Incident Investigation Procedure

Purpose and Scope

This procedure applies to all Staff, Students, Contractors, and other personnel at workplaces under the management or control of Murdoch University.

Objectives

- To establish a systematic, consistent, and documented methodology within Murdoch University for incident investigation, identification of the root cause(s), analysis, and closure.

Overarching Policy

Health and Safety Policy

Procedure

1. The School/Office Manager must, upon receipt of notification of an incident, classify the incident as either low, minor, medium, high or very high in the work health and safety risk management procedure and appoint a suitably qualified investigator and investigation team members.
2. Investigation requirements
    - 2.1. The investigation of insignificant incidents is at the discretion of the relevant School Dean/Director (Annexure 1).
    - 2.2. Investigation of minor incidents is at the discretion of the relevant School Dean/Director, apart from when the root cause is not obvious, then a 5 Why Analysis must be conducted as prescribed in Annexure 1.
    - 2.3. The investigation of moderate incidents requires a root cause analysis to be conducted as prescribed in Annexure 2. Investigation teams for minor incidents may consist of:
        - 2.3.1. The incident investigator appointed by the School Dean/Director.
        - 2.3.2. The reporting person.
        - 2.3.3. Person(s) injured in the event, if possible; and
        - 2.3.4. The supervisor of the injured person.

2.4. The team gathers as much information as possible regarding observations before, during and after the event occurrence, determines possible causes and completes the 5 Why Analysis (see steps 1, 2 and 3 of Annexure 1). Ask “Why?” until the team is in agreement that the problem’s root cause is identified. This may take fewer or more times than five Whys – adjust the form accordingly, if required. The investigator submits a copy of the completed 5 Why Analysis into WorkDay.

2.5. The investigation of Major and Catastrophic incidents is mandatory. Such investigations are conducted by appointed investigation teams, facilitated by an adequately trained incident investigator. An initial Investigation Report Form (Annexure 2) must be completed. Investigation teams for Major or Catastrophic incidents shall consist of, as required:

2.5.1. The Head of Health, Safety and Wellbeing.

2.5.2. The incident investigator appointed by the Head of Health, Safety and Wellbeing.

2.5.3. The incident reporting person.

2.5.4. Person(s) injured in the event, if possible.

2.5.5. The Manager or Supervisor of the injured person.

2.5.6. Relevant technical specialists.

2.6. The investigation team shall:

2.6.1. Collect and record the facts surrounding the incident.

2.6.2. Photograph the incident site, equipment involved, and components directly involved in the event.

2.6.3. Secure any loose equipment or components directly involved in the event for potential further investigation. If it is not possible to secure the equipment, make note of who has taken such property and where it has been taken. Do not release any item(s) without permission from incident investigator.

2.6.4. Record exact descriptions of any equipment involved, including make, model number and serial numbers.

2.6.5. Obtain the names, addresses and telephone numbers of all available witnesses. Listen to and report any comments made by witnesses to each other or to other persons (Annexure 3).

2.6.6. Obtain written statements, if necessary, from each person involved and all witnesses of the incident. Include, for the individuals: name (printed), signature, address, telephone number and the date on each statement.

2.6.7. Conduct a root causes analysis to determine the basic causes and identify appropriate controls to prevent recurrence.

2.6.8. Develop a detailed incident investigation report and attach or reference all relevant evidence.

2.6.9. Submit the incident investigation reports to Head of Health Safety and Wellbeing normally within 20 days from the date of the incident.

3. Communication

3.1. Lessons learned from incidents are disseminated and communicated to relevant Murdoch University staff, contractors, and other personnel in a number of ways, including:

3.1.1. Distribution of the incident investigation report;

3.1.2. Distribution of a preliminary incident/nonconformity report;

3.1.3. Bulletins or memos;

3.1.4. Email system notifications;

3.1.5. Incident/non-conformity loss announcements; and

3.1.6. Safety alerts.

Performance Indicators

Name	Description	Type	Unit	Formula	Target Value
Incident investigation	Moderate/Severe Incident investigations completed within 21 days	%	%	No. of Incident investigations completed within 21 days/Total No. Incidents	90%

Responsibilities

Role	Responsibility
School Deans and Office Directors	• Ensure that training in incident management in accordance with the Safety, Health, and Wellbeing (SHW) Training Matrix is provided. • In the event of an incident, oversee or commission investigations in their area of responsibility. • Implement recommendations of the incident report and review incident data to identify patterns, gaps and areas that require action.
School/Office Managers and Supervisors	• Support their staff by generating a culture of openness and transparency that allows disclosure of all incidents, as they occur. • Take any steps, within their area of responsibility, to respond to and manage any incidents that arise. • Cooperate with and support staff to participate in investigations.

