Complete Specialized Retail Solutions (PTY) Ltd

INVESTRAC

LEARNER GUIDE

Unit Standard Title:	Conduct an investigation into workplace safety, health, and environmental incidents
Unit Standard ID No:	259617
Unit Standard Credits:	3
NQF Level:	2
Duration:	2 Days

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CONTENT

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Welcome!

To the INVESTRAC (Incident Investigation) Training programme!

Follow along in the guide as your facilitator takes you through the material. Make notes and sketches that will help you to understand and remember what you have learnt.
Take notes and share information with your colleagues. Important and relevant information and skills are transferred by sharing!

This module is divided into sections. Each section is preceded by a description of the required outcomes and assessment criteria as contained in the unit standard/ss specified by the South African Qualifications Authority.

These descriptions will define what you have to know and be able to do in order to be awarded the credits attached to this module. These credits are regarded as building blocks towards achieving a National Qualification upon successful assessment and can never be taken away from you!
We wish you all the best with the journey of learning through of this module!

Kind regards

Your training team

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Chapter 1

Introduction to the Programme

Sections in this Chapter:

1. Introduction
2. Programme outline and duration
3. The portfolio of evidence (PoE)
4. Assessment and Language Policy
5. Learner Support
6. Learner Administration
7. Learner Role and Responsibilities
8. Facilitator Role and Responsibilities
9. The unit standard

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INTRODUCTION

How does the training work?

Follow along in the guide as the facilitator takes you through the material. Make notes and sketches that will help you to understand and remember what you have learnt. Take notes and share information with your colleagues. Important and relevant information and skills are transferred by sharing!
This module is a skills programme based on one unit standard. Once you have completed this unit standard successfully, you will qualify to work at heights in your organisation.

The unit standard is made up of various specific outcomes with associated assessment criteria in which you must demonstrate competence. This evidence is produced by means of you completing the associated workbook that makes up your Portfolio of Evidence (PoE).

The Purpose of this training

This unit standard is for learners who have to demonstrate the ability to conduct a base-line risk assessment in a workplace. Learners credited with this unit standard will be capable of:

- Explaining the specified requirements to conduct a base-line risk assessment.
- Preparing for a base-line risk assessment.
- Conducting a base-line risk assessment.
- Initiating remedial actions for hazards identified and risks assessed.

PROGRAMME OUTLINE AND DURATION

This unit standard has been allocated a credit value of 3. As a guide, this value is translated into 30 notional hours (1 credit = 10 notional hours). This notional hours'value is considered to be the average time it would take an average learner to achieve the outcomes of the unit standard.
This time includes time spent in classroom activities, self-study, workplace experience and assessment.

The training duration has been outlined as follows (this has been based on "average" learners):

- Structured learning = 16 hours

- Individual learning = 5 hours
- Structured workplace learning = 5 hours
- Coaching = 3 hours
- Assessment & other = 1 hours

Total = 30 hours

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Day 1

Time	Section/ activities to be completed
9h00 – 10h30	Learner registration, signing attendance register and introduction to the programme.
	Chapter 1 - Facilitator to provide the introduction to the programme
	Chapter 2 – Introduction to OH&S Management
10h30 – 10h45	**Tea break**
10h45 - 13h00	Chapter 2 – Introduction to OH&S Management cont. Chapter 3 – Introduction to Occupational Health Chapter 4 – Legal requirements
13h00 – 13h30	**Lunch break**
13h30 – 14h30	Chapter 5 – Extracts from OHaSA Regulations
14h30 – 15h00	Chapter 6 – Reporting incidents Chapter 7 – Reporting and investigating incidents
15h00 – 15h15	**Comfort / Tea break**
15h15 - 16h00	Chapter 8 – DoL inquiries Chapter 9 – Reporting incidents
16h00 – 17h00	Chapter 10 – Documents and records Chapter 11 – Causes of incidents Chapter 12 – Root cause analysis

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Day 2

Time	Section/ activities to be completed
9h00 – 10h30	Learner registration, signing attendance register and introduction to the programme.
	Chapter 13 – Investigation preparation Chapter 14 – Conducting interviews Chapter 15 – Taking statements
10h30 – 10h45	**Tea break**
10h45 - 13h00	Chapter 16 –The 9-step investigation process
13h00 – 13h30	**Lunch break**
13h30 – 15h00	Summative assessment
15h00 – 15h15	**Comfort / Tea break**
15h15 - 16h30	Portfolio building
16h30 – 17h00	Wrap up and way forward

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THE PORTFOLIO OF EVIDENCE (POE)

You will see that you have also been given a learner PoE/Workbook. The purpose of this workbook is to record evidence of your competency against the requirements of the unit standard. You will see that the workbook includes a number of assessment components:

- Formative assessment activities: these are activites which you must complete during the learning process. The purpose of these activities are to provide you with an opportunity to practice the skills associated with the outcomes of the unit standard. These activities are assessed by your facilitator, enabling them to evaluate the progress of learners before progressing onto the summative assessment. These activities include discussions, tests, group activities, etc. It is important that these activities are kept as part of your portfolio of evidence.

- Summative assessment activities: these are activities which you must complete at the end fo the learning process. These activities are used to assess whether you have grasped all of the outcomes of the unit standard. These activities include: tests and practical activities.

- Logbook: the workplace logbook must be used to record your workplace evidence and experience, where you will apply the knowledge which you have gained during the learning process.

It is important that you complete the learner PoE/workbook to the best of your ability. You must be found competent on all the specific outcomes and programme requirements in order to obtain the certificate.

ASSESSMENT AND LANGUAGE POLICY

Types of Assessment

- **Formative Assessments**

The assessment process is easy to follow. You will be guided by the Facilitator. Your responsibility is to complete all the activities in the Formative Assessment Workbook and submit it to your facilitator.

- **Summative Assessments**

You will be required to complete a series of summative assessments. The Summative Assessment Guide will assist you in identifying the evidence required for final assessment purposes. You will be required to complete these activities on your own time, using real life projects in your workplace or business environment in preparing evidence for your Portfolio of Evidence. Your Facilitator will provide more details in this regard.

To qualify and receive credits towards your qualification, a registered Assessor will conduct an evaluation and assessment of your portfolio of evidence and competency.

Assessment Methods

- Direct Observation
- Product Evaluation
- Written and/or Oral Questioning

Language Policy

All coursed will be presented in English, but assistance with interpretation can be provided where necessary.

LEARNER SUPPORT

The responsibility of learning rests with you, so be proactive, ask questions and seek assistance and help from your facilitator, if required.

This Skills Programme is based on outcomes-based education principles which implies the following:

You are responsible for your own learning – make sure you manage your study, research and workplace time effectively.
Learning activities are learner driven – make sure you use the Learner Guide and Workbook in the manner intended and are familiar with the workplace requirements.
The Facilitator is there to reasonably assist you during contact, practical and workplace time for this programme – make sure that you have his/her contact details.
You are responsible for the safekeeping of your completed Workbook/PoE.
If you need assistance, please contact your facilitator who will gladly assist you.
If you have any special needs, please inform the facilitator

LEARNER ADMINISTRATION

Attendance Register

You are required to sign the Attendance Register every day you attend training sessions facilitated by a facilitator.

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Programme Evaluation Form

On completion you will be supplied with a “Learning programme Evaluation Form”. You are required to evaluate your experience in attending the programme.
Please complete the form at the end of the programme, as this will assist us in improving our service and programme material. Your assistance is highly appreciated.

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LEARNER ROLE AND RESPONSIBILITIES

During the training, the learner is expected to perform the following roles and responsibilties:

- The learner is expected to take part in the activities and, wherever necessary to ask questions and enter into discussions about the topic.
- The training is meant to enable the learner to master skills, and this can only be done if the learner makes an effort to learn.
- While the training is not necessarily a part of the productive workplace, learners are expected to behave in a manner required in the workplace (e.g. wearing of personal protective equipment where necessary).
- Learner will be procided with a Learner Guide and a Workbook/PoE. These books must be kept safe for assessment purposes.

FACILITATOR ROLE AND RESPONSIBILITIES

The main role of the facilitator is to ensure that learners are given an opportunity to learn new skills effectively.

The expectations of the facilitator are:

- To prepare the learning environment by ensuring the venue, equipment and materials are prepared.
- Establish rapport between learners, and between learners and facilitator, through welcoming activities appropriate to the situational requirements.
- Determine a learner's frame of reference and entry level assumptions. Reflect on learning styles, preferences and motivations and their relationship to learning.
- Facilitate learning by applying selected strategies for group and individual learning and by improvising appropriately as needed.
- Facilitate learner's performance of learning activities and provide information in a way that ensures effective learning by all learners.
- Provide self-study materials, activities and assist learners in planning their own self-study activities, either in preparation for a learning event or to follow a learning event. File administrative records including attendance registers, notes and materials used, written evaluations and other details.

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THE UNIT STANDARD

SOUTH AFRICAN QUALIFICATIONS AUTHORITY

Conduct an investigation into workplace safety, health and environmental incidents

SAQA US ID	UNIT STANDARD TITLE			
259617	Conduct an investigation into workplace safety, health and environmental incidents			
ABET BAND	**UNIT STANDARD TYPE**	**PRE-2009 NQF LEVEL**	**NQF LEVEL**	**CREDITS**
Undefined	Regular	Level 2	NQF Level 02	3
REGISTRATION STATUS		**REGISTRATION START DATE**	**REGISTRATION END DATE**	**SAQA DECISION NUMBER**
Reregistered		2018-07-01	2023-06-30	SAQA 06120/18
LAST DATE FOR ENROLMENT		**LAST DATE FOR ACHIEVEMENT**		
2024-06-30		2027-06-30		

PURPOSE OF THE UNIT STANDARD

The person credited with this unit standard is able to identify and explain the legal and organisational-specific requirements regulating the reporting and investigation of workplace incidents. The learners will be able to complete the required reports and be able to process any physical evidence which may have been collected.

The qualifying learner is capable of:

- Describing requirements for workplace safety, health and environment incident investigation.
- Gathering information for workplace safety, health and environment incident investigations.
- Conducting post-investigation activities.

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LEARNING ASSUMED TO BE IN PLACE AND RECOGNITION OF PRIOR LEARNING

- Communication at NQF Level 1 or equivalent.
- Mathematical Literacy at NQF Level 1 or equivalent.

UNIT STANDARD RANGE

- For the purpose of this unit standard, conducting an investigation is limited to the actions carried out immediately the incident happens or is discovered.
- Environmental incidents include but are not limited to ventilation incidents.
- Safety and health incidents refer to hygiene and medicine.

Specific Outcomes and Assessment Criteria:

SPECIFIC OUTCOME 1

Describe requirements for workplace safety, health and environment incident investigation.

ASSESSMENT CRITERION 1

The legal and organisational specific requirements regulating the reporting and investigation of workplace incidents are identified in order to determine applicable governance procedures.

