



Accident, Critical Incident, Investigation, and Reporting Procedure

Scope

To implement an incident investigation program that focuses on recordable injuries, illnesses and near miss and minor incidents.

Purpose

The purpose of incident investigations is to determine the “root cause(s)” of an incident, so that corrective action can be taken to eliminate or control specific hazards. Through the investigation of incidents, the Taillem Bend Community Centre Inc. is able to analyse and learn about causes, which in turn will give better control of incidents.

General

This process is a guiding tool to use when implementing the incident investigation program

1 Incident definition:

All incidents should be reported. Those with serious potential should be selected for further investigation. A serious or serious potential incident is one that either results or could reasonably result in:

- 1.1 An injury or illness involving lost or restricted activity to any person, including volunteers, students and employees.
 - 1.2. A significant spill or release of chemical or product
 - 1.3. Significant damage to buildings or equipment
 - 1.4 Critical Incidents – significant negative impact to health, safety or wellbeing of a client.

2 First Aid Incidents

First aid cases must also be investigated and reported: although not in as rigorously a manner as major incidents.

3. The Incident Investigation Process

The incident investigation process contains 5 steps:

1. Gather Information
2. Determine Causes (direct and indirect)
3. Corrective Action(s)
4. Communication
5. Follow-Up

Step 1- Gather Information

Before beginning this process, it is very important to have the correct people involved to perform an investigation, they should include but not be limited to:

3.1.1 Coordinator

3.1.2 Injured or involved person(s)

3.1.3 Witness

The initial investigation should take place at the scene. The investigating team will be able to examine the scene and visually see what took place. It is critical to document what was said and observed.

Step 2- Determining Causes (Direct and Indirect)

As the investigation team gathers information from an incident, it is important to investigate the behaviours involved in an incident. Remember, between 90 and 96% of all injuries that occur in industry are related to a person's own behaviour.

Behaviours fall into two categories direct or indirect. Direct causes are usually easily identified, and in most cases the incident investigation stops here. However, indirect causes require more effort to bring to the surface and this is usually an indication of a breakdown in a management system (i.e. procedures not being up-to-date, taking shortcuts to get a job task completed, etc.).

To better illustrate direct and indirect here is an example: A volunteer was running to the lunch room and slipped on a water spot that was on the floor and injured themselves. Most investigations would identify the volunteer running and the water as the direct cause to the incident and in most cases, the investigation would stop here. However, you have not identified the "root cause" of the incident. You need to find out where the water came from, and let's say it was a leak from the refrigerator. The indirect causes would be the refrigerator. Unless you correct the leak, you will not eliminate the incident from occurring again within your facility. So, to identify direct and indirect causes, it will require the investigating team to ask detailed questions and not be satisfied with first general impressions.

Step 3- Corrective Actions

Once the investigation team completes the investigation and generates a report that identifies how the incident occurred, direct and indirect causes, the next step is to identify corrective actions that will address the incident. Corrective actions that require little time to execute should be done immediately. However, situations where the corrective action is more involved (i.e. ordering materials etc.), the recommendations should involve a short and long range plan. These recommendations should be tracked to ensure closure.

Communication

Once the incident investigation report has been completed and corrective actions identified. It is important to communicate the incident report with the Management Committee when a serious injury (i.e. WH&S incident, near misses that had the potential for serious injury and/or

property damage that exceeds more than \$500.00). The purpose of communicating and sharing incident investigations is that the potential for the same incident to occur is lessened. Also, the name of the injured volunteer/student/visitor etc. should be removed when communicating incident reports.

Follow-Up

The final step (follow-up) is where a lot of incident investigation programs fail. Once an investigation has been completed and corrective actions identified most investigations stop here. The reason for this is that we fail to monitor corrective actions and they fall through the cracks. It is vital to the incident investigation process to develop a tracking system that will give you the capability to see what corrective items have not been completed. By having a monitoring system that tracks closure will ensure a successful investigation program.

Reporting Requirements

Anytime the Taillem Bend Community Centre Inc. encounters a serious WH&S Recordable or Environment Incident, the centre must place a copy of the investigation report on file. Every incident must be reported to the Board by the next full Committee Meeting.

Critical Incidents must be managed in accordance with Department for Communities and Social Inclusion Policy http://dcsi.sa.gov.au/_data/assets/pdf_file/0009/50499/Critical-Client-Incidents-Policy.pdf

Critical Incident definition

The Coordinator is responsible for determining if a specific incident is to be classified as a Critical Client Incident.

Critical Incident is an event (or alleged event) that occurs as a result of, or during the delivery of services directly provided or funded by TBCC, and has caused or is likely to cause negative impact to the health, safety or wellbeing of a client or service recipient.

Critical client incidents may include but not limited to;

- 1 Un-expected death, serious injury or alleged assault (including physical, sexual abuse, of services
- 2 Serious unlawful or criminal activity or conduct that has potential to cause serious harm to another
- 3 As serious fire, natural disaster, accident or other incident which will, or is likely to prevent, service provision, or which results in closure or significant damage to premises or property, or which poses a significant threat to the health and safety of clients.