Health Safety and Wellbeing Team	• Provide guidance on incident investigations to investigators. • Receive and analyze incident reports and statistics from all Schools/Offices on a monthly basis; review the corrective and preventive action; and prepare a summary for the Director People and Culture. • Lead the catastrophic incident investigation teams and prepare a comprehensive report for the Chief People Officer. • Maintain records of all investigations and recommendations and maintain protection of all forms of evidence and liaise with external independent investigators.
All Staff	• Must, when called upon, participate in incident interviews and investigations relevant to them or their service area, or as required, so as to identify its root cause(s) and prevent recurrence.

Governance

Approval Authority	Senior Leadership Team
Owner	Chief People Officer
Legislation mandating compliance	Work Health and Safety Act 2020 Work Health and Safety Regulations 2022
Category	Primarily a function of management
Related University Legislation and Policy Documents	Incident Reporting Procedure Work, Health and Safety Risk Management Procedure HSW Training Matrix and Training Needs Analysis
Date effective	21/08/2025
Review date	15/04/2027

Revision History

Approved/Amended	Date Approved	Resolution No. (if applicable)
Administrative Amendments	21/08/2025	
Approved	15/04/2024	
Administrative Amendments	10/04/2024	
Approved	22/02/2018	
Approved	05/06/2017	

Please refer to the electronic copy in the Policy and Procedure Manager to ensure you are referring to the latest version.

Attachments

ANNEXURE 1

ROOT CAUSE ANALYSIS "5 WHY" INVESTIGATION FORM

Online Reporting System Incident Report Reference:	
Step 1: Describe the Problem Provide as much detail as possible regarding observations pre, during, and post the event occurrence. Attach supporting documentation if necessary.	
Step 2: Brainstorm possible problem causes Consider all parts of the process and list the possible causes WHY the event did occur. List up to 5 possible causes with the highest contributing probability.	
1	
2	
3	
4	
5	
Step 3: Determine the root cause for each cause listed in Step 2 For each of the possible causes, pose the question WHY? and repeat 3 more times. By the time you get to the fifth WHY, you will likely be looking squarely at management practices.	
Step 1.	
Why did 1 occur? 1.1	
Why did 1.1 occur? 1.2	
Why did 1.2 occur? 1.3	
Why did 1.3 occur? 1.4	
Step 2.	
Why did 2 occur? 2.1	
Why did 2.1 occur?	

2.2
Why did 2.2 occur? 2.3
Why did 2.3 occur? 2.4
Step 3.
Why did 3 occur? 3.1
Why did 3.1 occur? 3.2
Why did 3.2 occur? 3.3
Why did 3.3 occur? 3.4
Step 4.
Why did 4 occur? 4.1
Why did 4.1 occur? 4.2
Why did 4.2 occur? 4.3
Why did 4.3 occur? 4.4
Step 5.
Why did 5 occur? 5.1
Why did 5.1 occur? 5.2
Why did 5.2 occur? 5.3
Why did 5.3 occur? 5.4
Step 4: Prioritise the findings from Step 3 Identify and prioritise two or three most likely systemic causes of the incident and develop action plans to address these causes.

Priority 1: Cause No.	Description			
Priority 2: Cause No.	Description			
Priority 3: Cause No.	Description			
Corrective/Preventive Action Request reference			Date	
Facilitator name			Signature	
Team Member 1 name			Signature	
Team Member 2 name			Signature	
Team Member 3 name			Signature	
Team Member 4 name			Signature	

ANNEXURE 2

INCIDENT INVESTIGATION FORM

Online Reporting System Report No.		Date of Report:	
Reported by:			

Name:			Contact Details:	
			Tel:	Fax:
Age:	Gender:	M / F / X	Email:	
School/Office:			Location:	

General Information

Type of Incident

☐ Fatality / LTI ☐ Explosion / Fire ☐ Occupational ☐ Natural Event

☐ Environmental ☐ Damage of Asset ☐ Equipment Failure ☐ Non Conformance

Brief description of the Incident and photos:

Details of Witnesses, if any:

Project Name:

Identifying Information

Date of Incident:	Time of Incident:
Date of report:	School/Office:
Location/Facility:	

Occupational Injury / Illness:

Name of the Injured:	Employer/Organisation:		
Years in service:	Age:	Gender:	M / F / X
Occupation:	Years in Job:		

	Work Permit No.
Weather Conditions:	

