tellthe STORY

Telling and Reviewing Stories



What is the purpose of telling and investigating Stories?





It's all about you...

This is about continuous improvement



- Makes the workplace a safe place for you, fellow workers and your guests
- Ensures that you can all go home safe



Telling Stories is...

Sharing information about what has happened, so that:

- Data can be captured about the incident
- New Risks can be identified
- Existing Risks can be reviewed
- You can make improvements
- You can meet your legal obligations





Reviewing or Investigating is...

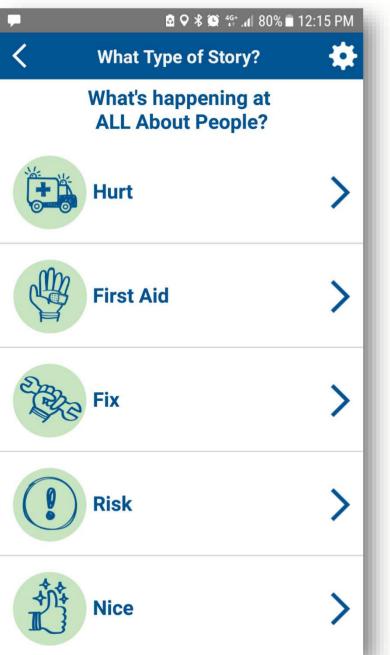


A formal or systematic examination to determine the cause of the incident and identify corrective actions.

Who, What, Where, When, Why and How?



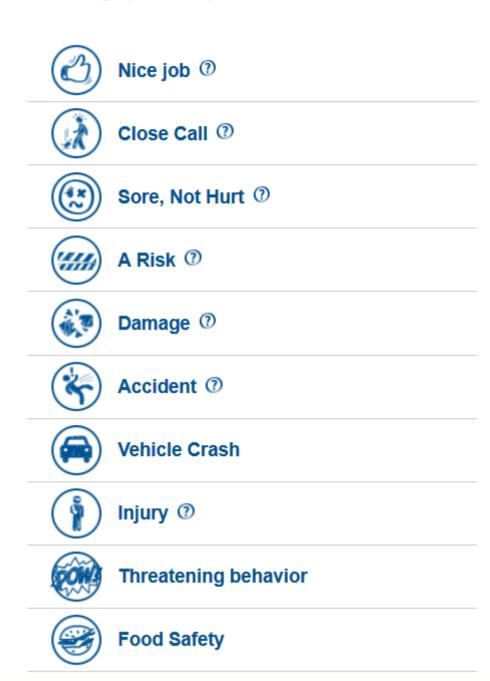
What is a Story?



What's the Story?

START BASICS COMPLETE

Choose all the things your story is about...



The Legislation says...

- Duty to identify, assess and manage Risk
- Duty to provide First Aid
- Duty to prepare, maintain and implement
 Emergency Plans
- Duty to report a Notifiable Injury, Illness or Event
- Duty to review Control Measures



What should you be reporting?



Near Miss



...a narrowly avoided collision, impact, damage or potential injury or other accident.



Unsafe Act









Injuries



...harm or damage: an act or event that causes someone or something to no longer be fully healthy or in good condition.



Work Related Illness



...a disease or period of sickness affecting the body or mind.



'Nice Job' Stories

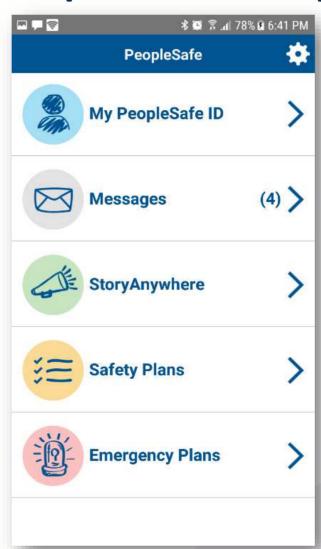


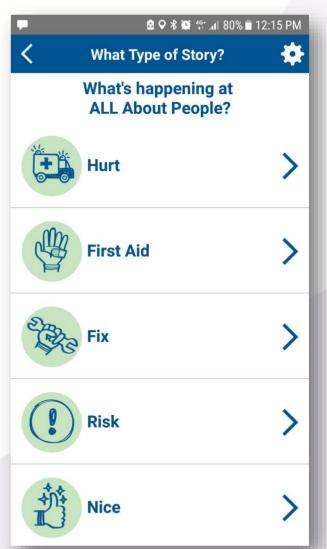
...occurrences where someone did something well to prevent an incident from happening, or reacted well to an event.



