and/or loss or damage or adverse consequences. This definition of an incident includes near misses.
Incident Cause Analysis Method (ICAM)	The ICAM process is an industrial safety analysis tool that sorts the findings of an investigation into a structured framework.
	An ICAM analysis clarifies why the incident happened and identifies all the factors that contributed to the event. The contributing factors are classified into four categories of the ICAM Model which are: absent or failed defences,

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Term	Definition
	individual or team actions, task or environmental factors.
Individual or team actions	The errors or violations made by people directly involved in the event.
Lost time injury	A work-related incident that results in an injury or illness and time lost from work of one day/shift or more.
Medically treated injury	An incident which results in the consequence of an injury to a person requiring treatment by, or under the order of, a qualified medical practitioner, or treatment of any injury that could be considered as being one that would normally be treated by a medical practitioner.
Near miss	Any unplanned incident that occurred at the workplace that, although not resulting in any injury or illness, had the potential to do so.
	Note – A near miss may also be a notifiable incident in accordance with the definition of the term.
Notifiable incident	An incident which involves:
	the death of a person
	a serious injury or illness of a person
	a dangerous incident.
Organisational factors	The latent system-based factors present before the incident which may have contributed to the presence of specific adverse task/environmental conditions, individual/team actions or absent/failed defences.
Preventive action	Any action to eliminate the cause of a potential non- conformity or other undesirable potential situation.
Reasonably practicable	The following criteria must be applied in determining what is reasonably practicable:
	What the person knows or ought to reasonably know about the hazard and ways of eliminating or minimising the hazard
	 Availability and suitability of ways of eliminating or minimising the hazard
	 The cost associated with the availability and suitability of ways of eliminating or minimising the hazard, taking into account the cost if it is grossly disproportionate to the risk.
Relevant statutory authority	Relevant statutory authority may be Work Health and Safety Queensland (WHSQ) or the Electrical Safety Office (ESO).
Risk	Risk is the likelihood and consequence of injury or harm occurring when exposed to a hazard.
Risk control	Means taking action to eliminate health and safety risks so far as is reasonably practicable, and if that is not possible, minimising the risks so far as is reasonably practicable. Eliminating a hazard will also eliminate any risks associated with that hazard.
Root cause	A root cause is the most basic reason for an incident, which if corrected would prevent reoccurrence of the

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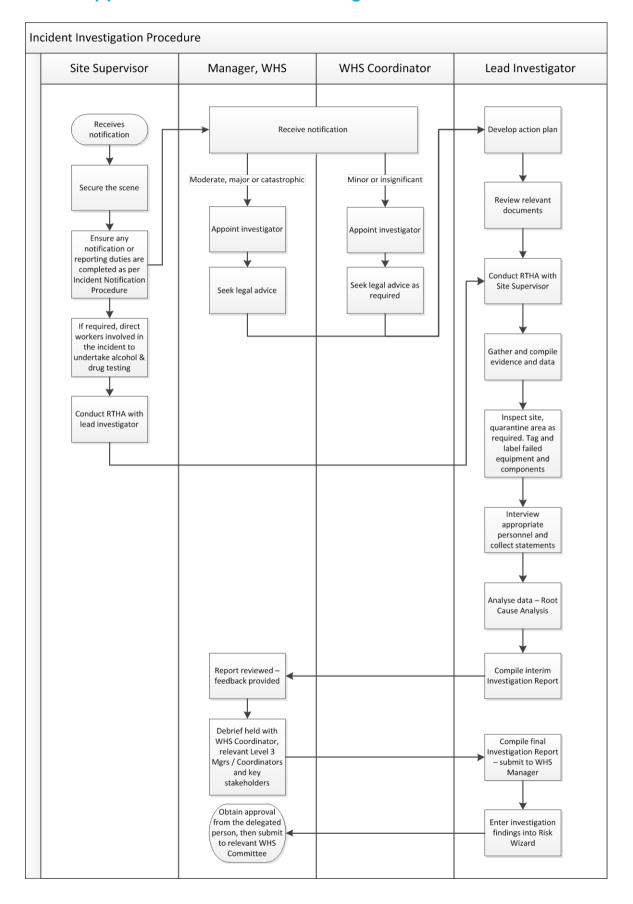


