Black Diamond
BD Drill Drilling Services Australia

Black Diamond Drilling Services

Incident Management Standard

BDD-WHS-STD-003

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1 Introduction

1.1 Purpose

The intent of this Standard is to provide a process for incident reporting and investigation at any Black Diamond Drilling Services project site. It details the minimum requirements for incident notification, incident reporting, and incident investigation. This procedure addresses the requirements of the WHS/OHS legislation.

1.2 Scope

This Standard applies to all incidents where the main consequence type is “Harm to People”. Where an investigation and report are required, this procedure may be used to meet those requirements and/or the requirements to undertake an additional investigation in this procedure. This procedure applies to all Black Diamond Drilling Services personnel, contractors and visitors who work at or visit any BDD project operation.
This procedure or any aspect of it may be overridden, varied, or not followed, at the discretion of Black Diamond Drilling Services legal counsel or external legal counsel.

2 Immediate Incident Response and Notification

2.1 Preliminary Incident and Notification

A verbal notification of any incident must be made by the area supervisor **as soon as possible** after becoming aware of the incident event.

2.2 Injury Notification

In **ALL** cases where the injured person is treated by the Paramedic and/or a Treating Medical Practitioner, the Supervisor for the injured person must inform the relevant BDD Project Manager as soon as practicable following the injury occurring. This includes all first aid injuries.

All lost time/disabling injuries or diseases must be reported to the WHS/OHS Regulator by the BDD WHS/OHS Manager or delegate, using the applicable State Regulator WHS notification report, as soon as the relevant information is available.

2.3 Prevent Escalation

The following must be done immediately after an incident to prevent escalation:

- Activate the site Emergency Response process, if required
- Notify the supervisor responsible for the person(s) involved
- Make the area safe for first responders, and to prevent escalation
- Treat any injured or potentially injured persons by engaging the site paramedic
- Not interfere with the site of a Serious Accident or Dangerous Event

Records must be made of actions taken to prevent escalation, at the time they are taken, or as soon as practicable, as they will need to be recorded into the company incident report database.

3 Incident Investigation and Action

The quality of the investigation and report must comply with the following standards at a minimum:

- The data, and sources of the data used to reach a conclusion are noted
- Any potential inaccuracy in the data is noted
- Any assumptions or opinions are recorded as such, rather than as facts

- The scope of the investigation and report is specific to the event

The goal of the process is to identify:

- Contributing factors
- Corrective and preventive actions needed to prevent an event, or recurrence of an event

At the discretion of BDD legal counsel or external legal counsel an incident may be investigated for the purposes of obtaining legal advice and/or because legal proceedings are reasonably anticipated.

A WHS/OHS Inspector is required to be notified of, and may determine the need to investigate the site of, a notifiable incident. Accordingly, the scene of a notifiable incident **must not** be interfered with, without the permission of the Regulator. An Inspector may require the scene of a notifiable incident to remain secured and untouched until the Inspector has carried out an investigation in person.

3.1 Incident Type and Classifications

For any Incident and/or Near Hit that has a loss type of **Harm to People** the incident is then assigned a sub-incident, based on the initial incident category.

For Injury/Illnesses, one of the following category severities is to be chosen:

Injury/Illness Category Severity	
FAC	A first aid case (FAC) is recorded when first aid treatment (of any sore) is required as a result of a work-related injury or illness
MTC	A Medical Treatment Case (MTC) is a work-related injury or illness resulting in the medical management and care of a patient to company disease or disorder, including any loss of consciousness
LTI	A Lost Time Injury (LTI) is a work-related injury or illness resulting the in the employee / contractor being unable to attend work on the next calendar day after the day of the injury
Occ ill:	An Occupational Illness (Occ Ill) is any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to factors associated with employment. It includes acute or chronic illness or disease, which may be caused by inhalation, absorption, ingestions or direct contact
DE	A Dangerous Event (DE) means an event caused by specified high risk plan, or an event as a workplace or relevant workplace area, if the even involve or could have involved exposure of person to risk to their health and safety
Fatality	Death, loss of life

3.2 Appointment of Investigator

Following the event of an incident, the relevant area supervisor must report the details to the BDD WHS Manager, who will immediately appoint a Supervisor as the investigator for the incident.

