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RISK MANAGER
CONSULTING
PREQUAL
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TALENTBANK
SAFEWORX

WORKPLACE HEALTH & SAFETY INCIDENT INVESTIGATION

UNIT STANDARD 17601

+IMPAC The Health + Safety Company

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As NZ's leading full-service H+S solutions provider, we have unrivalled experience and expertise at getting the best possible H+S outcomes for our clients. We work alongside them to become true partners, to fully diagnose their needs and deliver solutions to keep their teams safe.

We partner

We diagnose

We deliver

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GUIDE

This guide is designed to go with the ***Workplace Health and Safety Incident Investigation*** course. You will need to refer to it during the course. It also makes a great reference guide for back in the workplace, to help you apply what you have learnt, and to show your colleagues.

Please feel free to add notes to this guide during the course.

Tips

As you go through this manual with your trainer use a highlighter or underline important words as you are reading. This will make it easier to find key information later.

Use a different colour to highlight or underline words you do not understand or are unsure about, this will make it easier to find them later so that you can ask someone, or look them up.

The New Zealand Qualifications Authority

This course provides the training required towards the achievement of:

NZQA Unit Standard 17601 — Produce an occupational health and safety incident investigation.

Your IMPAC course trainer will provide you with instructions as to what you need to do to achieve this Unit Standard.

As an NZQA candidate, you are expected to:

- Participate fully in the training session
- Share your knowledge and experience
- Participate in discussions and activities
- Complete all assessment activities as notified by your trainer
- Take responsibility for your own learning needs
- Discuss with your trainer any assistance you may need.

If you are being disruptive, your trainer will advise you that your behaviour is disrupting learning for other trainees.

If the behaviour continues to disrupt or disturb others, your trainer will ask you to leave the course, and your employer will be notified immediately.

THE CHALLENGES AND BENEFITS OF INCIDENT INVESTIGATION AT WORK

What you need to know:

- Why incidents at work need to be reported and investigated from a health and safety perspective
- Why incidents are sometimes not reported and what to do about it

NOTES

THE CASE FOR REPORTING AND INVESTIGATING WORKPLACE HEALTH AND SAFETY INCIDENTS

An 'incident' is an unplanned and unwanted event that caused, or could have caused, losses of some kind. To investigate means to inquire or look into something, in order to learn what is not currently known.

KEY POINT

The purpose of reporting is to provide information to the organisation about how work is happening in the workplace; not just negative incidents when things go bad but also positive incidents when things go well.

The purpose of investigating is to find out what happened and why, to improve how work is done, to stop re-occurrences of similar negative incidents and to repeat positive incidents.

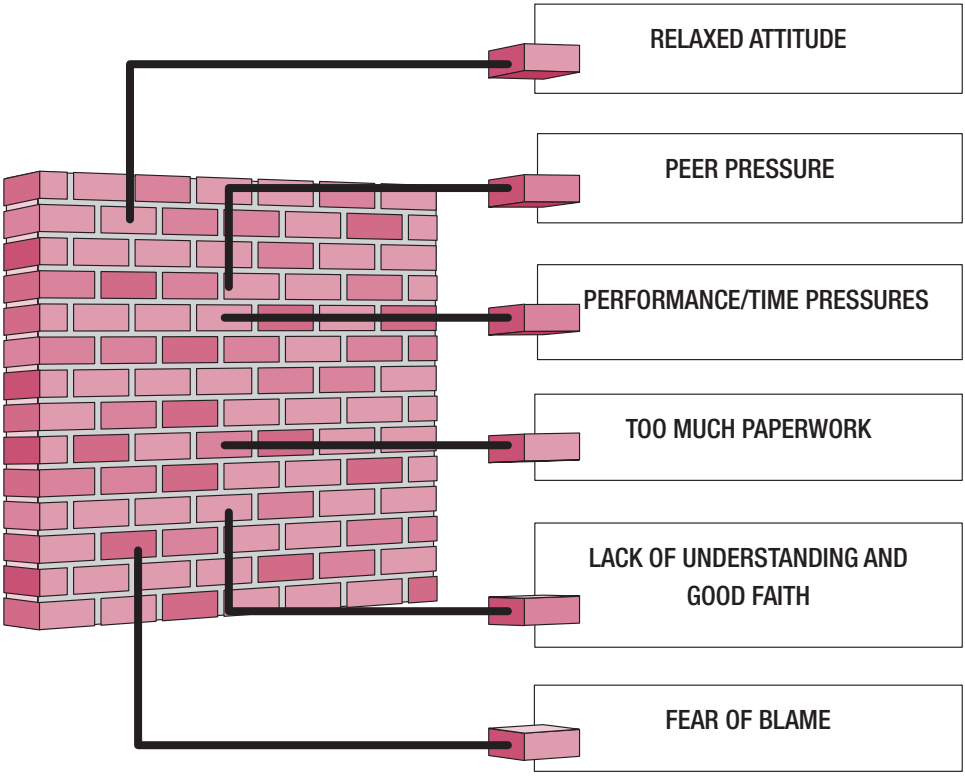
Benefits of reporting and investigating health and safety incidents

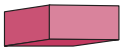
Good incident reporting and investigation can:

- Improve the way health and safety risks are controlled
- Reduce costs by identifying common factors that are having a negative impact on the business
- Avoid legal liability by showing a willingness to learn and improve
- Gather data about how work is done in practice, which can help the organisation do a better job of managing and organising work
- Identify trends and patterns over time that can help an organisation understand what is needed for successful work.

BARRIERS TO REPORTING INCIDENTS

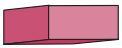
Here are some common reasons why health and safety incidents don't get reported:





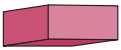
RELAXED ATTITUDE

"She'll be right." Incidents are seen as no big deal. The culture in the workplace accepts that incidents are just a part of work.



PEER PRESSURE

"A real Kiwi doesn't complain—they just get on with the job". In workplaces, reporting incidents is seen as complaining or a sign of weakness. This pressure to 'fit in' to what everyone else is doing (or not doing) can be very strong.



PERFORMANCE/TIME PRESSURES

"We just work through the pain—when you slow down you don't get your bonus." When there is pressure to meet performance targets at all costs, workers are less likely to take the time to report incidents.

CHALLENGES AND BENEFITS OF INCIDENT INVESTIGATION AT WORK

TOO MUCH PAPERWORK

"I might report incidents if the form wasn't so complicated—it takes too long to fill out." Systems that are overly complex are less likely to be used, especially when there are literacy and language barriers.

LACK OF UNDERSTANDING AND GOOD FAITH

"What's the point—no-one ever does anything about it." Incidents are less likely to be reported where there is bitterness and no clear information about the reasons why incident reporting is important.

