QRMC RISK, SAFETY AND BUSINESS ADVISORY CONSULTANCY

insight

QRMC NEWSLETTER

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Insight aims to provide useful information, links and tips in the areas of Risk Management, Work Health and Safety, Business Continuity Management, and other areas relating to management systems and corporate governance.

Incident Investigations – Opportunities for Improvement and Learning

Without meaning to sound callous, workplace incidents can and should be seen as opportunities for system improvement and implementing a more robust risk management process.

In an *Insight* article from a number of years ago, we discussed that rather than focusing the blame on the poor old worker, we should be optimising the lessons to be learned from our incident investigations. Here we build on that advice with some specific areas to focus on.

There are three critical areas where lessons learned from incident investigations frequently are not fully identified or implemented.

1. *Identify all Contributing Factors*

We would all like to think that modern organisations have accepted that workplace incidents don't typically occur just because "somebody didn't follow the procedure". Whilst this may be part of the story (or not at all in many cases), the reality is that the vast majority of incidents occur due to *more than one contributing factor*.

There are many incident investigation models used today, and one of the core objectives for all of these models is to identify all of the contributing factors to the incident's occurrence. Despite this, frequently factors such as fatigue, the weather on the day, the worker's state of mind at the time and what was happening in the lead up to the incident are either not captured at all, or are buried within witness statements and not recognised as contributing factors.

2. *Action all Contributing Factors*

This may sound like common sense, but it is critical that each identified contributing factor be allocated an action to address why it was present and how it contributed to the incident occurrence.

Often the only corrective or preventative action resulting from an incident is to provide further training to the employee, leaving most contributing factors unaddressed.

3. *Identify and Review Other Areas Where the Same Incident Could Occur*

If there is the potential for the same incident to occur elsewhere within the organisation (e.g. in another team or department undertaking the same or similar work activity), then it would make sense to alert that area and ensure they implement preventative actions or safeguards. That's what Safety Alerts (or similar communiques) do, right? Well, yes and no. Safety Alerts are typically produced and distributed upon first becoming aware of an incident. At that point in time, the investigation is yet to commence and contributing factors (whilst some may be obvious) may not be all identified. It is when the investigation is complete, and all contributing factors have been identified, that other areas and activities where these factors exist should then be communicated with for their review and action if necessary.

Obviously, there is far more to incident investigations than the three areas identified above. That said, the opportunities for greatest improvement and learning lie largely with these three critical areas, and they prove highly effective in achieving the overall intent of why we do incident investigations in the first place: which is to prevent their recurrence and further injury to our people.

Please contact QRMC for more information.

Are you prepared for the new Psychosocial Code of Practice? Part 2

In the February edition of *Insight*, we explored the issues that PCBUs (persons conducting a business or undertaking) are now required to address as part of their work health and safety obligations under the *Managing the risk of psychosocial hazards at work* Code of Practice (CoP) 2022.

In this edition, we'll look at how PCBUs can go about checking and improving their systems, procedures and culture in order to have confidence that the issues are being managed as far as reasonably practicable.

As we described last month, most workplaces are used to managing physical hazards as part of their work health and safety management systems and procedures, however the new CoP requires the management of psychosocial hazards too.

A psychosocial hazard is "a hazard that arises from, or relates to, the design or management of work, a work environment, plant at a workplace, or workplace interactions and behaviours and may cause psychological harm, whether or not the hazard may also cause physical harm".

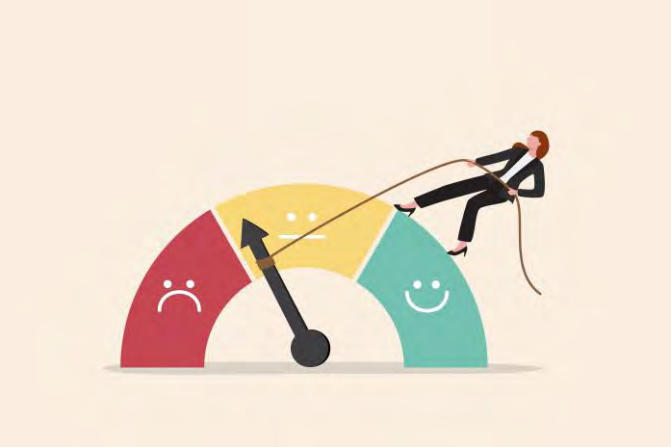
So what steps can PCBUs take to get their work health and safety practices up to scratch?

Worksafe Queensland advises that "PCBUs must adopt a risk management process, including eliminating psychosocial risks, so far as is reasonably practicable, or if it is not reasonably practicable to eliminate psychosocial risks, by minimising them."

The risk management process requires PCBUs to:

- Identify psychosocial hazards
- Assess the risk
- Control the risks
- Review the controls

In order to safeguard workers from psychosocial hazards, and to be able to demonstrate that all reasonably practicable steps have been taken to do so, this risk management process should be undertaken methodically and documented. We explore each step in the risk management process below.



1. Identify psychosocial hazards:

- Consult with workers. This could be by conducting workshops or group consultation meetings, providing anonymous surveys or other feedback mechanisms,
- Critically assess workplace culture, with the various kinds of psychosocial hazards in mind (refer back to our February article).
- Review historical records. For example:
  - EAP usage;
  - Disputes and industrial relations issues;
  - Trends in sick leave;
  - Workers' compensation for psychological injuries;
  - Worker knowledge of, and compliance with, workplace bullying and harassment or discrimination policies;
  - Trends in complaints or workplace grievances;
  - Increased overtime;
  - Indications of stress amongst workers.
- Undertake workplace inspections, to look for indications of psychosocial hazards and/or poor workplace culture.

2. Assess the risks:

- Once the risks have been identified, the process of assessing them is the same as for any WHS risk:
  - Identify the harm that could be caused by the risk;
  - Determine the possible consequences to workers, in light of known control measures; and
  - Determine the likelihood of it happening (this may incorporate frequency, intensity and duration of exposure to the risk).

- Don't forget that Consequence comes before Likelihood in the risk assessment process (see our earlier article on this topic here).

3. Control the risks:

- Keeping in mind any existing controls and their effectiveness, identify if any new controls need to be implemented to eliminate or manage the risk.
- Assign responsibilities for implementing the new controls.
- Assign timeframes, prioritising action according to the level of risk

4. Review the controls:

- Managing risks is never a set-and-forget exercise, so be sure to set a timeframe for revisiting the whole process, including:
  - Assessing the effectiveness of the new controls;
  - Re-assessing the risk level in light of the new controls and their level of implementation and effectiveness; and
  - Checking for new or emerging risks.

Please contact QRMC for assistance in conducting risk assessments, redeveloping your WHS management system, or for more information.