ASSESSMENT CRITERION 2

The legal and organisational specific requirements for an investigation into workplace incidents are explained in order to follow the prescribed requirements.

ASSESSMENT CRITERION 3

The procedures to be followed when an incident occurs in the workplace are explained in order to facilitate effective management of the incident.

ASSESSMENT CRITERION RANGE

Procedures may include but are not limited to securing the scene, handling of injured persons, handling of fatalities, dealing with work processes and initial reporting.

ASSESSMENT CRITERION 4

The consequences of non-compliance with legal and organisational specific requirements are explained in terms of the impact on safety, health and environment in the workplace.

SPECIFIC OUTCOME 2

Gather information for workplace safety, health and environment incident investigations.

ASSESSMENT CRITERION 1

The purpose, type and extent of information required are explained in accordance with prescribed requirements.

ASSESSMENT CRITERION 2

Resources required to conduct investigations are identified and selected in accordance with prevailing circumstances.

ASSESSMENT CRITERION RANGE

Resources may include but are not limited to documentation, human resources, tools and materials.

ASSESSMENT CRITERION 3

Information is gathered in accordance with the prescribed procedures.

ASSESSMENT CRITERION 4

The need for gathering accurate and relevant information about workplace incidents is explained in terms of the impact on the quality of the investigation.

SPECIFIC OUTCOME 3

Conduct post-investigation activities.

ASSESSMENT CRITERION 1

Reports are completed in the required formats in accordance with prescribed requirements.

ASSESSMENT CRITERION RANGE

Reports may include but are not limited to investigation reports, compensation documentation, required Government departmental documentation, and organisational documentation.

ASSESSMENT CRITERION 2

Reports are submitted and communicated to relevant designated persons in accordance with prescribed requirements.

ASSESSMENT CRITERION 3

Physical evidence gathered during the investigation is processed according to prescribed requirements.

ASSESSMENT CRITERION 4

Resources used during investigations are processed according to specified requirements.

Critical Cross-field Outcomes (CCFO):

UNIT STANDARD CCFO IDENTIFYING

Identify and solve problems which will impact the process of conducting an investigation into workplace health, safety and environmental incidents.

UNIT STANDARD CCFO WORKING

Work effectively with others in such a way so as to ensure that the investigation is conducted in a spirit of co-operation.

UNIT STANDARD CCFO ORGANISING

Organise and manage oneself and one's activities so that the process of conducting an investigation into workplace health, safety and environmental incidents runs smoothly.

UNIT STANDARD CCFO COLLECTING

Collect, analyse, organise and critically evaluate information in order to conduct a proper investigation into workplace health, safety and environmental incidents.

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UNIT STANDARD CCFO COMMUNICATING

Communicate effectively in the recording of information in the reports and when submitting the reports to designated persons.

UNIT STANDARD CCFO SCIENCE

Use science and technology where applicable to assist in the gathering and recording of information related to workplace health, safety and environmental incidents.

UNIT STANDARD CCFO DEMONSTRATING

Demonstrate an understanding of the world as a set of related systems where the poor conducting of an investigation may lead to unresolved issues.

UNIT STANDARD NOTES

This unit standard replaces unit standard 115087, "Conduct a preliminary incident investigation into workplace health, safety and environmental incidents", Level 2, 2 credits.

Terminology:
"Specified requirements" include legal and site-specific requirements and are contained in the following documents.

Legal:

- Relevant current legislation, regulations and directives pertaining to mining and occupational health and safety.
- Mandatory Codes of Practice.
- South African National Standards and other relevant Standards.

Site Specific:

- Hazard Identification and Risk Assessments (HIRA).
- Occupational Health and Safety Risk Management Programmes.
- Managerial Instructions.
- Organisational Standard Procedures.
- List of Recorded Occupational Health and Safety Risks.
- Working Guides.

- Equipment and Materials Specifications.

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Chapter 2

Introduction to OH&S Management

Sections in this Chapter:

1. Introduction to OH&S management
2. History of Health and Safety
3. Consequences of the problem
4. Management system – Symptoms vs systems
5. Management System – Overview
6. Management System – Health and Safety
7. Management System – Health and Safety Investigations
8. Introduction to HIRA – legal requirements
9. Conducting a HIRA
10. Mitigating Hazards – Hierarchy of Control

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INTRODUCTION TO THE COURSE

Overview

The OHaSA requires that the Health & Safety Committee investigate all Recordable and Reportable incidents.
If they are not available or suited for the task, the Employer must designate an Investigator in writing.

- The purpose for an investigation is to determine and eliminate the cause of the incident and NOT to find the guilty party at this stage.
- The investigation is primarily about discovering why the Health & Safety Management **SYSTEM** and processes failed.

Incident Case Study - Options

1. Refer to "The One Minute SAFETY Manager" or
   Design a case study based on a past incident
2. Complete and submit the provided forms:
   - Appointment of Incident Investigator Letter
   - Investigation Case Study Worksheet
   - Casualty / Witness Statement Template
   - Annexure 1 "Recording & Investigation of Incidents" Form
3. Form groups of 2 - 4 learners
4. Interaction between the Trainer & learners
5. Discuss the findings & opinions on a flipchart
6. Submit your case study for evaluation

Order extra copies of "The One Minute SAFETY Manager" from:

- www.safetytrainingkits.com
- ken@safetyhealthtraining.com
- Cell: 082 920 8912

Incident Case Study Forms

Incident Case Study Forms
To complete the investigation Case Study, you need:

- Appointment of Incident Investigator Letter
- Investigation Case Study Worksheet

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- Casualty / Witness Statement Template
- Annexure 1 “Recording & Investigation of Incidents”

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INTRODUCTION TO OH&S MANAGEMENT

Definitions, Terminology & Glossary - Essential Terms

DEFINITIONS, TERMINOLOGY & GLOSSARY

Additional common terms are found at the back of the Learner Workbook.

"**accident**" [OHaSA] means an accident arising out of and in the course of an employee's employment and resulting in a personal injury, illness or the death of the employee.

"**incident**" [OHaSA] means an unplanned, uncontrolled event as contemplated in Section 24 [1].

"**adverse incident**" includes an accident or incident, a near miss or undesired circumstance which can conceivably cause an occupational injury or disease.

"**danger**" [OHaSA] means anything which may cause injury or damage to persons or property.

"**hazard**" [OHaSA] means a source of or exposure to danger.

"**risk**" [OHaSA] means the probability that injury or damage will occur.

"**obvious cause**" the obvious reason/s [unsafe acts or unsafe condition] for an incident occurring, e.g. the casualty fell into an unprotected hole while walking in the dark.

"**obscure cause**" the concealed or underlying reason/s for an incident occurring, e.g. failure to formally identify / uncover and assess the hazard in advance, combined with pressing deadlines or high production demands.

"**Root Cause"** The original and most fundamental factors, faults or failures that trigger a domino like sequence or chain of manageable, identifiable, interrelated events, that lead to a predictable or preventable outcome or effect.

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HISTORY OF HEALTH AND SAFETY

- From the dawn of time people have been exposed to dangers, hazards and risks at home and work.
- Common-sense practices were implemented to protect the hunters, gatherers and their children from predators and marauders.
- As communities and agricultural practices emerged, tools and equipment were manufactured to ease the workload. In addition, they brought dangers and hazards, posing a risk to the users.
- Fundamental Safe Work Procedures [SWP] were adopted and taught to the next generation.
- Construction and transportation industries boomed. Mechanisation eased the load, increased production, but brought new hazards and risks.
- The demand for resources spurred the development of the mining, shipping and rail transportation. Global and local wars spurred on manufacturing and technology. Air travel and road traffic expanded at a remarkable rate. Each with their own hazards.
- Factories developed around all major centers and rural people flocked to the cities looking for a better life.
- Commercial and retail centers were created, drawing yet more job seekers.
- Technology, innovation, science and space travel introduced new substances into the workplace. With new chemicals and processes, new hazards and risks.
- Machinery, mass production and automation were the order of the day. Faster, better, cheaper. At each stage of the agricultural, industrial and technological revolution, a broadening range of dangers, hazards and risks emerged.
- As result, unabated incidents of injuries and diseases occurred, bringing consequent burdens on families, communities, organisations and the state.

CONSEQUENCES OF THE PROBLEM

Statistics are not readily available in South Africa, however in 2015, according to the 2017 ICOH - International Commission on Occupational Health report:

"We estimated 2.78 million deaths occurring annually across the countries being attributed to work, higher than the 2.33 million deaths estimated in 2014. Work-related mortality accounted for 5% of the global total deaths (based on the Global Burden of Disease Study 2015). **The biggest share of work-related mortality came from work-related diseases which accounted for 2.4 million (86.3%) of the**

total estimated deaths. Fatal accidents accounted for the remaining 13.7%". [Ref: http://www.icohweb.org/site/images/news/pdf/Report%20Global%20Estimates%20of%20Occupational%20Accidents%20and%20Work-related%20Illnesses%202017%20rev1.pdf]

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MANAGEMENT SYSTEM – SYMPTOMS VS SYSTEMS

A medical practitioner diagnoses a disease or failing human physiological SYSTEM, by identifying patient SIGNS and SYMPTOMS. They treat the SYSTEM, which in turns eliminates the SYMPTOMS.
An investigator identifies a failing or non-existent Management SYSTEM from the telltale H&S SYMPTOMS.
Evidenced by Unsafe Acts and Conditions, the Employer, CEO and Managers are responsible for the design and maintenance of an effective Management SYSTEM to eliminate all workplace risks.

MANAGEMENT SYSTEMS - OVERVIEW

According to Wikipedia, a management SYSTEM is defined as "The framework of policies, processes and procedures used by an organization to ensure that it can fulfill all the tasks required to achieve its objectives".

The management SYSTEM elements may include:

01. Leadership Involvement & Responsibility
02. Identification & Compliance with Legislation & Industry Standards
03. Employee Selection, Placement & Competency Assurance
04. Workforce Involvement
05. Communication with Stakeholders (others peripherally impacted by operations)
06. Identification & Assessment of potential failures & other hazards
07. Documentation, Records & Knowledge Management
08. Documented Procedures
09. Project Monitoring, Status and Handover
10. Management of Interfaces
11. Standards & Practices
12. Management of Change & Project Management
13. Operational Readiness & Start-up
14. Emergency Preparedness
15. Inspection & Maintenance of facilities
16. Management of Critical SYSTEMs
17. Work Control, Permit to Work & Task Risk Management
18. Contractor/Vendor Selection & Management
19. Incident Reporting & Investigation
20. Audit, Assurance and Management System review & Intervention

Extracted verbatim from https://en.wikipedia.org/wiki/Management_system

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MANAGEMENT SYSTEM – HEALTH AND SAFETY

The OHaSA provides for:

- Identification of dangers, hazards and risks.
- The establishment of healthy and safe SYSTEMs of work.
- Protection from risks.
- A channel of communication between Employee and Employer.
- Formation of a Health & Safety Committee.
- Regular inspections, investigations and a recording system.