FEAR OF BLAME

"I might get in trouble if I report these incidents—makes me look like I don't know what I'm doing." Where there is a culture of finding individual blame for incidents, workers at all levels will be unlikely to report them.

ACTIVITY

You are an HSR or supervisor trying to improve the culture of reporting incidents in your company. Respond to the following statements.

STATEMENT	YOUR RESPONSE
"There's too much paperwork to fill out when I've only had a minor injury, like a cut finger."	
"But nobody was hurt."	
"I got injured because I was showing off, and I don't want to report the incident because I might get sacked."	
"I've had this sore back for a few weeks now, but I don't know if I injured it at home or at work."	

CHALLENGES AND BENEFITS OF INCIDENT INVESTIGATION AT WORK

STATEMENT	YOUR RESPONSE
"I don't want to get the company prosecuted by WorkSafe."	
"We've filled out heaps of incident forms before, but nothing seems to happen."	
"I'm new. I didn't know we had to report incidents. No-one else seems to be bothered."	
"Incident reports have been investigated in the past and people have got into trouble."	

Overcoming barriers and encouraging reporting

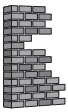
Luckily, we can overcome many of these barriers by making sure the following are in place:

- **Training and information**—good induction training and access to clear information will set out the importance of reporting incidents, and emphasise that it is part of the PCBU's legal duty. Training will also help workers understand how the incident report will make a difference to everyone's health and safety.

- **Feedback**—it is also very important for the reporting system to include feedback to the person who made the report – they need to know that the report is appreciated, valued, and that it will be investigated.

- **Encouragement**—when a few key people are seen to be actively supporting the incident reporting system, this will give encouragement and help to combat any negative peer pressure and bad attitudes.

- **Just culture**—incident investigations must focus on the 'big picture' when it comes to finding out what went wrong. It is very important to make it clear that individuals will not be singled out because of reporting an incident. Personal fault does exist, but it will not be the main focus of investigations. Learning to avoid a repeat is the key, not blaming people.



- **User friendly paperwork**—design incident report forms or systems that are very simple, quick and easy to use. Pictograms and simple language will help with literacy and language barriers.

CHALLENGES AND BENEFITS OF INCIDENT INVESTIGATION AT WORK

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LEGAL REQUIREMENTS FOR REPORTING AND INVESTIGATION

What you need to know:

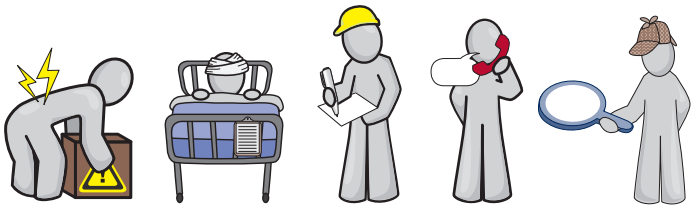
› The legal requirements for health and safety incident reporting and investigation in New Zealand

NOTES

THE DUTY TO MANAGE RISKS s30

The Health and Safety at Work Act 2015, Section 30 says that PCBUs and other duty-holders must eliminate or minimise risk, so far as is reasonably practicable.

This includes setting up tools and systems to report, record and investigate incidents which are work-related. Notifiable injuries/ illnesses and incidents must also be reported to WorkSafe NZ. By investing in a robust incident reporting and investigation system, your organisation can be sure it is meeting its legal obligations.



KEY POINT

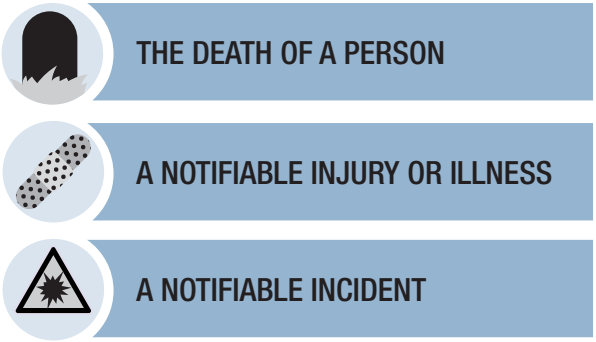
Managing health and safety risks 'so far as is reasonably practicable' includes having ways for incidents at work to be reported, recorded and investigated so that improvements can be made to how risks are managed and work is done.

NOTIFIABLE EVENTS

PCBUs are required to notify the regulator immediately after becoming aware that a notifiable event has occurred, to keep records of notifiable events, and to ensure that a site where a notifiable event has occurred is not disturbed until authorised by an inspector.

Notifiable events s25

A notifiable event is:



Duty to notify a notifiable event s56

A PCBU must, as soon as possible after becoming aware that a notifiable event arising out of the conduct of the business or undertaking has occurred, ensure that the regulator is notified of the event.

The notification may be by telephone, or in writing, including email or other electronic means. It must be the fastest possible means in the circumstances.

If required by the regulator, the event must be notified within 48 hours using the prescribed form or other form that contains the same details.

Duty to preserve the site  s55

A PCBU who manages or controls a workplace at which a notifiable event has occurred must take all reasonable steps to ensure that the site where the event occurred is not disturbed until authorised by an inspector.

The exemptions to this requirement are actions:

a To assist an injured person

b To remove a deceased person

c That are essential to make the site safe or to minimise the risk of a further notifiable event

d That are done by, or under the direction of, a constable acting in execution of his or her duties

e For which an inspector or the regulator has given permission.

Notifiable illness or injury s23

A notifiable injury or illness, in relation to a person, means:

a Any of the following injuries or illnesses that require the person to have 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 his or her skin from an underlying tissue (such as degloving or scalping)
- A spinal injury
- The loss of a bodily function
- Serious lacerations

b An injury or illness that requires, or would usually require, the person to be admitted to a hospital for immediate treatment

c An injury or illness that requires, or would usually require, the person to have medical treatment within 48 hours of exposure to a substance

d 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:

- With micro-organisms
- That involves providing treatment or care to a person
- That involves contact with human blood or bodily substances
- That involves handling or contact with animals, animal hides, animal skins, animal wool or hair, animal carcasses, or animal waste products
- That involves handling or contact with fish or marine mammals

e Any other injury or illness declared by regulations to be notifiable injury or illness for the purposes of this section.

Notifiable incidents s24

A notifiable incident means an unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health or safety arising from an immediate or imminent exposure to:

a An escape, a spillage, or a leakage of a substance

b An implosion, explosion, or fire

c An escape of gas or steam

d An escape of a pressurised substance

e An electric shock

f The fall or release from a height of any plant, substance, or thing

g The collapse, overturning, failure, or malfunction of, or damage to, any plant that is required to be authorised for use in accordance with regulations

h The collapse or partial collapse of a structure

i The collapse or failure of an excavation or any shoring supporting an excavation

j The inrush of water, mud, or gas in workings in an underground excavation or tunnel

k The interruption of the main system of ventilation in an underground excavation or tunnel

l A collision between two vessels, a vessel capsize, or the inrush of water into a vessel

m Any other incident declared by regulations to be a notifiable incident for the purposes of this section.