Asset Loss / Damage, Explosion / Fire / Environmental Impact / Equipment Failure Losses

Asset Loss / Damage:	Nature of Loss / Damage:
Object / Equipment / Substance involved:	Nature of Spill:
Extent of Spill:	Amount of Spill:
Person in control of activity at the time of incident:	Cost estimated:
Remarks:	
HSR Representative at site:	

Cause Analysis

Immediate Circumstances: What actions and conditions may have or could have caused the event?	**Basic Circumstances:** What specific personal or job factors may have or could have caused this event?
Photos and remedial actions taken at the scene:	

Investigated by:	Name & Signature:	Date:

Cause Checklist

Type of Contact:

- ☐ 1. Struck Against
- ☐ 2. Struck By
- ☐ 3. Caught In
- ☐ 4. Caught On
- ☐ 5. Caught Between
- ☐ 6. Slip
- ☐ 7. Fall at Same Level
- ☐ 8. Fall to Lower Level
- ☐ 9. Over Stress
- ☐ 10.Other

Contact with:

- ☐ 1. Electricity
- ☐ 2. Building
- ☐ 3. Structure
- ☐ 4. Automotive
- ☐ 5. Toxic or Noxious Substances
- ☐ 6. Equipment
- ☐ 7. Machinery
- ☐ 8. Natural forces
- ☐ 9. Others

Incident Information / Evidence

- ☐ 'Who' – People Evidence
- ☐ 'What' – Parts Evidence
- ☐ 'Where' – Position Evidence
- ☐ 'Written' – Paper Evidence

☐ 'How' – Process Evidence

Coding for Immediate Circumstances (check all applicable)

Sub-standard Acts:	**Sub-standard Conditions:**
☐ 1. Non-compliance to procedures	☐ 1. Inadequate protective systems
☐ 2. Improper use of tools or equipment	☐ 2. Inadequate or Tools, Equipment or Materials
☐ 3. Failure to use protective methods	☐ 3. Defective Tools, Equipment or Materials
☐ 4. Inattention / lack of awareness	☐ 4. Excessive Work exposure to hazards
☐ 5. Other:	☐ 5. Inadequate work environment / layout
	☐ 6. Other:

Coding for Basic Root Causes (check all applicable)

Human Factors Involving:	**Job Factors Involving:**	
☐ 1. Capability	☐ 1. Supervision	☐ 6. Work Planning / Maintenance
☐ 2. Physical Condition	☐ 2. Training / Knowledge	☐ 7. Material handling / control
☐ 3. Mental state	☐ 3. Supplier Selection	☐ 8. Inadequate procedures
☐ 4. Stress	☐ 4. Engineering / Design	☐ 9. Inadequate communication
☐ 5. Behaviour	☐ 5. Tool / Equipment	☐ 10. Other:
☐ 6. Skill Level		

Coding for System Deficiencies (check all applicable)

☐ 1. Planning & Leadership	☐ 2. Training & Communication
☐ 3. Management of Operational Risk & Change	☐ 4. Operational Management & Design
☐ 5. Purchasing Systems	☐ 6. Work Processes & Operating Permits
☐ 7. Inspections	☐ 8. Occupational Health Systems
☐ 9. Personal Protective Equipment	☐ 10. Incident / Nonconformity Reporting
☐ 11. Emergency Preparedness	☐ 12. Audits
☐ 13. Corrective & Preventive Action Management	

Photograph Register	
Photo reference no:	INSERT PHOTOGRAPH 1 HERE
Date and Time taken:	
Location:	
Brief description:	
Photographer:	
Photo reference no:	INSERT PHOTOGRAPH 2 HERE & FURTHER EVIDENCE BELOW BY EXPANDING TABLE
Date and Time taken:	
Location:	
Brief description:	
Photographer:	

Corrective Actions

Corrective actions or recommendations made by the team are designed to address the specific issues that caused the incident. In addition to preventing recurrence, recommendations should be directly related to the root cause, they should be practical and reasonable without introducing new or unacceptable risks, and they should be within the ability of the organisation to implement.

Number	Action Item Description	Assigned By (Name)	Assigned To (Name)	Target Due Date	Root Cause Reference Number

ANNEXURE 3

INCIDENT INVESTIGATION WITNESS STATEMENT

I, (Name)			**was involved in an incident**
on (Date)		at (Time)	AM / PM
At (Location)			

and the following statement is my account of the incident:

I fully understand the above statement taken down by:

(Name)	**(Signature)**

and acknowledge that the above is my statement in my own words.

(Name of the Injured)	
(Signature)	
(Date)	