We call this **SYSTEM** the Health & Safety Management **SYSTEM.**

It is advisable to familiarise yourself with all the definitions in the OHaSA. Continue the explanation of the H&S Management **SYSTEM.**

MANAGEMENT SYSTEM – HEALTH & SAFETY INVESTIGATIONS

The OHaSA has provides for a cycle of activities that must be implemented the before, during and after an incident, whether reportable or not:

BEFORE

- Create a H&S Management **SYSTEM** and structure.
- Identify, assess & rate the dangers, hazards & risks present [HIRA] [Section 8]
- Provide the necessary safeguards, protection and control measures.
- Establish Safe Work Procedures
- Collect supplier Material Safety Data Sheets [MSDS].
- Provide information, instruction & training to employees. [Section 8].
- Appoint Investigator/s [GAR 9]
- Appoint, train and authorise Supervisors [Section 8].
- Implement physical and medical monitoring SYSTEMs .
- Promote the Health & Safety Management **SYSTEM** [Section 19 (1)].
- Enforce the policies and procedures.
- Take disciplinary action against offenders.

DURING

1. Activate the incident response / action plan.
2. Report the incident to the various parties.
3. Activate incident investigation team.

AFTER

- Gather the necessary facts, data and evidence.
- Analyse the facts, data and evidence.
- Convene and conduct a formal internal inquiry.
- Determine the Root Cause of the incident.
- Make recommendations to the employer.
- Implement the internal findings.
- Provide the findings to the Inspector.
- Participate in the OH&S Inspector's inquiry.
- Await possible prosecution.
- Lead evidence as an accused or witness.
- Await verdict, sentencing and penalties.
- Review policies, procedure and practices.
- Retrain management and employees.

The post-incident measures must be recorded, reviewed and actively promoted by the employer and Health & Safety Committee.

INTRODUCTION TO HIRA – PRE-INCIDENT

HIRA [Hazard Identification and Risk Assessment] is a critical part of an on-going H&S Management **SYSTEM**.

Whatever the nature of your industry, organisational activities or occupational hazards, the basic methods of identifying hazards and assessing the risks remains the same.
HIRA is used as:

- A management process, tool or technique to detect and assess hazards found in or emanating from the workplace.
- Meaningful H&S management direction and guidance.
- An early warning **SYSTEM** that can predict future incidents, accidents and events.
- A risk rating / profiling tool to determine which risk alerts must be brought to the attention of employers, employees, residents and community.
- Known hazards can be managed by reasonable mitigation and monitoring.

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INTRODUCTION TO HIRA – LEGAL REQUIREMENT

According to Section 8 of the OHaSA [General duties of employers to their employees], all employers must conduct a HIRA to determine which hazards exist in or emanate from their activities. It says:

[1]. Every employer shall ….

> [d] **establish, as far as is reasonably practicable, what hazards to the health or safety of persons** are attached to any work which is performed, any article or substance which is produced, processed, used, handled, stored or transported and any plant or machinery which is used in his business and he shall, as far as is reasonably practicable, further establish what precautionary measures could be taken with respect to such work, article, substance, plant or machinery in order to protect the Health & Safety of persons and he shall provide the necessary means to apply such precautionary measures;

CONDUCTING A HIRA

HIRA must be conducted before, during or after:

- A request by employees or H&S Rep.
- An incident or insurance claim.
- Change in legislation, standards or policy.
- Embarking on an OHSAS 18001 or ISO 45001 programme.
- Planned or unplanned change in work or workplace.
- Technical or scientific info updates becoming available.
- Creation or implementation of a purchase / requisition process.
- The introduction of new or a change to existing plant, processes, project, material, substances, etc.
- Writing organisational SWPs or operational procedures and standards.

MITIGATING HAZARDS – HIERARCHY OF CONTROL

An inverted pyramid is used to illustrate the Hierarchy of Control and represents decreasing effectiveness of mitigation.
The Hierarchy exists to mitigate or eliminate exposure to hazards, rendering the workplace or process healthy and safe.

The order of priority is:

1. Remove.
2. Replace.
3. Redesign.
4. Regulate.
5. Educate.
6. Supervise.
7. PPE and PPC.

1. REMOVE - the physical removal of the hazard such as the levelling of walkways to remove the possibility of tripping.
2. REPLACE - the replacement of coal-fired electricity generation with wind or solar generators The replacement of chemical cleaning solvents and agents with equally effective organic substances.

3. REDESIGN - by mechanically creating a physical barrier to enclose hazards and or isolate people from the hazards. An example of this may be the installation of machine guards, ventilation hoods, handrails and so forth. A further example could be the design and manufacture of a mechanism that removes the necessity for human contact with the process, plant or machinery.

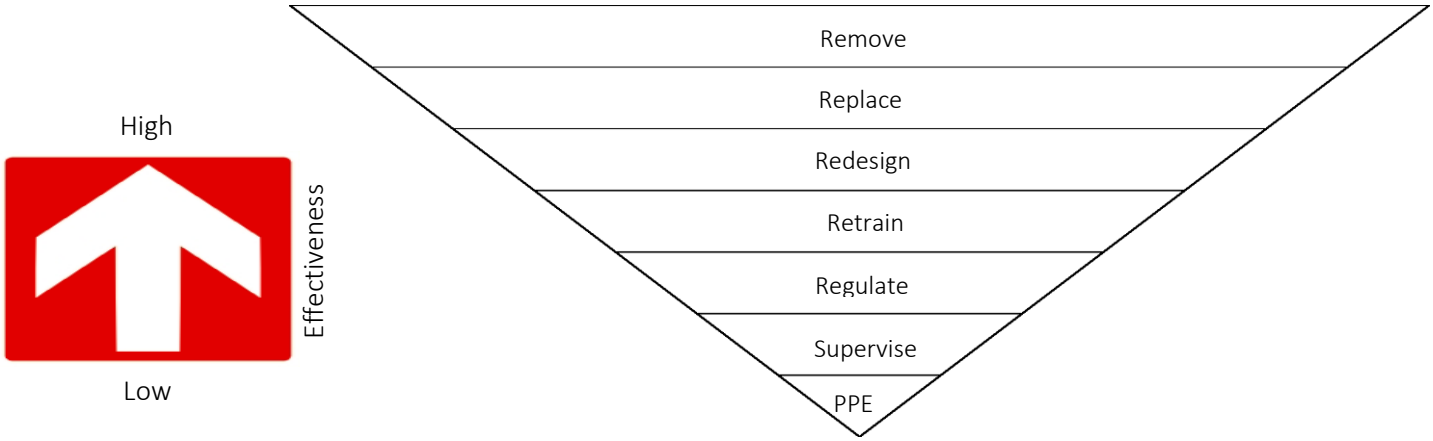
4. RETRAIN - Section 8 of the OHaSA requires that all employees be informed, instructed and trained in the dangers, hazards and risks they will be exposed to at work.

5. REGULATE - the employer can create and implement administrative SYSTEMs to guide and control work in and around the hazard. This could include:
   - Job Descriptions.
   - Safe Working Procedures [SWP].
   - Operating Procedures.
   - Lockout and Tag Out Procedures.
   - Peak hour task management.

Administrative controls may be enhanced by means of:
- Signs, notices, labels and colour-coding.
- Audible or visual alarms.

6. SUPERVISE -The appointment and training of a supervisor who is familiar with the hazards is a legal requirement. Empowered with the authority to enforce the policies and procedures, they can exercise considerable control in the workplace. Section 8 [OHaSA].

7. PPE and PPC [Personal Protective Equipment]. The absolute last resort to mitigating a hazard is to issue PPE and PPC. This is the least effective means as it relies on the individual's willingness to use the equipment. Certain pieces of PPE and PPC are uncomfortable or unsightly and may even hinder the physiological activity to perform the task.



Introduction to Occupational Health

Sections in this Chapter:

1. Introduction to Occupational Health
2. Diseases – Symptom Manifestation
3. Sources of Health Hazards
4. Sources of Safety Hazards
5. Safety vs Security

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INTRODUCTION TO OCCUPATIONAL HEALTH

Employee's health can be affected by their work. Occupational Health focuses on a H&S Management **SYSTEM** to prevent illness and diseases resulting from the handling of hazardous substances or exposure to physical hazards associated with their work.
The amended COIDA Schedule 3 lists the occupational diseases recognised by the Compensation Commissioner.
These and other diseases are because of prolonged and repetitive exposure and are contracted by means of:

- INHALATION
  breathing in air borne substances such as odours, dust, fumes, gases, mist, smoke and vapour.
- INGESTION
  swallowing dirt, chemicals, poisons, etc.
- ABSORPTION
  absorbing hazardous substances through the skin, bones or blood.
- PHYSICAL EXPOSURE
  to temperature extremes, vibration, lighting, noise, radiation, stress and fatigue. These are absorbed through skin, bones, ears or blood.

DISEASES – SYMPTOM MANIFESTATION

It is common knowledge that most Occupational diseases only manifest years, if not decades after exposure.
The Compensation Commissioner may only receive a claim once the employee has retired and, in some instances, only after they have died.
The employer and Health & Safety Committee should be particularly focused on identifying and investigating past, present and possible causes that did or may result in the death of the employee from a disease contracted while at work.

SOURCES OF HEALTH HAZARDS

Health hazards differ from place to place. Common Health Hazards include:

BIOLOGICAL.

- Bacteria.

ERGONOMIC.

- Lifting.

- Fungi.
- Virus.

CHEMICAL.

- Dusts.
- Fibres.
- Fumes.
- Gases.
- Liquids.
- Mists.
- Smoke.
- Solids.
- Vapour

- Posture.
- Repetitive motion.
- Stretching.

PHYSICAL.

- Electromagnetism.
- Lighting.
- Noise.
- Radiation.
- Temperature.
- Vibration.

PSYCHOSOCIAL.

- Fatigue.
- Stress.
- Workload

SOURCES OF SAFETY HAZARDS

Occupational Safety focuses on identifying and putting in place a H&S Management SYSTEM, mechanisms and procedures to control exposure to hazards that could injure or kill employees while at work. Occupational Safety hazards differ from place to place. These include:

- Confined spaces.
- Electricity.
- Fire and explosions.
- Housekeeping.
- Mechanical devices.
- Radiation.
- Substances that burn, scald or freeze.
- Substances under pressure.
- Tools and equipment.
- Transportation.
- Welding, cutting and grinding.
- Working at heights.
- Working in excavations, trenches and underground.

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SAFETY VS SECURITY

Safety and security are interconnected views that relate to policies, procedures, protection and practices of people and assets:

- SAFETY: to ensure employees are free from, or not exposed to unintentional accidental Injury, Danger, Death, Disability, Damage, Delays, Destruction, Disruption, etc.

- SECURITY: to ensure that people, property and assets and are free from or not exposed to deliberate, intentional criminal or civil dangers and threats.