LEGAL REQUIREMENTS FOR REPORTING AND INVESTIGATION

Requirement to keep records s57

A PCBU must keep a record of each notifiable event for at least 5 years from the date on which notice of the event is given to the regulator.

The duty holder review

A duty holder review is an incident investigation done by the organisation, under the supervision of WorkSafe.

When an event is notified to WorkSafe, if the organisation can show that they have good capability to investigate and learn from incidents themselves, WorkSafe may consider a duty holder review instead of a formal WorkSafe investigation. The process identifies why the incident happened and what actions need to be taken by the duty holder to prevent it happening again.

EXAMPLE

The Real Pet Food Company

After a worker at the Christchurch plant lost the tip of a finger in an incident with a bandsaw, WorkSafe decided to require a Duty Holder Review rather than do a formal investigation.

The Real Pet Food Company "was very open to the process of learning. They had good CCTV footage of the incident and were keen to share that and discuss how they could make their workplace safer. They had already put interim measures into action, including lengthening the bench between the bandsaw and the worker, to reduce the likelihood of coming into contact with the blade."

The WorkSafe Inspector also suggested an engineered control, and after looking into it, The Real Pet Food Company replaced its bandsaws with the BladeStop bandsaw, uniquely designed to reduce risks of serious injury. When the unit senses a person has come into contact with the blade, the blade stops operating within 0.009 seconds – the difference between a small skin cut or an amputation.

The Duty Holder Review helped the organisation to implement both immediate and longer term improvements.

LEGAL REQUIREMENTS FOR REPORTING AND INVESTIGATION

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IDEAS ABOUT WHY INCIDENTS HAPPEN

What you need to know:

- The idea that incidents happen because of lots of different things happening and contributing to a situation
- The principle that good investigations must look for ways to learn and improve not only where front-line work happens, but also in how the organisation is managed

NOTES

INCIDENT CAUSATION MODELS

Models are a useful way to simplify complicated concepts.

It is important for organisations to use evidence-based models for their incident investigations because they:

- Enable a common understanding of incidents and why they happen
- Structure and communicate learning opportunities
- Help to downplay personal biases and question assumptions
- Guide data collection and analysis in a consistent way
- Encourage looking for improvement opportunities in how the organisation is managed, and not just with how workers do work.

KEY POINT

GUIDING PRINCIPLES

Multiple causation is the principle that incidents are the result of many different contributing factors all acting together.

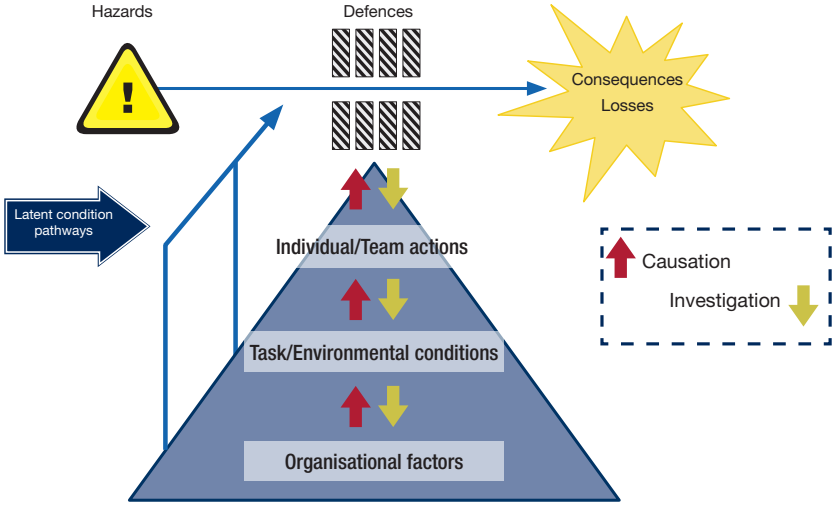
Root cause analysis is the principle that a good incident investigation will dig deep into the situation to try to uncover not only surface-level contributing factors, but also factors embedded in how the organisation works and is managed.

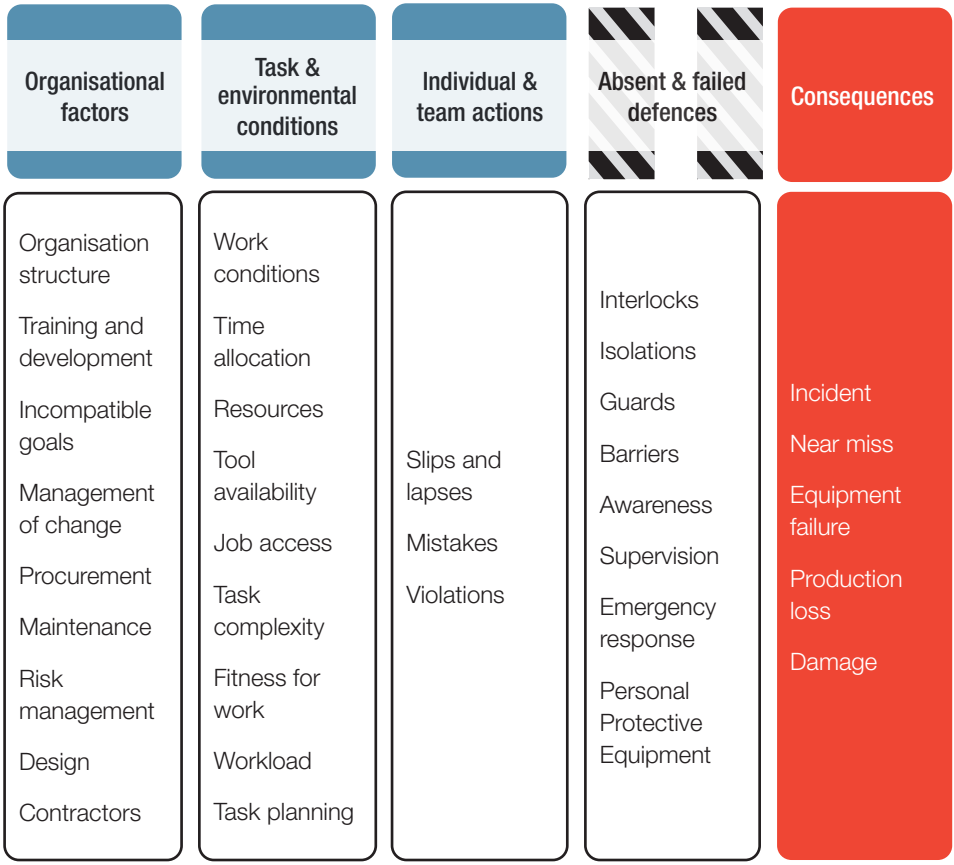
THE DEFENCES MODEL

The Defences Model has layers of defences which sit between operational hazards and what they could harm (people, the environment, product etc.). The model shows that defences don't exist by themselves, but are dependent on and supported by other things happening in the organisation.