The (Lead) investigator is required to complete the Incident Investigation Form to confirm all required actions are taken following an incident occurring.

3.3 Collecting Data

The Investigator's role is to collect and organise information associated with the incident. Evidence must be gathered as quickly as possible. All collected data must be logged, preserved,

and controlled. A team approach may be used for investigations, if a team approach is used, then an Incident Investigation Team Leader must be appointed by the BDD WHS/OHS Manager.

Collecting data is a critical part of the investigation. It is important to confirm that all relevant information is collected and that the information is accurate. Collecting data is an iterative process that takes place in the first half of the investigation cycle.

As preliminary analysis is conducted on the initial evidence, gaps will become apparent, requiring the team to collect additional evidence.

Generally, many data collection and analysis iterations occur before the incident investigation team can be certain that all pertinent evidence has been gathered and analyses are finalised.

The following must be collected prior to interfering with the scene of an event:

1. The details about the incident must be recorded and if possible, photographed
2. Sufficient measurements or survey data must be collected to develop an accurate plan of the site
3. A list of witnesses must be compiled

Any data collected must be treated as confidential and must be secured in the event that a Regulator requests evidence.

There are five major steps that must be followed in gathering evidence:

1. Collecting human testamentary evidence – locating and interviewing witnesses
2. Collecting physical evidence – identifying, documenting, inspecting, and preserving relevant matter (e.g. equipment, parts, debris, hardware, and other physical items)
3. Collecting documentary evidence (e.g. paper and electronic information, such as records, reports, procedures, and documentation)
4. Examining organisational factors, management systems and management factors

5. Preserving and controlling evidence

The Investigator (and/or investigation team) must gather all necessary information as a matter of priority.

Record witness details including name, contact details, geographic position (location) and activity being performed at the time of the incident.

Witnesses must not be interviewed together and must not discuss their interview with other witnesses.

4 Incident Investigation Report Completion

4.1 Section One

This section is to be completed by the worker directly involved in the incident or the area Supervisor within four hours of the incident occurring.

This section requires information relating to the worker details (worker who was involved in the incident).

4.2 Section Two

This section is to be completed by the worker directly involved in the incident or the Supervisor within four hours of the incident occurring.

The "Incident Type" and "Injury Category" sections (based on the available information at the time) require that the event is classified by the "Actual" known outcomes and, in the estimate of the person completing the report, the "Potential" severity of the incident.

If it is known or immediately obvious that this is or could be a Notifiable Incident then mark the relevant question but DO NOT contact any external agency as this will be managed directly by the BDD WHS Manager once the report has been made.

4.3 Section Three

This section is only relevant in the event of a personal injury.
This should be completed by the treating first aid attendant or treatment provider in conjunction with the injured worker and area Supervisor.
Some information required may not be immediately available, but this can be entered later by the Investigator and should not hinder processing the report or commencing the investigation.

4.4 Section Four

This section signifies the commencement of the formal process of investigation.
While each investigation is unique, it is a consistent requirement that each investigation will require:

- An area Supervisor
- An Investigator who will facilitate the investigation and analysis and finalise the draft report

This section provides the framework of critical sub-headings for reporting the findings once the investigation and analysis has been completed.

Sequence of Events

A description that defines the actual event outcome, i.e. “Worker dislocates finger”, and the sequence in which events leading up to and including the incident, took place. The timeline is simply the chronological order of events preceding, during, and subsequent to the incident. Record events back as far as is relevant to understand the reasons why the chain of events occurred. Include also the activities of those planning, approving or providing direction to persons involved in the relevant activities when the incident occurred.

The acronym PEEPO is applied to define the general headings of the types of documents, records and information that will need to be gathered for review – subject to the circumstances of each event.

General examples are as follows:

People: training records, competency assessments, certificates of training and assessment, job descriptions, organisation charts, induction records, witness statements (both those directly involved and those who provide direction, instruction or were otherwise associated with the activity) etc.

Equipment: records of test, inspection and maintenance, operator instructions, load charts, risk assessments, SDS, manufacturer’s instructions, position of warning signs, alarms and lights, HAZOP records, wiring diagrams etc.