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Chapter 4

Legal Requirements

Sections in this Chapter:

1. Incident vs Accident?
2. Structure of the Act
3. Regulations
4. Introduction to standards
5. Organisational Structure
6. Health and safety committee structure
7. Documents and records

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INCIDENT VS ACCIDENT?

According to the OHaSA;

- “accident” means an accident arising out of and in the course of an employee's employment and resulting in a personal injury, illness or the death of the employee.].
- “incident” means an unplanned, uncontrolled event as contemplated in Section 24 [1].

STRUCTURE OF THE ACT

Identify each portion and explain:

The law comprises of an Act [which was enacted by Parliament], various Regulations [which are implemented by the Department of Labour] and several Standards.

2. UPPER PORTION.

This portion can only be changed by an act of Parliament. The OHaSA establishes the main principles such as the structure of the Health & Safety [H&S] Management **SYSTEM** to be enforced by all employers in South Africa.

The OHaSA applies to all employers including the local government, agricultural, retail and wholesale, hospitality, manufacturing, education and domestic sectors. It does not apply to those who work in mines, at sea or with explosives.

You will also find reference to other pieces of legislation such as the Basic Conditions of Service Act, Labour Relations Act, Compensation for Injuries and Diseases Act, etc.

3. MIDDLE PORTION.

Continue by explaining that:

These are the Regulations to the OHaSA and can be amended or replaced by the Minister of Labour after consultation with the Health & Safety Council. They are technical by nature and are written by subject matter specialists, such as Engineers, Scientists and so forth.

REGULATIONS

Work through them individually explaining the nature of each briefly identifying those that are relevant to them.

1. Asbestos.
2. Certificate of Competency.
3. Construction.
4. Diving.
5. Driven Machinery.
6. Electrical Installation.
7. Environmental for Workplaces.
8. Explosives.
9. Facilities.
10. General Administrative.
11. General Machinery.
12. General Safety.
13. Hazardous Biological Agents.
14. Hazardous Chemical Substances.
15. Hazardous Work by Children.
16. Lead.
17. Lift Escalator and Passenger Conveyor.
18. Major Hazard Installation.
19. Noise-induced Hearing Loss.
20. Pressure Equipment.
21. Etc.

Additional draft Regulations may have been published since the design of this course. Check http://www.labour.gov.za/DOL/legislation and update the information where necessary.

INTRODUCTION TO STANDARDS

Some Regulations and many organisations have adopted additional international standards or SYSTEMs such as:

- ISO 9001 [Quality] standards and guidelines for the establishment of a Quality Management **SYSTEM** [QMS].

- ISO 14001 [Environmental] standards and guidelines for the establishment of an Environmental Management **SYSTEM** [EMS].
- OHSAS 18001 [Health & Safety] are British guidelines for the establishment or improvement of an Occupational Health & Safety Management **SYSTEM** and are to be replaced by:
- ISO 45001 [Health & Safety] standards and guidelines for the establishment or improvement of a Health & Safety Management **SYSTEM** [HSMS].
- SABS [South African Bureau of Standards].

ORGANISATIONAL STRUCTURE

Explain your current structure:

1. EMPLOYER.
The Employer is either the company, the organisation, Council or Board. It need not be registered, but could be a partnership or even a management committee.

2. CHIEF EXECUTIVE OFFICER. [Section 16.1]
This is the person with the overall responsibility of ensuring compliance with the Act, the employer's duties and ensuring the Health & Safety of ALL the employees.
In our organisation.
This position is held by: _____ who is the _____
[Director, Manager or the person in overall control of the daily running of the organisation].

3. ASSIGNED OR NOMINATED PERSON. [Section 8 and 16.2]
The OHaSA allows the CEO to assign any person, any duty, to comply with the requirements of the law. This could even include the duty to make further assignments.

3. USER.
In our organisation the position of User is held by the person in overall control of the machinery. At present it is: _____.

4. MANAGEMENT NOMINEES / ASSIGNEES. [Section 8
As the OHaSA requires compliance, it stands to reason that the CEO must assign specific duties to people who are suitably qualified to conduct routine activities, inspections and investigations.
These positions are normally filled by employees of supervisory level or with the necessary experience or technical qualifications. Specialist elements such as the Occupational Hygiene measurements would be

assigned to Inspection Authorities, Consultants, Engineers, Health & Safety Managers, Industrial Nurses and so forth.

5. EMPLOYEE.

The Act defines an employee as subject to the provisions of subsection [2], “any person who is employed by or works for an employer and who receives or is entitled to receive any remuneration or who works under the direction or supervision of an employer or any other person”.

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HEALTH AND SAFETY COMMITTEE STRUCTURE AND DUTIES

Health and Safety Committee Structure

Discuss the roles of the various people serving on the committee:
The Act defines a Health & Safety committee as a committee established under Section 19.
The Health & Safety Representative is automatically a member of the Committee. Other people who can contribute to the Health & Safety Programme must be designated in writing.

- As the Employer is required by law to consult with The Health & Safety Committee at every meeting, a senior Health & Safety Representative should representative them.
- Employer
- Employer Nominees
- Assigned persons
- Designated H&S Reps
- Designated members
- Advisory members

Duties of the H&S Committee

The Section 19 & 20 of the OHaSA requires that all Health & Safety Committees be allowed to:

- Participate in the activities of a Health & Safety Committee.
- Meet to discuss the findings of the Health & Safety Representative's reports, evaluating procedures, rules, management SYSTEMs , policy, incident investigations, suggestions and complaints by employees.
- Make recommendations to the Employer.
- Investigations & reports - Annexure 1
- Employee complaints & suggestions
- Registers and logbooks
- H&S Inspection reports
- H&S Meeting minutes
- Follow-up

Committee and Minutes of Meeting

H&S Committees meet:

- Every 3 months

- Ideally once a month
- Emergency meetings

Minutes must be:

- Kept for a minimum of 3 years.
- Signed by the CEO, assigned person and chairperson.
- Copies must be circulated to all involved

Completing and circulating minutes just before the meeting must be avoided at all costs
The minutes will be needed during an investigation or an inquiry by an Inspector.

DOCUMENTS AND RECORDS

The OHaSA requires that the Chief Executive Officer establish and document investigations and control SYSTEMs . These must be archived, some for up to 3 years, others for up to 40 years.

1. HEALTH & SAFETY REPRESENTATIVE REPORTS.
Tell them that reports of Health & Safety inspections, surveys, audits and studies must be submitted to the Health & Safety Committee and the employer.

2. COPY OF THE ACT.
Tell them that Act requires that a copy be available for use by all employees. It should be current and include all the Regulations.

3. EXEMPTION LETTERS.
Tell them that Act makes provision for the exemptions by the Department of Labour from certain provisions of the Act. These letters should be maintained.

4. COMMITTEE MINUTES.
These are to be submitted on a minimum quarterly basis. They are to be signed by the Employer, their designated person and the Chairman of the Health & Safety Committee.

5. APPOINTMENT / DESIGNATION LETTERS.
Managers, Supervisors, Incident Investigators, Health & Safety Representatives, Health & Safety Committee members, Users and other assigned / designated persons must be appointed in writing.
6. INCIDENT INVESTIGATION FORM.
Circulate a copy of the GAR Annexure 1 Incident Investigation Form.

7. HEALTH & SAFETY RULES.
A documented Health & Safety **SYSTEM** should be established which includes the rules, procedure and policy when it comes to investigations.

8. REGISTERS, LOGBOOKS, RECORD BOOKS, ETC.
Registers for lifting gear, pressure vessels, scaffolding, boilers, forklift trucks, etc., must be established and maintained.
Tell the Learners which appointees are responsible for conducting the relevant inspections.

9. RECORDS OF MEDICAL, BIOLOGICAL MONITORING, ETC.
Records of all medical tests, surveillances and biological monitoring, occupational hygiene surveys, etc., must be established and maintained. Privacy matters must be respected always.

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Chapter 5

Extracts from OHaSA & Regulations

Sections in this Chapter:

1. Employers duties to employees
2. Inform H&S Reps of investigation
3. Functions of health & safety representatives
4. Health & Safety committees
5. H&S Committees to discuss workplace incidents
6. H&S Committee meetings and records

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EMPLOYER'S DUTIES TO EMPLOYEES

[1]. **Every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees.**

[2]. Without derogating from the generality of an employer's duties under subsection [1], the matters to which those duties refer include in particular-.

[a] the provision and maintenance of SYSTEMs of work, plant and machinery that, as far as is reasonably practicable, are safe and without risks to health;

[b] taking such steps as may be reasonably practicable to eliminate or mitigate any hazard or potential hazard to the safety or health of employees, before resorting to personal protective equipment;

[c] making arrangements for ensuring, as far as is reasonably practicable, the safety and absence of risks to health in connection with the production, processing, use, handling, storage or transport of articles or substances;

[d] **[Refer to our HIRA Trainer's Kit] establishing, as far as is reasonably practicable, what hazards to the health or safety of persons are attached to any work which is performed, any article or substance which is produced, processed, used, handled, stored or transported and any plant or machinery which is used in his business, and he shall, as far as is reasonably practicable, further establish what precautionary measures should be taken with respect to such work, article, substance, plant or machinery in order to protect the Health & Safety of persons, and he shall provide the necessary means to apply such precautionary measures;**

[e] **providing such information, instructions, training and supervision as may be necessary to ensure, as far as is reasonably practicable, the Health & Safety at work of his employees;**

[f] **as far as is reasonably practicable, not permitting any employee to do any work or to produce, process, use, handle, store or transport any article or substance or to operate any plant or machinery, unless the precautionary measures contemplated in paragraphs [b] and [d], or any other precautionary measures which may be prescribed, have been taken;**

[g] taking all necessary measures to ensure that the requirements of this Act are complied with by every person in his employment or on premises under his control where plant or machinery is used;

[h] enforcing such measures as may be necessary in the interest of health and safety;

[i] **ensuring that work is performed, and that plant or machinery is used under the general supervision of a person trained to understand the hazards associated with it and who have the authority to ensure that precautionary measures taken by the employer are implemented; and.**

[j] causing all employees to be informed regarding the scope of their authority as contemplated in Section 37 [1] [b].

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INFORM H&S REPS OF INVESTIGATIONS OR INQUIRIES [SECTION 13]

Every employer shall-.

[b] **inform the Health & Safety representatives concerned beforehand of inspections, investigations or formal inquiries** of which he has been notified by an Inspector, and of any application for exemption made by him in terms of Section 40; and.

[c] **inform a Health & Safety Representative as soon as reasonably practicable of the occurrence of an incident in the workplace or section of the workplace for which such representative has been designated.**

FUNCTIONS OF HEALTH & SAFETY REPRESENTATIVES [SECTION 18]

[1] A Health & Safety Representative may perform the following functions in respect of the workplace or section of the workplace for which he has been designated, namely-.