These include the actions and behaviours of frontline workers (individuals and teams), as well as the task and environmental conditions they work in. Underpinning both are 'organisational factors' - the management systems and structures the organisation has in place. The effectiveness of defences relies on interactions between individual/team actions, task and environmental conditions, and organisational factors.

The Defences Model also shows that "latent conditions" can also have an impact on defence effectiveness. These are things about the organisation that have been in place for a long time, and have either gone unnoticed or never caused trouble before.




Organisational factors
Task & environmental conditions
Individual & team actions
Absent & failed defences
Consequences
Organisation structure
Training and development
Incompatible goals
Management of change
Procurement
Maintenance
Risk management
Design
Contractors
Work conditions
Time allocation
Resources
Tool availability
Job access
Task complexity
Fitness for work
Workload
Task planning
Slips and lapses
Mistakes
Violations
Interlocks
Isolations
Guards
Barriers
Awareness
Supervision
Emergency response
Personal Protective Equipment
Incident
Near miss
Equipment failure
Production loss
Damage
LEARNING FROM INCIDENTS
Continuously improving organisational factors
Task and environmental conditions suited to workers
High levels of human performance
Resilient defences and resources which allow for safe failure
Organisational objectives achieved

IDEAS ABOUT WHY INCIDENTS HAPPEN

Absent and Failed Defences

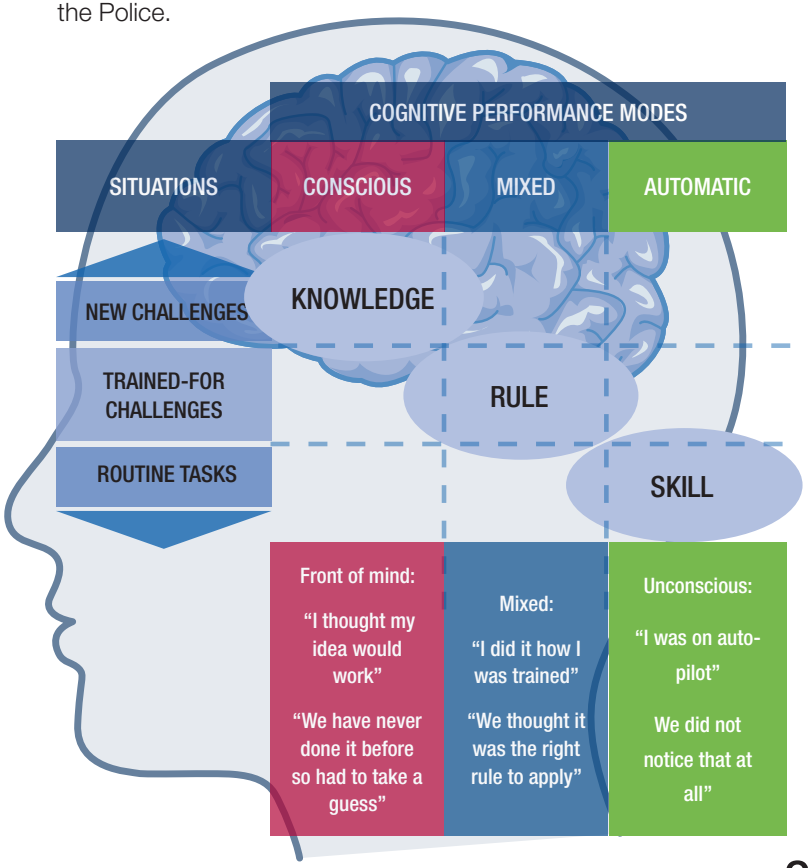
Defences are the controls and resources that an organisation puts in place to manage the risk of harm to workers and others. They should work together as a safe system of work and include 'hard defences' such as items of warning or detection equipment, guards, barriers, fail safe devices and protective equipment, as well as 'soft' defences such as information, instruction, training, supervision, experience, and knowledge. Post-incident defences such as escape and rescue planning and resourcing are also important to consider.

An investigation must first identify from the facts gathered, which defences were absent altogether, or were present but failed in some way. Effective investigations will identify **immediate actions** to put in place and improve systems of defences.

TYPES OF DEFENCES	EXAMPLES
Awareness	Information, training, instruction and supervision, pre-job briefings, plans, diagrams, experience, procedures
Detection	Warning lights and sirens, signs and notices, atmospheric hazard detectors, alarms, audible signals, fire detectors, motion detectors, a spotter or safety watch person
Control and Recovery	Machine guarding, fences, impact barriers, pressure relief valves, shut down systems, circuit breakers, residual current devices, trip switches and interlocks
Protection and Containment	Personal protective equipment, fire fighting media, spill kits, bunded areas, first aid.
Escape and Rescue	Emergency escape routes, emergency planning, alarms, emergency communications, rescue equipment and capability.

Individual and Team Actions

These are the things that people involved in the incident did (actions, inactions, decisions). What people do usually makes sense to them at the time, given the conditions at the time. The investigators' role is to find out what people did, what 'performance mode' or mental state they were in, why it made sense for them at the time, and not to blame. If an investigation does find clear evidence of deliberate, malicious and damaging behaviour, the investigation should be handed over to Human Resources or even the Police.



IDEAS ABOUT WHY INCIDENTS HAPPEN

Task and Environmental Conditions

Task and environmental conditions are all about what it was like for those involved at the time of the incident. They can be things to do with the task demands, the work environment, individual capabilities and personal factors at the time like being tired or distracted. Task and environmental conditions have strong positive and negative impacts on how effectively work can be done by people. In other words, they are how people are set up for success or struggle at work.

Common error predictors:

- **Work environment demands** e.g. extremes of heat or cold, high humidity, noise, vibration, poor lighting, restricted space
- **Task demands** e.g. high workload, high concentration requirements, repetitive and unstimulating tasks, distractions and interruptions
- **Social demands** e.g. low staffing levels, inflexible work schedules, peer pressure, conflict with co-workers
- **Individual stressors** such as inadequate training and experience, impairment through fatigue or substances, ill-health, social problems outside of work, mental ill-health
- **Equipment stressors** e.g. confusing displays and controls, inaccurate information or procedures, wrong tool for the job, poor condition.