Report on PeopleSafe App

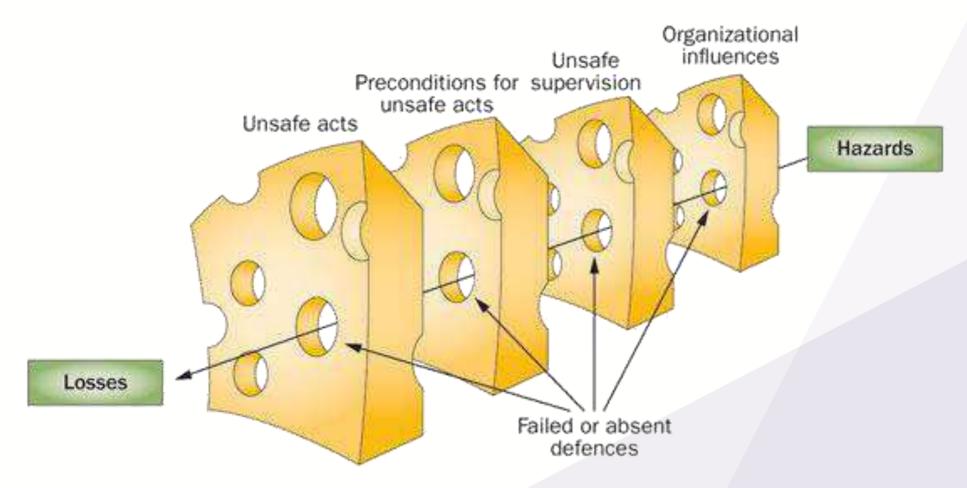








Sequence of Dominoes





Is reporting important?



Reporting a Notifiable Injury, Incident or Illness





What is a Notifiable Injury?

- 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



What is a Notifiable Illness?

An injury or illness that requires, or would usually require, the person to be admitted to a hospital for immediate treatment; or to have medical treatment within 48 hours of exposure to a substance.

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.



What is a Notifiable Incident?

An unplanned or uncontrolled incident in relation to a workplace that exposes the health and safety of workers or others to a serious risk arising from immediate or imminent exposure to any of the following:

- a substance escaping, spilling, or leaking
- an implosion, explosion or fire
- gas or steam escaping
- a pressurised substance escaping
- electric shock



Incident Investigation





Step One: Gather Information





Scene and Reporting

- Preserve the scene
- Report on PeopleSafe
- Note the names of the people, equipment involved and the names of the witnesses
- Report to your Manager or CEO
- Report to WorkSafe



Who, What, Where, When, How?

- What happened?
- What conditions / actions influenced the adverse event
- Where and when?
- Who was injured? Who else involved?
- How and what?
- Chain of events before and after?
- Changes to plant / equipment?



Who, What, Where, When, How?

- What activities were being carried out at the time?
- Were working conditions different?
- Good procedures in place? Were they followed?
- What are the injuries?
- What caused the injury & how did it occur?
- Where the risks known / controlled?

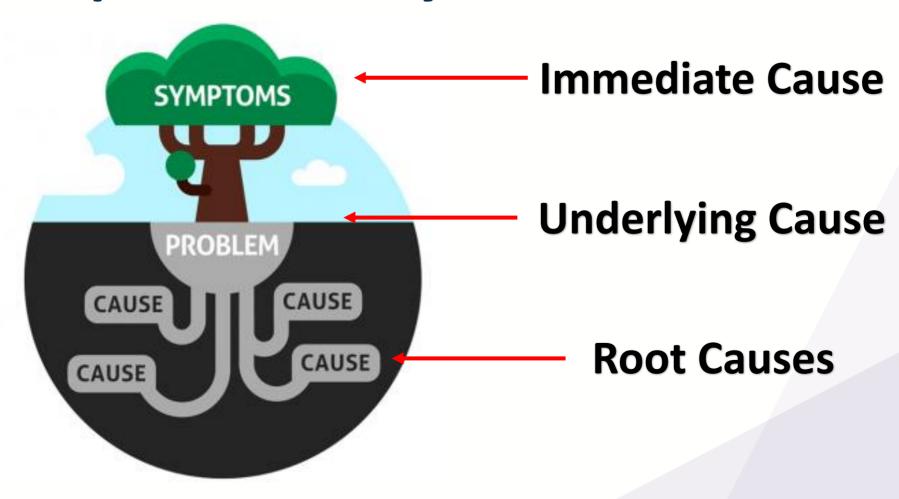
all**aboutpeople**

Who, What, Where, When, How?

- Influences of work arrangement and organisation?
- Maintenance, pre-start checks and cleaning ok?
- Competent and suitable operator?
- Workplace layout?
- Information adequate?
- Was safety equipment sufficient?