[a] review the effectiveness of Health & Safety measures;

[b] identify potential hazards and potential major incidents at the workplace;

[c] **in collaboration with his employer, examine the causes of incidents at the workplace;**

[d] **investigate complaints by any employee relating to that employee's health or safety at work;**

[e] make representations to the employer or a Health & Safety committee on matters arising from paragraphs [a], [b], [c] or [d], or where such representations are unsuccessful, to an Inspector

HEALTH & SAFETY COMMITTEES [SECTION 19]

(1) An employer shall in respect of each workplace where two or more health and safety representatives have been designated, establish one or more health and safety committees and, at every meeting of such a committee as contemplated in subsection (4), **consult with the committee with a view to initiating, developing, promoting, maintaining and reviewing measures to ensure the health and safety of his employees at work.**

(5) The procedure at meetings of a health and safety committee shall be determined by the committee.

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H&S COMMITTEE: TO DISCUSS WORKPLACE INCIDENTS [SECTION 20]

[1] A Health & Safety committee-.

[a] may make recommendations to the employer or, where the recommendations fail to resolve the matter, to an Inspector regarding any matter affecting the health or safety of persons at the workplace or any section thereof for which such committee has been established;

[b] **shall discuss any incident at the workplace or section thereof in which or in consequence of which any person was injured, became ill or died, and may in writing report on the incident to an Inspector;** and.

[c] shall perform such other functions as may be prescribed.

[2] A Health & Safety committee shall keep record of each recommendation made to an employer in terms of subsection [1] [a] and of any report made to an Inspector in terms of subsection [1] [b].

H&S COMMITTEE MEETINGS AND RECORDS [GAR 5]

Where a Health & Safety committee has been established in terms of section 19 of the Act, an employer shall —.

[a] make available a suitable meeting place to such committee; and.

[b] **ensure that the records, as contemplated in section 20[2] of the Act, are kept for a period of at least three years.**

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Chapter 6

Legal Requirements – Reporting Incidents

Sections in this Chapter:

1. Report incidents to the inspector
2. Victimisation forbidden
3. Report incidents and diseases
4. Reporting of risk and emergency
5. Report incidents to employer
6. Employees to report injuries
7. Proof of certain facts

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REPORT INCIDENTS TO THE INSPECTOR [SECTION 24]

[1] **Each incident occurring at work** or arising out of or in connection with the activities of persons at work, or in connection with the use of plant or machinery, in which, or in consequence of which-.

[a] **any person dies, becomes unconscious, suffers the loss of a limb or part of a limb or is otherwise injured or becomes ill to such a degree that he is likely either to die or to suffer a permanent physical defect or likely to be unable for a period of at least 14 days either to work or to continue with the activity for which he was employed or is usually employed;**

[b] **a major incident occurred**; or.

[c] **the health or safety of any person was endangered and where**-.

[i] **a dangerous substance was spilled**;

[ii] **the uncontrolled release of any substance under pressure took place;**

[iii] **machinery or any part thereof fractured or failed resulting in flying, falling or uncontrolled moving objects;** or.

[iv] **machinery ran out of control,** shall, within the prescribed period and in the prescribed manner, be reported to an Inspector by the employer or the user of the plant or machinery concerned, as the case may be. [NOTE: Also mentioned in GMR 7]

VICTIMISATION FORBIDDEN [SECTION 26]

[1] **No employer shall dismiss an employee, or reduce the rate of his remuneration, or alter the terms or conditions of his employment to terms or conditions less favourable to him, or alter his position relative to other employees employed by that employer to his disadvantage, by reason of the fact, or because he suspects or believes, whether or not the suspicion or belief is justified or correct, that that employee has given information to the Minister or to any other person charged with the administration of a provision of this Act** which in terms of this Act he is required to give or which relates to the terms, conditions or circumstances of his employment or to those of any other employee of his employer, or has complied with a lawful prohibition, requirement, request or direction of an Inspector, or has given evidence before a court of law or the industrial court, or has done anything which he may or is required to do in terms of this Act or has refused to do anything which he is prohibited from doing in terms of this Act.

REPORT INCIDENTS & DISEASES [GAR 8]

[1].

An employer or user, as the case may be, shall —.

[a] **within seven days of any incident referred to in Section 24[1][a] of the Act, give notice thereof to the Provincial Director [Dept of Labour]** in the form of W.Cl.1 or W.Cl.2; and.

[b] **where a person, in consequence of such an incident, dies, becomes unconscious, suffers the loss of a limb or part of a limb, or is otherwise injured or becomes ill to such a degree that he or is likely either to die or to suffer a permanent physical defect**, such incident, including any other incident contemplated in Section 24[1][b] and [c] of the Act, be reported to the provincial director by telephone, facsimile or similar means of communication.

[2] If an injured person dies after notice of the incident in which he or she was injured was given in terms of subregulation [1], the employer or user, as the case may be, shall forthwith notify the provincial director of his or her death.

[3] Whenever an incident arising out of or in connection with the activities of persons at work occur to persons other than employees, the user, employer or self-employed person, as the case may be, shall forthwith notify the provincial director by facsimile or similar means of communication as to the —

[a] name of the injured person;
[b] address of the injured person;
[c] name of the user, employer or self-employed person;
[d] address of the user, employer or self-employed person;
[e] telephone number of the user, employer or self-employed person;
[f] name of contact person;
[g] details of incident:

[i].
What happened;
[ii].
where it happened [place];
[iii].
when it happened [date and time];
[iv].
how it happened;
[v].
why it happened; and.

[h].
names of witnesses.

[4] **Any registered medical practitioner shall, within 14 days of the examination or treatment of a person for a disease contemplated in Section 25 of the Act, give notice thereof to the chief Inspector and the employer in the form of W.Cl.22.**

[5] Any other person not contemplated in this regulation may in writing give notice of any disease contemplated in Section 25 of the Act, to the employer and chief Inspector.

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REPORTING OF RISK AND EMERGENCY OCCURRENCES [MHIR 7]

In terms of the Major Hazard Installation Regulations:

1) Every employer, self-employed person and user of a major hazard installation and owner or user of a pipeline shall -

a) subject to the provisions of regulation 6 of the General Administrative Regulations, within 48 hours by means of telephone, facsimile or similar means of communication inform the chief inspector, the provincial director and relevant local government of the occurrence of a major incident or an incident that brought the emergency plan into operation or any near miss;

b) submit a report in writing to the chief inspector, provincial director and local government within seven days; and

c) investigate and record all near misses in a register kept on the premises, which shall at all times be available for inspection by an inspector and the local government.

2) Every employer, self-employed person and user shall in the case of a major incident or an incident contemplated in subregulation (1) that was or may have been caused by a substance, inform the supplier of that substance of the incident.

3) An employer, self-employed person and user shall -

a) record all near misses in a register kept on the premises, which shall at all times be available for inspection by an inspector; and

b) ensure that the contents of the register contemplated in paragraph (a) shall also be available in the event of an inspection contemplated in regulation 5(4).

REPORT INCIDENTS TO EMPLOYER [SECTION 14]

Every employee shall at work-.

> [e] if he is involved in any incident which may affect his health or which has caused an injury to himself, **report such incident to his employer or to anyone authorized thereto by the employer, or to his Health & Safety representative, as soon as practicable but not later than the end of the particular shift** during which the incident occurred, unless the circumstances were such that the reporting of the incident was not possible, in which case **he shall report the incident as soon as practicable thereafter.**

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EMPLOYEES TO REPORT INJURIES [GSR 3 (7)]

[7] An employee with an open wound, cut, sore or any similar injury, who works in a workplace where a substance contemplated in sub regulation 5 is used, handled, processed or manufactured, **shall report such injury to his employer forthwith.**

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PROOF OF CERTAIN FACTS

[1] Whenever in any legal proceedings in terms of this Act it is proved that any person was present on or in any premises, that person shall, unless the contrary is proved, be presumed to be an employee.
[2] In the absence of satisfactory proof of age, the age of any person shall, in any legal proceedings in terms of this Act, be presumed to be that stated by an Inspector to be in his opinion the probable age of the person; but any person having an interest who is dissatisfied with that statement of opinion may, at his own expense, require that the person whose age is in question appear before and be examined by a district surgeon, and a statement contained in a certificate by a district surgeon who examined that person as to what in his opinion is the probable age of that person shall, but only for the purpose of the said proceedings, be conclusive proof of the age of that person.
[3] In any legal proceedings in terms of this Act, **any statement or entry contained in any book or document kept by any employer or user or by his employee or mandatary, or found on or in any premises occupied or used by that employer or user, and any copy or reproduction of any such statement or entry, shall be admissible in evidence against him as an admission of the facts set forth in that statement or entry**, unless it is proved that that statement or entry was not made by that employer or user or by any employee or mandatary of that employer or user within the scope of his authority.
[4] Whenever in any legal proceedings in terms of this Act it is proved that any untrue statement or entry is contained in any record kept by any person, he shall be presumed, until the contrary is proved, willfully to have falsified that record.

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Chapter 7

Reporting and Investigation of Incidents

Sections in this Chapter:

1. Employers: Recording and investigating of incidents
2. Incident caste study
3. Disturbing incident site / scene
4. Consequences -offences, penalties and special orders of court
5. Offences and penalties

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EMPLOYERS: RECORDING AND INVESTIGATION OF INCIDENTS [GAR 9]

[1] **An employer or user shall keep at a workplace or section of a workplace, as the case may be, a record in the form of Annexure 1 for a period of at least three years**, which record shall be open for inspection by an Inspector, of all incidents which he or she is **required to report in terms of Section 24 of the Act and also of any other incident which resulted in the person concerned having had to receive medical treatment other than first aid.**

[2] **An employer or user shall cause every incident which must be recorded in terms of sub regulation [1], to be investigated by the employer, a person appointed by him or her, by a Health & Safety Representative or a member of a Health & Safety committee within 7 days from the date of the incident and finalised as soon as is reasonably practicable, or within the contracted period in the case of contracted employees**.

[3] **The employer or user shall cause the findings of the investigation contemplated in sub regulation [2] to be entered in Annexure 1 immediately after completion of such investigation.**

[4] **An employer shall cause every record contemplated in sub regulation [1] to be examined by the Health & Safety committee for that workplace or section of the workplace at its next meeting and shall ensure that necessary actions, as may be reasonable practicable, are implemented and followed up to prevent the recurrence of such incident.**

Incident Case Study - Continued

Work in groups of 2 - 4 learners
Complete the form with available information

- **Appointment of Incident Investigator Letter**
- Investigation Case Study Worksheet
- Casualty / Witness Statement Template
- **Annexure 1 "Recording & Investigation of Incidents" Form**

Interaction between the Trainer & learners
Discuss the findings & opinions on a flipchart
Submit your case study for evaluation at the end

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DISTURBING INCIDENT SITE / SCENE [SECTION 24]

[2] **In the event of an incident in which a person died, or was injured to such an extent that he is likely to die, or suffered the loss of a limb or part of a limb, no person shall without the consent of an Inspector disturb the site at which the incident occurred or remove any article or substance involved in the incident therefrom: Provided that such action may be taken as is necessary to prevent a further incident, to remove the injured or dead, or to rescue persons from danger.**

The provisions of subsections [1] and [2] shall not apply in respect of-.