Common violation predictors:

- **Expectation** that rules have to be bent to get the work done
- **Power imbalance** - the rules don't apply to some people
- **Opportunities** for short-cuts and easier ways of getting a task done
- **Planning** not done or incomplete, resulting in work done 'on the fly'.

Organisational Factors

Organisational factors are the features of the organisation and how it normally functions.

Common organisational factors:

- The **organisation's structure** of roles and responsibilities, reporting lines and authority for decision-making
- The organisation's internal **culture** - the set of values, beliefs, attitudes and behaviours that make up the 'feel' of an organisation
- The **management systems** in place for making sure things are done, including health and safety, risk, quality, environment, finance, maintenance, production and human resources
- The way **procurement and design** is done when the organisation is buying, hiring or building things for the work the organisation does
- How **procedures and training** programs for ways of doing work are developed and kept up to date
- How the **relationships** between the organisation and its contractors and suppliers are managed
- The way that **organisational change** is managed and communicated
- The influence on the organisation of **outside factors** such as legal compliance requirements, client and customer demands, and voluntary audit programs.

Organisational factors can be seen as the 'root causes' of incidents, because they are also the 'root causes' of everything that happens in the organisation, both good and bad. Effective investigations will recommend **longer-term actions** to modify the organisational factors that appear to have contributed to the incident.

IDEAS ABOUT WHY INCIDENTS HAPPEN

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THE INCIDENT INVESTIGATION PROCESS

What you need to know:

- Initial actions to deal with an incident
- Deciding how big the investigation needs to be and who should be involved
- Conducting an investigation
- Reporting and communicating the findings

NOTES

THE INCIDENT INVESTIGATION PROCESS

It is important to have a consistent and planned approach that guides an organisation from the moment an incident happens at work, through to putting the learning opportunities from the incident into practice. The following process represents good practice. The extent of what is done at each stage will depend on the level of the investigation (low/medium/high).

THE INCIDENT INVESTIGATION PROCESS

1. IMMEDIATE ACTIONS

When an incident happens at work, there are a lot of things that need to be done more or less at the same time. It is important to plan carefully and identify specific roles and responsibilities so that these actions can be taken quickly and effectively.

- Raise the alarm
- Provide first aid if safe to do so
- Notify the emergency services
- Evacuate the area if necessary
- Notify next of kin
- Notify authorities (WorkSafe, Police etc)
- Notify legal advisor/insurer
- Secure the incident scene
- Record and report the incident details.

2. PLANNING THE INVESTIGATION

The planning stage is about deciding on the level of the investigation and who should be involved.

It is important to take into account:

- The actual consequences of the incident
- The potential consequences of the incident
- Other impacts such as cost and legal implications.

LOW LEVEL

This is appropriate for incidents where no critical risks were involved. It will not take long (an hour or so) and is done by the relevant supervisor or line manager alongside the workers involved. The report will be informal and likely recorded as part of the incident report. The lessons learnt are owned by **department or site management**.

MEDIUM LEVEL

This level is appropriate for incidents where someone was (or could easily have been) hurt requiring immediate medical attention. This a more detailed investigation, taking several hours, led by the relevant supervisor or line manager, supported by an HSR. The report will be formal. The lessons learnt are owned by **regional management**.

HIGH LEVEL

This level is appropriate for incidents involving critical risks, and where a person has been permanently harmed. This is an in-depth investigation, over several weeks, involving multiple levels of workers, management, and relevant experts. It will be led by an experienced investigator. The report will be formal and detailed, and presented at Director level. The lessons learnt are owned by **national management**.

3. GATHERING INFORMATION

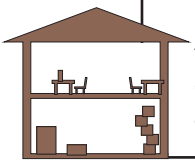
It is important to use both primary and secondary sources of information. **Primary sources** are directly from the incident e.g. eyewitnesses, CCTV, the incident scene itself. **Secondary sources** provide background information e.g. workers on a different shift, training records, procedures, a subject matter expert.

There are three main ways to get information for investigations:

LISTEN TO THE WORKERS INVOLVED AND OTHERS

The workers who usually do the work where the incident happened will have a good understanding of how work is done, and how the day of the incident was different to a normal day. Get the workers in a group and invite them to talk about their perspectives on the incident, and on the work generally.

For interviewing tips please refer to the appendices at the end of this manual.



LOOK AT THE INCIDENT SCENE

Take pictures and video of the place the incident happened, making note of the layout, the equipment, the positions of things and people, and the environmental conditions like noise, dust, lighting, space, and clutter. Try to find out what it was like at the time of the incident, and what it normally is like.

REVIEW RECORDS

Hunt for all records to do with the workers involved, the work being done, and the workplace. This could be CCTV footage, emails, phone records, vehicle tracking data, training records, maintenance schedules, cleaning rotas, shift rosters, timesheets, quality and production results, meeting notes, plans, etc.

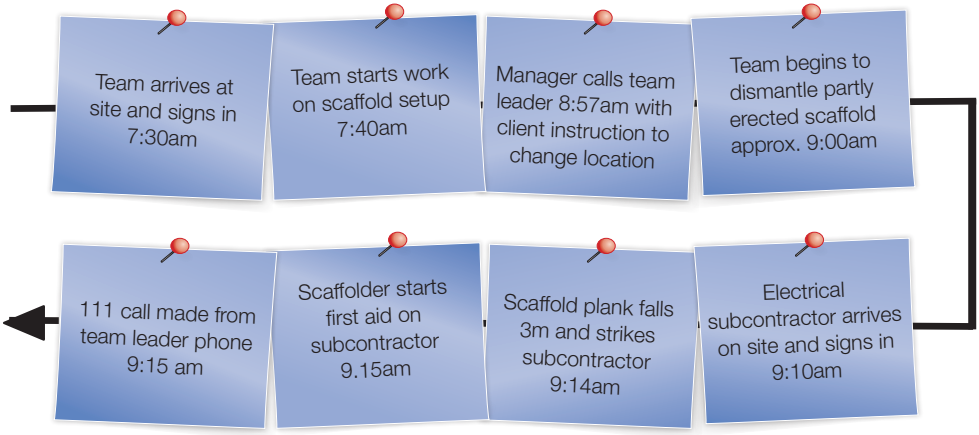
4. ORGANISING INFORMATION

The goal of this stage of the investigation is to organise the information you have gathered to tell a story of what happened and how it was at the time for the people involved.