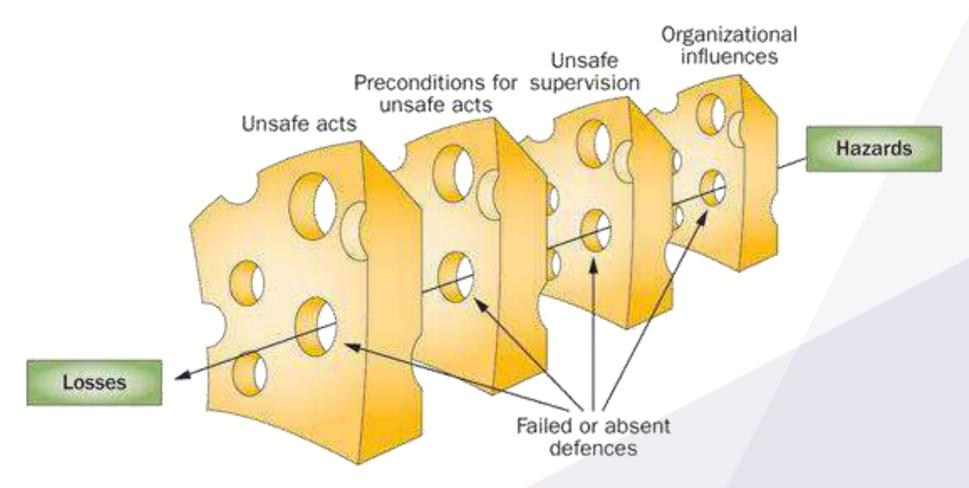


Step Two: Analysis Information





Sequence of Dominoes





What was the <u>Immediate</u> Cause?

The most obvious reason why an adverse event happens, e.g.:

- The safety restraint was not done up / secure
- The Worker slipped
- The member of public tripped on the path etc.

There may be several immediate causes identified in any one adverse event.



What are the **Underlying Causes?**

The less obvious 'system' or 'organisational' reason for an adverse event happening, e.g.:

- Pre-Start Checks not carried out or insufficient
- The hazard has not had a suitable and sufficient risk assessment
- Training / Induction of Workers not sufficient
- Supervision / Instruction of public poor etc.



What are the Root Causes?

- Pre-Start Checking process not reviewed / upto-date
- Risk Assessment process inadequate and not enforced
- Training / Induction programme not in place;
- Inadequate KPI's / KPI's not reviewed
- Health and Safety not driven at Board / CEO level



Step Three: Control the Risk

- Have similar adverse events happened before?
- Is there any new or changed risk?
- What risk control measures are needed / recommended?
- Do similar risks exist elsewhere? If so, what and where?



Risk Assessment / Review

- Review / identify the hazards
- Assess the risk(s) of each hazard
- Identify Controls
- Re-assess Residual risk



Methods of Risk Assessment

Review:

- Process
- Task
- Equipment

Involve:

- Operating procedures
- Industry Experts
- Key Personnel



Step Four: Risk Action Plan

- Which Risk Control measures should be implemented in the long and short term?
- What is the Action Plan going forward?
- Who is responsible?
- What are the timelines?
- What resources are required?



Step Five: Review and Evaluate

- Are there ongoing Checks?
- Are the Controls working?
- Have there been any further incidents?
- What is the feedback from Workers?



Worker Participation

- Involve key Workers/Contractors/Experts
- Communicate any findings and changes
- Get and act on feedback





Is it Serious?



THIS STORY

Looks like it could be serious...

Now we need some humans to help decide what to do next:

PeopleSafe thinks it's serious because:

 The person telling this story thought it was really important and might be something you need to look at straight away.

If you don't know what to do, make sure you talk to your boss about it straight away. That way you can make sure that you've done your duty to keep people safe.



Reviewing the Story Includes:

- Further investigation/questioning
- Review of existing Risks and Safety Plans
- Addition of new Risks and Safety Plans
- Allocation of Tasks
- Follow-up on Tasks (are they complete?)





Story Review – H&S Committee:

Health and Safety Committee

- Reviewing Trends
- Reviewing Risks and Safety Plans
- Making Recommendations (e.g. Controls)
- Assisting Management and Workers



Story Review - Management:

Management

- Reviewing Recommendations
- Questioning
- Making decisions
- Closing out Tasks



Board Review:

- Reviewing Management Report on Safety
- Reviewing Recommendations (e.g. Controls)
- Questioning
- Making decisions
- Supporting Management





Summary

- To manage Risks, Management needs to know about Risks
- Identifying Root and Contributing Causes enables better Risk Controls
- Telling your Stories in PeopleSafe contributes to robust, live and effective health and safety
- Managers review Stories to better understand the Risks in the business and implement Risk Management actions.