- a traffic accident on a public road;
- an incident occurring in a private household, provided the householder forthwith reports the incident to the South African Police; or.
- any accident which is to be investigated under Section 12 of the Aviation Act, 1962 [Act No. 74 of 1962].

A member of the South African Police to whom an incident was reported in terms of subsection [3] [b], shall forthwith notify an Inspector thereof.

CONSEQUENCES – OFFENCES, PENALTIES, AND SPECIAL ORDERS OF COURT [SECTION 38]

[1] Any person who-

[a] contravenes or fails to comply with a provision of Section 7, 8, 9, 10 [1], [2] or [3], 12, 13, 14, 15, 16 [1] or [2], 17 [1], [2] or [5], 18 [3], 19 [1], 20 [2] or [4], 22, 23, **24** [1] or **[2],** 25, 26, 29 [3], 30 [2] or [6], 34 or 36;
[b] contravenes or fails to comply with a direction or notice under Section 17 [6], 19 [4] or [7], 21 [1] or 30 [1] [a], [b] or [c] or [3], [4] or [6];
[c] contravenes or fails to comply with a condition of an exemption under Section 40 [1];
[d] **in any record, application, statement or other document referred to in this Act willfully furnishes information or makes a statement which is false in any material respect;**
[e] hinders or obstructs an Inspector in the performance of his functions; refuses or fails to comply to the best of his ability with any requirement or request made by an Inspector in the performance of his functions;
[f] deleted.

[g] refuses or fails to answer to the best of his ability any question which an Inspector in the performance of his functions has put to him;
[h] willfully furnishes to an Inspector information which is false or misleading;
[i] gives himself out as an Inspector;
[j] having been subpoenaed under Section 32 to appear before an Inspector, without sufficient cause [the onus of proof whereof shall rest upon him] fails to attend on the day and at the place specified in the subpoena, or fails to remain in attendance until the Inspector has excused him from further attendance;
[k] having been called under Section 32, without sufficient cause [the onus of proof whereof shall rest upon him]-.

[i] refuses to appear before the Inspector;
[ii] refuses to be sworn or to make affirmation as a witness after he has been directed to do so;
[iii] refuses to answer, or fails to answer to the best of his knowledge and belief, any question put to him; or.
[iv] refuses to comply with a requirement to produce a book, document or thing specified in the subpoena or which he has with him;

[l] **tampers with or discourages, threatens, deceives or in any way unduly influences any person with regard to evidence to be given or with regard to a book, document or thing to be produced by such a person** before an Inspector under Section 32;
[m] prejudices, influences or anticipates the proceedings or findings of an inquiry under Section 32 or 33;
[n] tampers with or misuses any safety equipment installed or provided to any person by an employer or user;
[o] fails to use any safety equipment at a workplace or in the course of his employment or in connection with the use of plant or machinery, which was provided to him by an employer or such a user;
[p] willfully or recklessly does anything at a workplace or in connection with the use of plant or machinery which threatens the health or safety of any person, **shall be guilty of an offence and on conviction be liable to a fine not exceeding R50000 or to imprisonment for a period not exceeding one year or to both such fine and such imprisonment.**

[2] Any employer who does or omits to do an act, thereby causing any person to be injured at a workplace, or, in the case of a person employed by him, to be injured at any place in the course of his employment, or any user who does or omits to do an act in connection with the use of plant or

machinery, thereby causing any person to be injured, shall be guilty of an offence if that employer or user, as the case may be, would in respect of that act or omission have been guilty of the offence of culpable homicide had that act or omission caused the death of the said person, irrespective of whether or not the injury could have led to the death of such person, and on conviction be liable to a fine not exceeding R100 000 or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

[3] Whenever a person is convicted of an offence consisting of a failure to comply with a provision of this Act or of any direction or notice issued thereunder, the court convicting him may, in addition to any punishment imposed on him in respect of that offence, issue an order requiring him to comply with the said provision within a period determined by the court.
[4] Whenever an employer is convicted of an offence consisting of a contravention of a provision of Section 23, the court convicting him shall inquire into and determine the amount which contrary to the said provision was deducted from the remuneration of the employee concerned or recovered from him and shall then act with respect to the said amount mutatis mutandis in accordance with sections 28 and 29 of the Basic Conditions of Employment Act, 1983 [Act No. 3 of 1983], as if such amount is an amount underpaid within the meaning of those sections.

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OFFENCES AND PENALTIES [GAR 12]

Any person who—

(a) contravenes or fails to comply with any provision of regulations 2(1), 4, 5, 6(1), 7, 8(1), 8(2), 8(3), 8(4), **9(1), 9(2), 9(3), 9(4),** 10(2) or 10(3);

fails to furnish a return required in terms of Regulation 11; or

(c) refuses or fails to comply, to the best of his or her ability, with a request made by the Inspector to make available a person to accompany him or her during the visit of the workplace,

shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 12 months and, in the case of a continuous offence, to an additional fine of R200 for each day on which the offence continues or to additional imprisonment of one day for each day on which the offence continues: Provided that the period of such additional imprisonment shall in no case exceed 90 days.

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Chapter 8

DoL Inquiries and Investigations

Sections in this Chapter:

1. Witness at DoL inquiry
2. Investigations by Inspectors
3. Formal inquiries by inspectors
4. Joint inquiries by inspectors
5. Obstruction of investigation or inquiry

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WITNESS AT DOL INQUIRY [GAR 10(9)]

Witness at inquiry [GAR] 10.
[1] When an Inspector is directed to hold a formal inquiry into an incident in terms of section 32[1] of the Act, he or she shall notify the employer or user concerned of the date, time and place of such inquiry.

[2] The employer or user shall forthwith advise in writing those persons who witnessed an incident, the union recognised by him or her and any other person specified by the Inspector, of such date, time and place, and that their presence shall be required at the inquiry.

[3] The employer or user concerned shall ascertain which of the persons he or she has advised in terms of sub regulation [2] are likely to refuse to attend the inquiry, and shall forthwith advise the Inspector of the names and addresses of such persons in for the Inspector to subpoena such persons.

[4] A subpoena issued in terms of section 32[2] of the Act shall be in the form of Annexure 2: Provided that, when a subpoena is served personally on a person, the service of such subpoena may be effected by any person authorised thereto by the Inspector who has signed it.

INVESTIGATIONS BY INSPECTORS [SECTION 31]

[1] **An Inspector may investigate the circumstances of any incident which has occurred at or originated from a workplace or in connection with the use of plant or machinery which has resulted, or in the opinion of the Inspector could have resulted, in the injury, illness or death of any person in order to determine whether it is necessary to hold a formal investigation** in terms of section 32.

[2] After completing the investigation in terms of subsection [1] the Inspector shall submit a written report thereon, together with all relevant statements, documents and information gathered by him, to the attorney-general NPA [National Prosecuting Authority] within whose area of jurisdiction such incident occurred, and he shall at the same time submit a copy of the report, statements and documents to the chief Inspector.

[3] Upon receipt of a report referred to in subsection [2], the attorney-general shall deal therewith in accordance with the provisions of the Inquests Act, 1959 [Act No. 58 of 1959], or the Criminal Procedure Act, 1977 [Act No. 51 of 1977], as the case may be.

[4] An Inspector holding an investigation shall not incur any civil liability by virtue of anything contained in the report referred to in subsection [2].

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FORMAL INQUIRIES BY INSPECTORS [SECTION 32]

[1] **The chief Inspector may, and he shall when so requested by a person producing prima facie evidence of an offence, direct an Inspector to conduct a formal inquiry into any incident which has occurred at or originated from a workplace or in connection with the use of plant or machinery which has resulted, or in the opinion of the chief Inspector could have resulted, in the injury, illness or death of any person**.

[2] For the purposes of an inquiry referred to in subsection [1] an Inspector may subpoena any person to appear before him on a day and at a place specified in the subpoena and to give evidence or to produce any book, document or thing which in the opinion of the Inspector has a bearing on the subject of the inquiry.

[3] Save as is otherwise provided in this section, the law governing criminal trials in magistrates' courts shall mutatis mutandis apply to obtaining the attendance of witnesses at an inquiry under this section, the administering of an oath or affirmation to them, their examination, the payment of witness fees to them and the production by them of books, documents and things.

[4] Any inquiry under this section shall be held in public: Provided that the presiding Inspector may exclude from the place where the inquiry is held, any person whose presence is, in his opinion, undesirable or not in the public interest.

[5][a] The presiding Inspector may designate any person to lead evidence and to examine any witness giving evidence at a formal inquiry.
[b] Any person who has an interest in the issue of the formal inquiry may personally or by representative, advocate or attorney put such questions to a witness at the inquiry to such extent as the presiding Inspector may allow.
[c] The following persons shall have an interest as referred to in paragraph [b], namely-.
[i] any person who was injured or suffered damage as a result of the incident forming the subject of the inquiry;
[ii] the employer or user, as the case may be, involved in the incident;
[iii] any person in respect of whom in the opinion of the presiding Inspector it can reasonably be inferred from the evidence that he could be held responsible for the incident;
[iv] a trade union recognized by the employer concerned or any trade union of which a person referred to in subparagraph [i] or [iii] is a member;

[v] any owner or occupier of any premises where the said incident occurred;
[vi] any other person who, at the discretion of the presiding Inspector, can prove such interest.

[6][a] An inquiry may, if it is necessary or expedient, be adjourned at any time by the presiding Inspector.
[b] An inquiry adjourned under paragraph [a] may at any stage be continued by an Inspector other than the Inspector before whom the inquiry commenced, and may after an adjournment again be continued by the Inspector before whom the inquiry commenced.

[7] **An affidavit made by any person in connection with the incident in respect of which the inquiry is held, shall at the discretion of the presiding Inspector upon production be admissible as proof of the facts stated therein,** and the presiding Inspector may, at his discretion, subpoena the person who made such an affidavit to give oral evidence at the inquiry or may submit written interrogatories to him for reply, and such interrogatories and any reply thereto purporting to be a reply from such person shall likewise be admissible in evidence at the inquiry: Provided that the presiding Inspector shall afford any person present at the inquiry the opportunity to refute the facts stated in such document, evidence or reply.

[8][a] Whenever in the course of any inquiry it appears to the presiding Inspector that the examination of a witness is necessary and that the attendance of such witness cannot be procured without a measure of delay, expense or inconvenience which in the circumstances would be unreasonable, the presiding Inspector may dispense with such attendance and may appoint a person to be a commissioner to take the evidence of such witness, whether within or outside the Republic, in regard to such matters or facts as the presiding Inspector may indicate.
[b] Any person referred to in subsection [5] [b] may in person or through a representative, advocate or attorney appear before such commissioner in order to examine the said witness.
[c] **The evidence recorded in terms of this subsection shall be admissible in evidence at the inquiry.**

[9] At the conclusion of an inquiry under this section, the presiding Inspector shall compile a written report thereon.