EVENTS

WHAT HAPPENED: SEQUENCE OF EVENTS

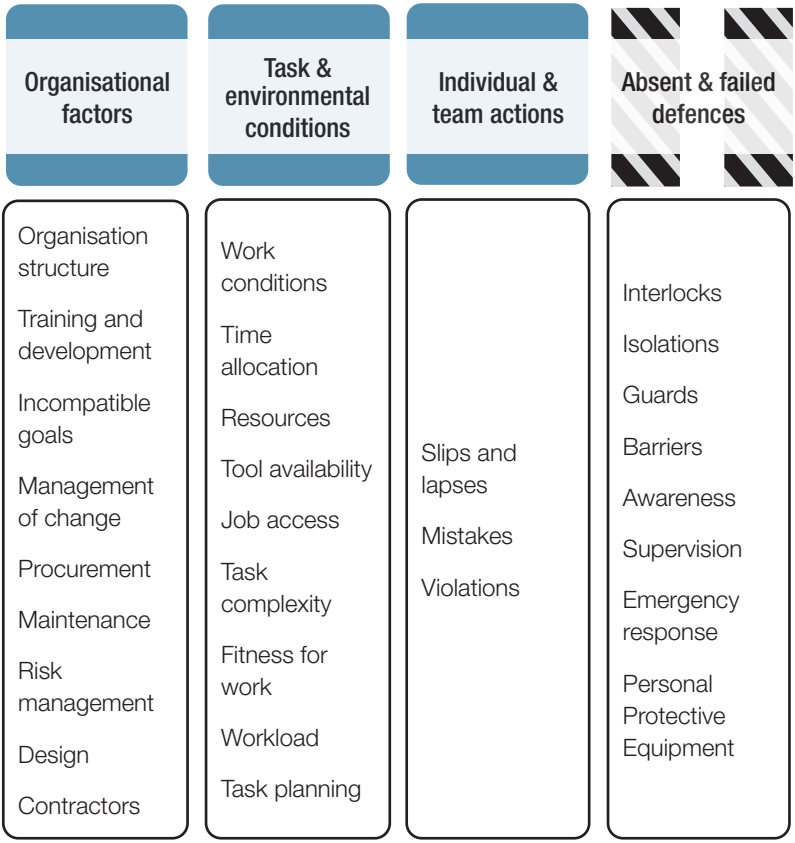
This involves identifying events (happenings, what was said or done) and arranging them in chronological order. You might spot gaps in the sequence of events where you need to gather more information. Look for 'time stamps' in the data you gather. These can be actual times that are recorded in phone data logs and CCTV footage, as well as the approximate times people remember.



5. ANALYSING INFORMATION

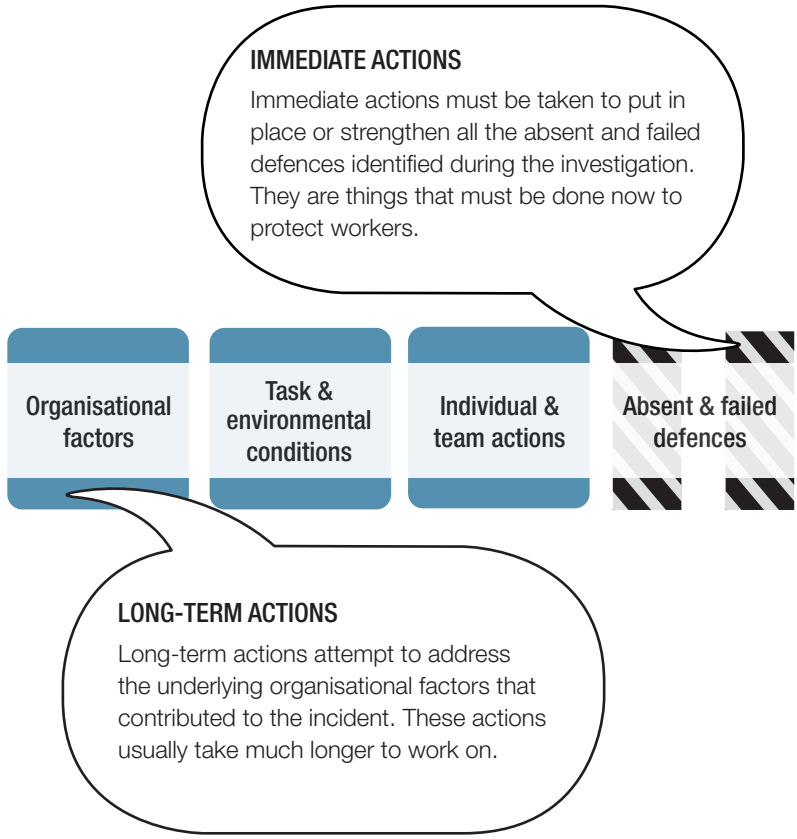
This stage is about making sense of **why** things happened, in order to learn and improve how work is done and address the root causes of how work is organised. The Defences Model is a useful sense making framework for workplace health and safety incidents.

Use the four categories of the Defences Model to make sense of the information you have gathered and organised.



6. DEVELOPING IMPROVEMENT ACTIONS

The stories you have uncovered and made sense of will lead to learning and improvement opportunities. The people involved in the incident should help come up with actions. The action plan must have both immediate and long-term improvement actions. It must include what the action is, how it will be monitored to see if it has been effective, who is responsible for getting it done, and the target date.



7. REPORTING THE FINDINGS

The Investigation Report

You need to record the findings of the investigation in a format that is easy to follow and appropriate for the people who will read it. The report must include a list of recommended improvement actions to management, in priority order and clearly showing the immediate actions and long-term actions.

The report then needs to go to the right people – those who are directly affected by the findings and have the authority to act on the recommendations.

Communicating the Findings

The level of the investigation affects how widely the findings are communicated. Generally speaking, the higher the level of investigation, the more people need to know about the findings.

It is very important to give feedback to everyone involved in the incident and its investigation—especially the injured person and their immediate colleagues. They need to know what will be done as a result of the incident, and that their co-operation has resulted in lessons learned and improvements to how work is done and organised.

Investigation Report Headings

Here are suggested headings for a medium level investigation report.

› EXECUTIVE SUMMARY

A brief and persuasive summary of the incident, lessons learned and improvement actions recommended, for the short and long-term.

› INCIDENT OVERVIEW

The main details of the incident, when and where it happened, who and what was involved, the consequences, immediate action taken.

› INVESTIGATION LEVEL

The level of the investigation, how this was determined, and who was part of the investigation team.

› INVESTIGATION PROCESS

How the investigation was done - an outline of the stages that were followed.

› SEQUENCE OF EVENTS

How the incident unfolded, including what happened leading up to the incident, the incident itself, and immediately after the incident.

THE INCIDENT INVESTIGATION PROCESS

› ANALYSIS

- An explanation of the incident analysis model used.
- The main findings of the investigation:
  - The absent and failed defences
  - The individual and team actions
  - The task and environmental conditions
  - The organisational factors.

› IMPROVEMENT ACTIONS

The immediate and long-term actions, with justification of how they may improve the organisation and prevent a reoccurrence of a similar incident, and how they will be monitored.