The assessment of whether an incident should be treated as a critical client incident should take into account the following:

- The extent of harm that resulted, or may result
- The likelihood that others may be affected
- The death, serious injury or harm has an obvious and direct correlation to the services the person was receiving
- The death, serious injury or harm is due to unusual circumstances
- The duty of care that may be expected of the department and /or the funded service provider in relation to the incident

DISCLOSURE: *providing information about a critical incident to others not directly involved in the incident, but who may be affected, either directly or indirectly (for example, family member's of the affected client, other clients who may have been harmed and / or their families). Please note that meeting reporting requirements (for example, mandatory notification, reporting to SAPOL) does not constitute disclosure. Disclosure decisions must take into account the potential for others to have been affected or harmed, the potential for others still to be at risk of harm or require*

assistance to alleviate the effects of harm; and risks in disclosing information. They must also take into account what information will be provided, to whom, for what purpose and with what justification, in what format and appropriate approval mechanisms.

Reporting Critical Incidents: Those involved in or aware of the incident must adhere to any mandatory or legislative reporting requirements within the appropriate timeframes, and any other statutory guidelines and procedures for incident management.

These reporting requirements may include, but are not limited to:

- Reporting an alleged offence to SAPOL
 - Reporting suspected abuse or neglect of a child to the Child Abuse Report Line (CARL)
 - Reporting all coronial matters consistent with legislation and Departmental Coronial Policy
 - Reporting to the Health and Community Services Complaints Commissioner
 - Reporting notifiable work-related injuries, fatalities or a dangerous occurrence to Safe Work SA
- In the case of a death, the Critical Client Incident Manager **MUST** refer to the DCSI Coronial Policy and Guidelines.

A disclosure must be undertaken for all Critical Client Incidents.

SAPOL reporting

Non-government organisations need to be aware of their responsibility to report serious incidents to South Australia Police (SAPOL). An incident must be reported immediately if:

- it is a serious concern or a criminal offence (for example, rape, unlawful sexual intercourse, indecent assault, aggravated physical assault, significant client abuse)
- there is a need to preserve physical evidence (for example, medical or scene examination, seizure of clothing)
- there is a serious risk to the safety/security of any person(s) on site or
- a person has an obvious injury resulting from an offence, or complains of an injury that may not be obvious but is considered reasonably likely to have occurred.

Other incidents of concern that, after consideration, are felt to require police intervention should be reported as soon as reasonably practicable.

Serious care concerns should be reported directly to:

Care Concerns Investigation Unit
Telephone +61 8 8207 0142
Email DCSI.CareConcernInvestigations@dcsi.sa.gov.au

DCSI reporting

DCSI implemented a critical client incident policy in 2014 to improve the handling of critical client incidents. The policy has recently been updated. The policy aims to support the safety and wellbeing of clients and ensure that critical incidents affecting DCSI clients are effectively responded to, managed and reported. Please report critical incidents to:

Team Leader Disability, SA Feedback and Incident Review team
Telephone +61 8 8207 0490
Email michelle.hosking@sa.gov.au
Reporting incidents to SA Police by non-government organisations

Date first formulated	12/09/2005	
Dates approved by Board	V1 V2 V3 V4	12/09/2005 June 2016 Feb 2018 March 2018
Next Review Date	June 2019	
Related Documents	<p>First Aid Policy Hot Weather Policy Human Resources Management Policy Privacy and Confidentiality Policy Information Sharing Guidelines (ISG) Appendix TBCC Information Sharing Guidelines and Consent form User Rights and responsibilities Complaints Policy & Procedure Child safe Policy Diversity and Social Inclusion Policy</p>	
Legislation	<p>Equal Opportunity Act 1984 https://www.legislation.sa.gov.au/LZ/C/A/EQUAL%20OPPORTUNITY%20ACT%201984.a.spx</p> <p>Work Health & Safety Act https://www.legislation.sa.gov.au/LZ/C/A/WORK%20HEALTH%20AND%20SAFETY%20ACT%202012.aspx</p> <p>Childrens Protection Act 1993 https://www.legislation.sa.gov.au/LZ/C/A/CHILDRENS%20PROTECTION%20ACT%201993.aspx</p> <p>Aged Care Act 1997 https://www.legislation.gov.au/Details/C2013C00389</p> <p>Commonwealth Privacy Act 1988 https://www.oaic.gov.au/privacy-law/privacy-act/</p> <p>DCSI Critical Client Incidents Policy Coronial Policy http://dcsi.sa.gov.au/about-us/policies/corporate</p> <p>State Records Act 1997 https://www.legislation.sa.gov.au/LZ/C/A/STATE%20RECORDS%20ACT%201997.aspx</p> <p>Guardianship Act 1993 https://www.legislation.sa.gov.au/LZ/C/A/GUARDIANSHIP%20AND%20ADMINISTRATIVE%20ACT%201993.aspx</p> <p>Information Sharing Guidelines for Promoting the Safety and Well-being of Children, Young People and their Families 2008. http://www.ombudsman.sa.gov.au/isg/</p>	
Signed on behalf of TBCC Board of Management by:		
Name: Jack Hunt		
Position held: Chairperson		
		Signature: 
		Signed 23 March 2018