[10] The evidence given at any inquiry under this section shall be recorded and a copy thereof shall be submitted by the presiding Inspector together with his report to the chief Inspector, and **in the case of an incident in which or as a result of which any person died or was seriously injured or became ill, the Inspector shall submit a copy of the said evidence and the report to the attorney-general** within whose area of jurisdiction such incident occurred.

[11] Nothing contained in this section shall be construed as preventing the institution of criminal proceedings against any person or as preventing any person authorized thereto from issuing a warrant for the arrest of or arresting any person, whether or not an inquiry has already commenced.

[12] Upon receipt of a report referred to in subsection [10], the attorney-general shall deal therewith in accordance with the provisions of the Inquests Act, 1959 [Act No. 58 of 1959], or the Criminal Procedure Act, 1977 [Act No. 51 of 1977], as the case may be.

[13] An Inspector presiding at any formal inquiry shall not incur any civil liability by virtue of anything contained in the report compiled in terms of subsection [9].

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JOINT INQUIRIES BY INSPECTORS [SECTION 33]

[1] The provisions of section 32 shall not affect the provisions of any law requiring and regulating inquests or other inquiries in case of death resulting from other than natural causes, and in respect of each incident referred to in that section in which or in consequence of which any person has died there shall be held, in addition to an inquiry under the said section, such inquest or inquiry as is required by any such law, but an inquiry under the said section and an inquest held by a judicial officer under the Inquests Act, 1959 [Act No. 58 of 1959], may be held jointly.

[2] At such a joint inquiry and inquest the judicial officer shall preside and thereupon the provisions of the Inquests Act, 1959, shall apply, but the Inspector and the judicial officer shall each make the report required of them by section 32 [9] and that Act, respectively

OBSTRUCTION OF INVESTIGATION OR INQUIRY [SECTION 34]

No person shall, in relation to any investigation or inquiry held in terms of section 31 or 32-.
[a] without reasonable justification fail to comply with any lawful direction, subpoena, request or order issued or given by the presiding Inspector;

[b] refuse or fail to answer to the best of his knowledge any question lawfully put to him by or with the concurrence of the presiding Inspector: Provided that no person shall be obliged to answer any question whereby he may incriminate himself;

[c] in any manner whatsoever advise, encourage, incite, order or persuade any person who has been directed, subpoenaed, requested or ordered to do something by the presiding Inspector, not to comply with such direction, subpoena, request or order or in any manner prevent him from doing so;

[d] refuse or fail, when required thereto by the presiding Inspector, to furnish him with the means or to render him the necessary assistance for holding such inquiry;

[e] refuse or fail, when required thereto by the presiding Inspector, to attend an inquiry; or.

[f] intentionally insult the presiding Inspector or his assistant or intentionally interrupt the proceedings thereof.

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Chapter 9

Reporting Incidents

Sections in this Chapter:

1. Reporting – purpose
2. Reporting – Incident types
3. Reporting – Investigating old incidents
4. Reporting – Guidelines
5. Reporting – Danger of zero incidents
6. Reporting – Immediate report / response
7. Reporting – Victimisation of employees
8. Reporting – Why employees to not report

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REPORTING - PURPOSE

The key goals of reporting all incidents are:

- Assist the incident investigation team.
- Create and preserve legal documentation.
- Determine the Root Cause of the incident.
- Develop decision-making strategies.
- Gather and analyse information from past incidents.
- Identify trends that could prevent future incidents and illnesses

REPORTING – INCIDENT TYPES

The OHaSA requires that certain incidents be reported, recorded and investigated by the employer. Whether required by law or not, the inclusion of all work-related incidents in the reporting **SYSTEM** creates a catch-net and quantifiable indicator of potential future incidents.
Employees must be trained to promptly report incidents such as:

- Accidents and Incidents [Section 24].
- Workplace Injuries [Section 14].
- Environmental incidents.
- First Aid and Medical Treatment.
- Health & Safety Management **SYSTEM** failures.
- Lost time injuries.
- Repeat incidents [similar cause, different employees].
- Repeat incidents [different cause, same employee].
- Near Misses.
- Property damage or loss.
- Quality control issues.
- Security incidents and Criminal Acts.
- Unsafe Acts or Conditions.
- Internal vehicle accidents

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REPORTING – INVESTIGATING OLD INCIDENTS

The benefit of deliberately investigating or re-investigating

- incidents or diseases
- previously reported or contracted
- during the former term of office
- managers, supervisor or Health & Safety committees

could reveal a wealth of insights and **SYSTEM** deviations

REPORTING - GUIDELINES

The following points will assist in the reliable reporting of incidents:

- Acknowledge all reports.
- Allow anonymous reporting.
- Create a simple report form / system.
- Create an online reporting App or website.
- Educate employees about the value of reporting incidents.
- Install a telephone / SMS / WhatsApp “hot-line”.
- Minimize the reaction time between report and response.
- Mount and empty report / suggestion boxes in the workplace.
- Promote and reinforce the importance of reporting.
- Protect those who report from victimisation.
- Train Supervisors and Health & Safety Reps how to respond to reports

REPORTING – DANGER OF ZERO INCIDENT PROGRAMS

“Negative Reinforcement Incentive Program”.

- One of the common measures to maintain awareness of incident prevention is to establish a reward **SYSTEM** for achieving zero incidents.
- The intention is to encourage employees to perform at optimum Health & Safety levels.

The weakness of this approach includes:

- Branding employees as “accident prone”.
- Covering up or hiding incidents.
- Diminishing the vital importance of reporting.
- Indirect incentives not to report.
- Manipulation of reporting criteria and statistics.
- Peer pressure not to report incidents.
- Reluctance to report, so as not to spoil the record.
- Submitting fraudulent reports.
- Unrealistic expectation of extra rewards for merely doing their job.

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REPORTING – IMMEDIATE REPORT / RESPONSE

Immediate reporting and responding offers:

- Activation of rapid response / medical care team.
- Notification of the incident investigation team.
- Demonstration of a culture of involvement.
- Initiation of compensation claim documentation.
- Keeps the OH&S team actively engaged.
- Maintains heightened OH&S situational awareness.
- Shows employer commitment.
- Method of improving supervisory control measures.
- Preservation of incident scene, evidence and witness details.
- Reduces time from investigation to implementation.

REPORTING – VICTIMISATION OF EMPLOYEES

Treating someone adversely because they did something required by law or internal procedure is regarded as "Victimisation" in terms of Section 26 of the OHaSA and must not be tolerated.

- Assure employees they will not be victimised for reporting an incident.
- Evaluations that rate employees for reporting must be avoided.
- Underscore the duty to look after themselves and others.

REPORTING – WHY EMPLOYEE DO NOT REPORT

Employees may choose not to report an incident for the following reasons:

- Concern about being branded an informant of whistleblower.
- Desire to keep their work record clean.
- Dislike of bureaucracy and red tape.
- Don't see any personal benefit to themselves.
- Failure to comprehend the consequences of not reporting.
- Fear of being the focus of an investigation.

- Hesitancy to spoil the safety record.
- Scared of losing production or personal time.
- Wanting to avoid management disapproval.

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Chapter 10

Documents and Records

Sections in this Chapter:

1. Legal Report Forms
2. Possible fraudulent reports

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LEGAL REPORT FORMS

The OHaSA and COIDA require specific forms be completed and submitted by the employer and medical practitioner to the Dept of Labour and Compensation Commissioner respectively. They include:

- Annexure 1 “Recording and Investigation of Incidents” [OHaSA]
- W.Cl.2 “Employer's Report of An Accident” [COIDA]

Copies of these forms must:

- Be circulated to and retrieved from the relevant parties.
- Archive Annexure 1 for a period of at least three years.
- Archive W.Cl.2 for a period of at least 40 years.
- Be kept by the HR and the OH&S department.

Due to confidentiality all investigation documents, safe keeping and disposal must be assured.

Annexure 1

ANNEXURE 1

Discuss the information required for the Annexure 1 “Recording and Investigation of Incidents”.

A. RECORDING OF INCIDENT.

1. Name of employer.
2. Name of affected person.
3. Identity number of affected person.
4. Date of incident.
5. Time of incident.
6. Part of body affected.
7. Effect on person sprains or strains.
8. Expected period of disablement.
9. Description of occupational disease.
10. Machine/process involved/type of work performed/exposure**.
11. Was the incident reported to the Compensation Commissioner and Provincial Director?
12. Was the incident reported to the police? *.
13. SAPS office and reference.

B. INVESTIGATION OF THE ABOVE INCIDENT BY A PERSON DESIGNATED THERETO.

1. Name of Investigator.
2. Date of investigation.
3. Designation of Investigator.
4. Short description of incident.
5. Suspected cause of incident.
6. Recommended steps to prevent a recurrence.

C. ACTION TAKEN BY EMPLOYER TO PREVENT THE RECURRENCE OF A SIMILAR INCIDENT.

1. Signature of employer.
2. Date.

D. REMARKS BY HEALTH & SAFETY COMMITTEE.

1. Remarks.
2. Signature of Chairperson of Health & Safety Committee.
3. Date

POSSIBLE FRAUDULENT REPORTS

The definition of fraud is the:

- Unlawful and intentional.
- Misrepresentation of facts.
- Calculated to harm another person or party.

Indicators that fraud [a criminal offence] may be planned or committed:

- Not reported promptly.
- No witnesses
- Details are vague.
- Witnesses contradict the reported facts.
- Incident not consistent with assigned job.
- Occurred shortly after start of work.
- After announcement of layoffs, cut-backs or shut-down.
- Disciplinary procedure prior to incident.

- Report is through a lawyer's letter.
- Casualty is in financial difficulty.

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Chapter 11

Causes of Incidents

Sections in this Chapter:

1. Causes of incidents
2. Causal chain – Domino Sequence

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CAUSES OF INCIDENTS - INTRODUCTION

- Incidents stem from a combination of manageable causes.
- "Acts of God", "Chance", "Fate", "Bad luck", "Freak" or "being in the wrong place at the wrong time" are flawed explanations for an incident occurring.
- Determining the actual cause requires the accurate identification of the sequence of elements leading up to the undesired consequences.
- This is commonly referred to as "The Domino Effect" or "Causal Chain". The elimination of one or more of the elements will result in the prevention of the detrimental effects.

The following will assist determining the cause of an incident:

- **Obvious Causes** - the obvious Unsafe Acts or Unsafe Condition for an incident occurring, e.g. the casualty fell into an unprotected manhole while walking in the dark.
- **Obscure Causes** - the concealed or underlying reason/s for an incident, e.g. failure to formally identify and assess the hazard in advance, pressing deadlines or high production demands.
- **Root Causes** -is the critical place in the Causal Chain, where, if the Health & Safety Management **SYSTEM** had identified and acted in time, would have prevented the triggering of a domino like sequence or chain of identifiable, preventable, manageable, and interrelated events.