› ACCEPTANCE AND SIGN-OFF

A section for the report and actions to be signed off by management.

› APPENDICES

List of primary and secondary sources of information used for the investigation e.g. photographs, people who contributed, documents reviewed.

NOTES

NOTES

NOTES

APPENDICES

This section covers:

- A note about privacy
- Interviewing tips and techniques

NOTES

PRIVACY AND DATA PROTECTION

When conducting an investigation, you may have to access private and confidential information. There could be situations where people may not want to give you information because they are worried about privacy.

Examples of information most affected by privacy issues are:

- Medical records
- Personnel files
- Records of disciplinary action
- Criminal records.

It is best to get written consent directly from the person the information relates to.

If you get access to personal information, remember these things:

- Look only for relevant information: Do not look at information that has nothing to do with the investigation
- If you need to refer to personal information in your report, keep it to a minimum
- If you need to make copies of personal information, let the person know what you want to copy, why you need to copy it, and who will have access to it
- Give the information back to the person as soon as possible (if applicable).

Some of the information you get hold of may be controversial, or even put someone's safety at risk. A person's home address could be an example. Discuss these issues with the person you're getting information from, and if in doubt, talk to your manager or HR department.

INTERVIEWING TECHNIQUES

You will almost always have to interview people as part of an investigation. These will be eye witnesses and affected people, and also others who can shed light on the events which led up to the incident.

Successful interviews can depend on a number of things, such as:

- Interviewing the right people who can help
- What to ask them
- How you ask them
- When you ask them.

You may need to conduct initial interviews and follow-up interviews.

Initial interviews

As soon as possible after the incident, interview eye-witnesses, the victim and other people (see previous section).

Don't ask for details, **just get "the big picture"** from them. You can come back to them for details later.

Always start off initial interviews with open questions. These are questions that the respondent has to reply using a sentence, rather than just one or two words. Open questions can give you more information than closed questions, and can lead on to other questions.

Open questions usually start with Who, What, When, Where, How, and Why.

The questions should also be free of bias and assumptions.

Follow-up interviews

Follow-up interviews are usually needed for checking facts and details.

Closed questions are often best for follow-up interviews, because they prompt people to give short, specific answers.

AVOID:	
	Questions that show bias, or leading questions. You're showing that you already have an opinion on the topic you're questioning them about.
	Double-barrelled questions. This is where you are asking more than one question at a time. This can confuse people, and you may end up only getting a response to one question.
	Finishing people's sentences or suggesting answers for them. People may take their time in responding to your questions because they have to think about it. Finishing their sentences for them shows impatience, and can make them nervous or irritated.
	Don't be accusing or argumentative when trying to find out information. They may not want to talk to you afterwards.
	Don't patronise or "talk down" to them: use language that the interviewee is comfortable with.
	Don't show off or confuse the interviewee by using large or confusing words. Explain jargon or technical terms if necessary.

DO:	
☑	Put the interviewee at ease beforehand. Tell them what the interview is about and why you need to ask them questions.
☑	Tell them it's okay for them to ask for clarification if they don't understand the questions.
☑	Question them at the incident scene if possible, but use your judgement. Some people may get upset at having to revisit the scene of a traumatic incident.
☑	If you're interviewing people some time after the incident, show them photos or diagrams to help jog their memory. Again, use your judgement. Photographs of huge amounts of blood on the floor aren't really necessary in most situations.
☑	Take notes. Explain to the person why you're taking notes (for accuracy) and tell them what you will do with their information.
☑	Listen carefully! They talk, you listen.

DO:	
☑	Consider your body language. Crossed arms, standing while they are sitting: these can mean something to the interviewee, even if it means nothing to you.
☑	Find somewhere quiet where you are not likely to be disturbed when doing detailed interviews. Constant interruptions can put the interviewee off their pace, or make them feel that they're not important.
☑	Be aware of cultural issues when interviewing people.

Investigation skills—interviewing

Suggested questions to ask:

- What happened? (Very general open-ended question)
- What did you see? Or, what did you hear, smell, or feel?
- Where were you standing when the incident happened?
- What were you doing when the incident happened?
- Did you notice anyone else at the incident scene that may be able to help as a witness?
- What time did the incident happen?
- Is there anything in particular you remember about the incident?

Try not to interview the incident victim until they have received medical attention and are able to cope with answering questions. Seriously harmed victims are going to be in shock, and may need lots of medical attention before they are able to talk to you.

You may find that because of interviewing other people first, you might be able to ask more specific questions of the victim, and this may help their memory recollection.

Active Listening

Some of the most important skills needed for clear and effective communication are active listening skills. Active listening skills help us to:

- Correctly identify the information, ideas or feelings being communicated.
- Understand the needs, wants, goals and concerns of others.
- Clarify the desired or appropriate response or action to take.

Active listening skills include:

- Asking **closed questions** that require yes/no or facts and figures answers to check accuracy and clarify details.
- Asking **open questions** to gain useful information. Such as, 'Tell me about...' or 'Can you describe the...'
- Reading and responding to **body language**
- **Paraphrasing** and **summarising** to check that you understand the details and how they fit together.

Using active listening skills takes effort. We need to pay attention to the types of questions that we ask and how we ask them. If we have genuine interest in the concerns, interests and needs of others it makes it easier to do this. Remember, we are required to act in good faith.

GLOSSARY OF TERMS

ACC	Accident Compensation Corporation.
Approved codes of practice	Developed by WorkSafe NZ and approved by government minister; sets out how to do certain things safely. Accepted in court as means of compliance in specific situations.
Good faith	A concept set out in the Employment Relations Act that describes positive ways of working and communicating between two groups e.g. workers and management.
Guidelines	Developed by WorkSafe NZ and/or Industry Body; sets out how to do certain things safely. Accepted in court as means of compliance in specific situations.
Harm	Death, injury and illness, including both physical and psychological harm.
Hazard	A situation or thing that has the potential to cause harm.
Incident	An unwanted event that caused or could have caused, harm, damage or loss of some kind.
Officer	Persons with significant influence over the management of the business or undertaking, such as Directors, Chief Executives and Partners.

FURTHER INFORMATION

PCBU	Person (legal entity) Conducting a Business or Undertaking.
PPE	Personal protective equipment.
Psychosocial	Relating to mental health in individuals and relationships between people.
Qualitative	Involving judgements, opinion and intuition.
Quantitative	Something that involves the measurement of quantity.
Reasonably practicable	Action which is, or was, at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters, including likelihood of the risk occurring, degree of harm that might result, knowledge about the hazard or risk, and risk control measures, availability and suitability of risk control measures, and cost of risk control measures, including whether the cost is grossly disproportionate to the risk.
Regulations	Made under the Health and Safety at Work Act (specifically health and safety related regulations). Legally enforcible, with specific duties and duty holders.