Term	Definition
	incident.
Serious electrical incident	An incident when a person:
	was killed by electricity
	 received a shock or injury from electricity, and was treated for the shock or injury by or under the supervision of a doctor
	 received a shock or injury from electricity at high voltage, whether or not the person was treated for the shock or injury by or under the supervision of a doctor.
	Note: high voltage means a voltage above 1000 V AC or 1500 V ripple-free DC.
Serious injury or illness	An injury or illness requiring the person to have:
	 immediate treatment as an in-patient in a hospital
	immediate treatment for:
	 the amputation of any part of his or her body
	 a serious head injury
	 a serious eye injury
	 a serious burn
	 the separation of his or her skin from an underlying tissue (such as degloving or scalping)
	- a spinal injury
	- the loss of a bodily function
	- serious lacerations
	 medical treatment within 48 hours of exposure to a substance.
Task or environmental conditions	The situational characteristics which existed immediately prior to the Incident, including the work situation, physical or social environment, or a person's mental, physical or emotional state.
Worker	Worker means a person who carries out work in any capacity for Seqwater, including work as:
	an employee
	a contractor or subcontractor
	an employee of a contractor or subcontractor
	 an employee of a labour hire company who has been assigned to work at Seqwater
	an outworker
	an apprentice or trainee
	a student gaining work experience
	 a volunteer
	a worker of a prescribed class.

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Appendix A - Incident investigation flowchart



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Appendix B - Incident levels

WHS incident category/level	Category description	Interim investigation summary	Incident investigation report	Incident investigation reports to be provided to	Incident investigation report approved by
Catastrophic	Single or multiple fatalities	Within 3 working days	Within 60 working days	General Manager, WHS Steering Committee WHS Team, Communications Manager, Level 3 Manager	CEO
	Serious injury or illness		Within 30 working days		
Major	Dangerous incident	Within 3 working days		General Manager, WHS Steering Committee, WHS Team Communications Manager, Level 3 Manager	Relevant general manager
	Enforcement notice issued by a regulator				
Moderate	Lost time injury	Within 3 working days	Within 20 working days	WHS Steering Committee, WHS Team, Level 3 Manager	Relevant manager
Minor	Medically treated injury*	Within 3 working days	Within 10 working days	WHS Team, Level 3 Manager	Relevant coordinator
Insignificant	First aid injury or minor injury with no treatment required*	Within 3 working days	Within 10 working days	WHS Team, Level 3 Manager	Relevant coordinator

Where an incident is a near miss, the WHS incident category/level will be based on the potential injury consequence detailed in the category description.

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^{*}Further examples of injuries falling into the categories of medically treated or first aid injury are available in Appendix C.



Appendix C - Incident classification examples

Medically treated injury and first aid injury

Medical treatment	First aid treatment
Treatment of an infection.	Tetanus Injection or precautionary antibiotics.
Application of antiseptics during second or subsequent visit to medical practitioner.	Application of antiseptics during first visit to medical personnel. Application of ointments to abrasions to prevent drying or cracking.
Treatment of second or third degree burns.	Treatment of first degree burn(s).
Admission to a hospital or equivalent medical facility for treatment.	Application of bandages(s) during any visit to medical personnel.
Application of sutures (stitches).	Use of elastic bandage(s) during first visit to medical personnel.
Removal of foreign bodies embedded in eye.	Removal for foreign bodies (not embedded) in eye if only irrigation is required.
Removal of foreign bodies from a wound if procedure is complicated because of depth of embedment, size or location.	Removal of foreign bodies from wound if procedure is uncomplicated, and is for example, by tweezers or other simple technique.
Use of prescription medication, except a single dose administered on first visit for minor injury or discomfort.	Use of non-prescription medications and administration of single dose of prescription medication on first visit for minor injury or discomfort.
Cutting away dead skin (surgical debridement).	Application of hot or cold compress during first visit to medical personnel.
Positive X-Ray diagnosis (e.g. fracture).	Negative X-Ray taken to confirm the existence or otherwise of a diagnosed condition.

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