Environment: Weather conditions at the time and beforehand, workplace layouts, arrangements for access and egress, what parallel activities were taking places, dust, fumes, gas and other emissions, lighting, noise survey data, housekeeping, floor conditions, obvious slip or trip hazards etc.

Procedures: What procedures were relevant to the work planning and execution, Safety Management Plans, TRA’s, risk assessments, policies, permit requirements and records, applicable legislation and Codes of Practice

Organisation: Inspection records, level and availability of supervision, previous audit reports, risk registers, minutes of safety committee and other meetings, hazard reports, incident investigation reports, training needs analysis, change management arrangements and approvals matrix, frequency and structure of inspections etc.

Records gathered and reviewed for relevance should be listed and those considered relevant to the investigation should be copied and maintained with the investigation report.

Contributing Causes

The collection of proven facts, described as the chain of inter-related events/conditions/actions or failures which occurred prior to or which failed to prevent the incident at the time.

Root Causes

These are the actual systemic or organisational failures that allowed the chain of events to occur. Each Root Cause description should address one or more common failures at the organisational level, rather than a single point of detail. This is a description of what defences were not effective, not a description of what needs to be done to correct it. i.e. “The organisation failed to ensure that an effective system was in place for the management and inspection of items of plant mobilised for use at site”.

Corrective Actions

Identify the Corrective Actions to prevent recurrence. The investigation team should map the Corrective Actions to each of the Root Causes. Each of these actions should be allocated to an individual to complete – or to facilitate their completion.

To ensure their effectiveness, each Corrective Action should be considered against the Hierarchy of Controls to determine that the highest order of control has been applied – so far is reasonably practicable. Lower order controls of Administration (procedures, signage, toolbox

meetings etc.) and PPE do not provide robust defences and are reliant on compliance to an instruction rather than control exposure to the actual risk.

Once agreed and implementation commences, then each of the Corrective Actions should be evaluated to ensure that they are both effective and have not inadvertently introduced a new or unrecognised risk.

4.5 Section Five

This section provides a sign off of the final report and allows those involved and the management team the opportunity to review the facts and findings, make additional comment as appropriate and signify their formal acceptance and approval.

5 Incident Investigation Report Close Out

5.1 Investigation Evaluation

Within 72 hours (or such further time agreed by the BDD CEO) of being sent the investigation, the BDD WHS/OHS Manager must approve or reject the investigation report, by evaluating the following:

• The incident investigation involves the appropriate personnel

• Adequate investigation in relation to the scope

• Identified root causes directly related to the specific incident under investigation, and are based on clear evidence

• Completeness of the investigation findings, and accuracy of the associated categorizations;

• The actions are specific, measurable and achievable, will truly address the root causes identified, and be able to prevent a re-occurrence if effectively implemented

• Actions are to be assigned to appropriate persons

Once approved by the BDD CEO, the BDD WHS/OHS Manger has 72 hours (or such further time agreed by the BDD CEO) to approve or reject the incident investigation. Once approved, the BDD CEO closes the incident.

5.2 Communicate Findings of Investigation

In the case of a notifiable incident, the incident investigation must be completed and submitted to the State WHS/OHS Regulator as per the required timeframe as stated by the Regulator OR if not stated, then no later than one month after the incident has occurred.
The BDD WHS/OHS Manager may distribute feedback about the incident within 72 hours (or such further time agreed by the BDD CEO) of the close out of the incident. Each area Supervisor will provide all workers have an opportunity to view the incident feedback. Where an incident has been investigated to obtain legal advice and/or in anticipation of legal proceedings the distribution requirements may not be applicable.

5.3 Incident Investigation Monitor and Review

All incident report actions must be reviewed within three months after the last action has been completed, but no later than six months after the incident occurred. The review must focus on the efficacy of the actions taken to prevent recurrence.

6 Attachments

- Nil

7 References

- State and Territory industry sector legislation
- BDD-WHS-PLN-001 Work Health and Safety Plan
- BDD-WHS-PLN-002 Emergency Response Plan
- BDD-WHS-PLN-003 Rehabilitation and Return to Work Plan