Risk	The possibility that harm (death, injury or illness) might occur when exposed to a hazard, including an estimation of the likelihood of an event occurring where someone is exposed to a hazard, and the consequence(s) of exposure to the hazard.
Risk control	An action taken to eliminate or minimise the risks to health and/or safety.
Standards	Developed by standard setting bodies e.g. Standards NZ, Standards Australia, ISO etc. Specific and detailed requirements for conformance to a standard.
Worker	A person who carries out work in any capacity for a PCBU, including an employee, a contractor or subcontractor, an employee of a contractor or subcontractor, an employee of a labour hire company, a homeworker (person who works from home), an apprentice or trainee, a person gaining work experience, and a volunteer.

REFERENCES AND FURTHER READING

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Dekker, S (2006) The Field Guide to Understanding Human Error; Surrey: Ashgate

Hollnagel, E. (2009). The ETTO Principle: Why things that go right sometimes go wrong. Farnham, UK: Ashgate.

Hopkins, A. (2012) Disastrous Decisions: The Human and Organisational Causes of the Gulf of Mexico Blowout, Sydney: CCH

Hopkins, A. (2006) Safety, Culture and Risk, Sydney: CCH

HSE (2005) A review of safety culture and safety climate literature for the development of the safety culture inspection toolkit RR367

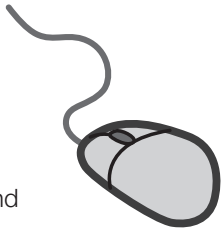
Hudson, P. (2014) Safety Culture and Leadership [Transcript] Delft University of Technology, The Netherlands

O'Neill, S & Wolfe, K, (2017) Measuring and reporting on work health & safety, Canberra, Safe Work Australia

Reason, J.T. (2008) The Human Contribution: Unsafe Acts, Accidents and Heroic Recoveries: Surrey: Ashgate

Schein, E. (2006) Organisational Culture and Leadership: John Wiley & Sons

Useful Websites



New Zealand Government

www.worksafe.govt.nz	WorkSafe NZ
www.standards.co.nz	Standards New Zealand
www.acc.co.nz	Accident Compensation Corporation
www.fireandemergency.nz	Fire and Emergency New Zealand
www.police.govt.nz	New Zealand Police
www.legislation.govt.nz	New Zealand Legislation
www.getthru.govt.nz	Get Thru Emergency Management
www.civildefence.govt.nz	Ministry of Civil Defence
www.eqc.govt.nz	Earthquake Commission

Private organisations

www.impac.co.nz	IMPAC Services Ltd
www.safeguard.co.nz	Safeguard Magazine

Trade unions

www.union.org.nz	New Zealand Council of Trade Unions

KEY POINT

For more useful websites and resources we recommend you login to IMPAC's student portal.

New Zealand Qualifications Authority: Course Information

Assessment

- NZQA assessment requirements will be explained by your trainer
- Assessment can be verbal if required
- Please let us know of any concerns you may have about completing the assessment criteria
- Assessment in te reo Maori is allowed but you must apply in writing to our training office.

Re-assessment

- Your trainer will advise you what you need to do to complete a re-assessment
- Re-assessment material is forwarded to our Napier office for marking.

Appeals of Results

1. Please contact our Training Manager on 0800 246 722 in the first instance
2. Your assessment can be re-marked by another IMPAC assessor if you are unhappy with your result
3. If you are not satisfied following re-marking, you can ask for independent moderation from the Industry Training Organisation (ITO).

Complaints

If you wish to make a formal complaint, you must:

☑	Write to the Training Manager, PO Box 308, Napier
☑	Provide full details of your complaint
☑	Please provide specific details of your complaint, including dates, times, and places
☑	Include your contact details (name, address, telephone number, email).

The Training Manager will:

☑	Acknowledge receipt of your complaint
☑	Log your complaint
☑	Analyse the content of your complaint
☑	Undertake an internal investigation of your complaint
☑	Advise you in writing of the outcome of the internal investigation.

My World Plan

Name:	Position:	Company:	Date:

Goal - What are you going to do?	Action steps- How are you going to do this?	Target date
		☐ Completed
		☐ Completed
		☐ Completed

		☐ Completed
		☐ Completed
		☐ Completed

OTHER IMPAC COURSES YOU MAY BE INTERESTED IN ARE:

HSR Stage 3: Workplace H&S Culture and Communication

This course is designed for students to understand workplace health and safety culture and practices, and how to communicate effectively about workplace health and safety.

ICAM Investigation Techniques

Incident Cause Analysis Method. This 2 day course will give you the knowledge and practical skills to become a lead investigator in your organisation. The method is relevant not only to health and safety incidents, but all potentially adverse events where organisational learning is desirable.

Bow-tie - Critical Risk Management

The Bow-tie diagram is a barrier analysis technique developed in the oil and gas industry but increasingly used in many critical risk settings. It allows detailed analysis and communication of defences-in-depth requirements for critical risks.

FOR MORE INFORMATION CONTACT US TODAY.

E: contactus@impac.co.nz

P: 0800 246 722

W: www.impac.co.nz

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We trust you enjoyed your training with +IMPAC, New Zealand's leading full service Health + Safety solutions provider.

Health + Safety is our life – it's what we do and we do it all:

RISK MANAGER
:MEXPRESS

Our cloud-based software solutions are designed to provide risk management processes to meet health and safety requirements and keep people safe. Choose between our cost effective, **set-up-and-go solution RM Express** - ideal for small to medium organisations; and **Risk Manager, with its fully customisable range of modules** which can be tailored to the needs of larger organisations.

CONSULTING

We work alongside businesses and organisations to understand their challenges and opportunities. Our hugely experienced consulting team assess, advise, investigate and **deliver relevant and practical solutions**, applying a sensible risk management approach to health and safety.

PREQUAL

Our **pan-industry solution to contractor prequalification** and ongoing management. We cater for both individuals needing contractor prequalification and companies wanting to manage all their contractors in one easy to navigate platform.

VRCOMPETENCY

Our innovative virtual reality programme to quickly and effectively upskill operators of motorised vehicles and machinery in a safe and risk free environment. Our courses accelerate training times, improve and certify skills and offer continuous learning.

TALENTBANK

With our unrivalled industry experience and wide network of talent, our **specialist recruitment service** helps to connect the right H+S people to an organisation's contract or permanent roles. We fully understand our clients' resourcing needs and know the best way to help H+S professionals build a better career.

SAFEWORX

We supply a comprehensive range of quality standards appraised **workwear, personal protection and safety equipment**, online and at retail branches nationwide. Our expert team partner closely with customers to develop innovative safety products to address gaps in high risk industries.

To discuss any of IMPAC's H+S services
contact 0800 246 722

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