Focusing on the Obvious Cause only, will not prevent a repetition of incidents of this nature.
Focusing on the Causal Chain, and especially "Root Causes", will address a far wider range of workplace inefficiencies.

CAUSAL CHAIN – DOMINO SEQUENCE

BACKGROUND: Herbert W. Heinrich was a pioneering occupational safety researcher, whose 1931 publication "Industrial Accident Prevention: A Scientific Approach" was based on the analysis of large amounts of accident data collected by his employer, a large insurance company. This work, which continued for more than thirty years, identified causal factors of industrial accidents including "unsafe acts of people" and "unsafe mechanical or physical conditions". Ref https://en.wikipedia.org/wiki/Herbert_William_Heinrich.

Causal Chain - A collection of chronological Root Cause factors, faults or **SYSTEM** failures that could or did result in a deliberate or unintentional outcome.

Domino Sequence demonstrates that one event can start a chain reaction, which can have dramatic results.

- Domino 1 [Lack of Control]
- Domino 2 [Human & Work Factors]
- Domino 3 [Unsafe Acts or Conditions]
- Domino 4 [Incident or Event]
- Domino 5 [Consequences / losses]
- Domino 6 [Cost of Incidents]

Causes - Domino 1 [Lack of Control]

LACK OF CONTROL

Discuss the role of Supervisors and Management in establishing and enforcing the necessary control SYSTEMs .
Lack of Control is a Management SYSTEM Failure. The managers role is to:

1. SELECT induct, train, develop.
2. PLAN conduct HIRA, establish procedures, set standards.
3. ORGANISE assign, place, coordinate.
4. LEAD communicate, direct.
5. CONTROL inspect, monitor, evaluate, maintain, enforce.
6. INVESTIGATE probe, problem solve.
7. MENTOR motivate, reward

Causes - Domino 2 [Human & Work Factors]

HUMAN & WORK FACTORS

Human Factors

Discuss the fact that we all come from different backgrounds, cultures, work experience, education and so forth.

This affects the way we work; some people have the necessary experience and know how to do the job. Others have very little education or training and do not understand what should be done, or the consequences of their actions.

Work Factors

Explain that each job has a degree of danger attached to it.
This could be as severe as working with toxic materials or just slipping and falling down a flight of stairs.

Causes - Errors or Violation

CAUSES - ERRORS OR VIOLATION

Recognizing why employees commit errors will facilitate the development of more effective controls. There are two primary types of human failure:

ERRORSunintended, unplanned action or decisions.
VIOLATIONS willful deviation from instructions, procedures or statutes.

Causes – Errors

First question whether the training, supervision, instructions, communication, promotional strategy and awareness, etc., were adequate. Errors could include:

- Lapses of concentration or memory.
- Missing a vital step in the process.
- Activating the wrong switch or valve.
- Reading the wrong screen.
- Adding the wrong ingredient or substance.
- Flawed decision-making.
- Using the wrong tool or equipment.

Causes - Violations

Interrogate whether these factors played a part:

- Insufficient supervision.
- Inadequate planning.
- Irrelevant or non-existent rules.
- Poor design of plant or processes.
- Problematic implementation.
- Unproductive procedures.
- Unsuitable equipment.

Causes - Deliberate Criminal Violation

CAUSES - DELIBERATE CRIMINAL VIOLATION
During the investigation you may encounter a deliberate violation of the law, organisational policy, procedure, rule or instruction.

To prove that a person was at fault [mens rea] and committed a crime, you will need to prove:

- Intention [dolus]; or
- Negligence [culpa].

Common-law and statutory crimes require either:

Dolus Directus, or direct intention, indicates that the person meant to commit the prohibited act, or to bring about the criminal consequence. Crimes of this nature could include sabotage or arson.

Dolus Indirectus, or indirect intention, occurs where, even if the prohibited conduct or consequence was not the intention, the person could have undeniably foreseen the consequence. Conscious failure to use the provided Health & Safety precautions and measures could fall into this definition.

Dolus Eventualis exists where the person did not intend to cause the unlawful circumstance or consequence, but could reasonably foresee the possibility of the resultant consequence, but still proceeds with their unlawful conduct. Not erecting barriers and guards or failing to place warning signs or lockout SYSTEMs .

There are times when a person makes a mistake and does the wrong thing, believing it to be right.

Motive for Violation

A situation may exist where the employee wishes to:

- Submit a fraudulent claim for an exaggerated injury or disease.
- Demonstrate their grievances as a part of a political or labour related protest.
- Hide a crime under the guise of an occupational injury.
- Commit arson, sabotage or disruption

Causes - Domino 3 [Unsafe Acts and Unsafe Conditions]

UNSAFE ACTS AND UNSAFE CONDITIONS

Unsafe Acts

An Unsafe Acts is human behaviour that could cause Injury, Damage, Death, Destruction, Disability, Disease, Disruption, Disturbance, Etc.

Unsafe Acts occur when people do not apply common sense, do not follow Health & Safety instructions and behave in an unsafe manner.

Unless the casualty is a daredevil, stuntman or suicidal, very few incidents can be attributed to Negligence or Recklessness but rather **Unsafe Acts**.

Causes - Unsafe Acts

UNSAFE ACTS EXAMPLES
Amongst others, the Unsafe Acts leading up to the incident could include inappropriate:

MINDSET / ATTITUDE

- Assistance or advice not sought.
- Being over confident.
- Fail to engage with the supervisor.
- Flawed decision making.
- Emotional or mental distractions.
- Pre-task risk assessment overlooked.
- Underestimating the task or team.

CONDUCT

- Distracting or quarreling.
- Fooling around.
- Misbehavior.
- Taking shortcuts.

OBSERVATION.

- Neglect to monitor and observe.
- Operating without authority, permission or permits.

HANDLING.

- Improper lifting, manual handling.
- Loading or placement.
- Stacking and storing.

PLANT, TOOLS AND EQUIPMENT.

- Incorrect use.
- Operating at improper speed.
- Performing “amateur” repairs.
- Servicing equipment in motion.
- Using defective equipment.

POSITION.

- Taking up an improper position or posture.

PPE.

- Incorrect use or lack of PPE.

WORK PERMIT.

- Permit not obtained.
- Rules and procedure not followed.

SAFETY DEVICES.

- By-passed, removed or made ineffective.

SECURE.

- Failure to secure or lock-out.
- Failure to place barriers.

TRAINING.

- Operating without training.
- Starting with incomplete instructions.

TRANSPORT.

- Motorised transport abuse.

WARNINGS.

- Failure to place warning signs or communicate warnings

OTHER

Causes - Unsafe Conditions

CAUSES - UNSAFE CONDITIONS.

Unsafe Conditions include physical objects, poor technological and engineering designs, environmental conditions, or SYSTEMs of work that are unsafe, unhealthy and constitute a risk to people or the cause of incidents.

The Unsafe Conditions leading up to the incident could involve the absence, defective, excessive, exposure, failure, inadequate, lack, poor, substandard or unsuitable biological, chemical, electrical, environmental, ergonomic, explosive, fire, hygiene, mechanical, nuclear or physical conditions including:

1. Atmosphere.
2. Confined spaces.
3. Congestion, overcrowding.
4. Diseases.
5. Excavations, shafts, openings, underground.
6. Guards, rails, supports, barriers.
7. Heights, aloft.
8. Housekeeping.
9. Lighting.
10. Noise.
11. Personal protective equipment.
12. Platforms, scaffolding, structures.
13. Repetitive motion.
14. Storage.
15. Supervisory control.
16. Tools, plant, equipment.
17. Ventilation.
18. Warning signs, devices, SYSTEMs .
19. Weather.
20. Work procedure, instructions.
    Other

Causes - Domino 4 [Incident or Event]

INCIDENT OR EVENT

This domino represents the accident, incident or event that can or did take place. It is the activity that occurs when the first three dominoes are not stopped from falling over. It could include:

- Absorption
- allergic reaction
- contamination
- Hyperthermia, hypothermia
- Ingestion
- Inhalation
- Involuntary intoxication
- poisoning
- Radiation
- amputation
- Bite, sting
- Caught in, by, between
- Collapse, crushed, buried, engulfed
- Crash, collisions, impact
- Cuts, laceration,
- Electrocution
- Explosion
- Exposure
- Falls from, to, slip, trip
- Fire, incineration
- Flood, sunk, deluge
- Overexertion, strains
- Rupture
- Spill, emissions, pollution, leak
- Struck against, by
- Suffocation
- Other

Causes - Domino 5 [Consequences / Loss]

The consequences of an incident are often a matter of circumstance or “fate”.

- The severity can be influenced by the position of the casualty at the time, the amount of force exerted, the extent of the exposure and so forth.
- A falling object that merely grazes a person's shoulder is no less serious, than where it struck the person on the head and caused brain damage.
- The fact that the incident occurred, and not the severity of the result, should be the deciding factor.
- If the investigation reveals and remedies the causes, then that investigation was worthwhile.

Consequences - Effect on Casualty

CONSEQUENCES - EFFECT ON CASUALTY

- Absenteeism.
- Death.
- Disability.
- Disease.
- Financial
- Injury.
- Meaning.
- Motivation.
- Pride.
- Usefulness

Consequences - Effect on Organisation

EFFECTS ON ORGANISATION

- Damage.
- Delays.
- Destruction.
- Disruption.
- Financial.
- Legal action.
- Productivity.
- Profit and Loss.
- Quality.
- Reputation.
- Skills retention.
- Staff turnover.

Consequences - Effect on Environment

CONSEQUENCES - EFFECT ON ENVIRONMENT

- Air quality.
- Carbon budgets.
- Chemical safety.
- Contaminant clean-up.
- Impact assessment.
- Land.
- Natural resources
- Noise.
- Societal responsibility.
- Spills.
- Sustainable development.
- Waste management.
- Water.
- Wildlife and plants

Causes - Domino 6 [Cost of Incidents - Iceberg]

ICEBERG

One of the best ways to determine how much money an organisation is wasting as a result of incidents, is to measure the costs involved.
These can be classified as **DIRECT** [insured] and **INDIRECT** [uninsured] unknowable or unknown costs.

The spectrum of losses can be likened to an iceberg. You only see the exposed portion above the surface. The rest cannot be seen, but they are there.
Costs are divided into two main areas:

- **VISIBLE COSTS** The exposed portion is known as the Visible Costs - these are the ones the accountants can record.

- **HIDDEN COSTS** The greater portion, are the costs we do not see immediately, such as overtime, transport, cost of replacement, cost of investigation, etc. These are known as the Hidden Costs. They often include societal costs that cannot be insured.

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Cost of Incidents - Organisation

COST TO ORGANISATION

An incident has an ongoing ripple effect on the organisation.

- Absenteeism.
- Administration.
- Cleanup.
- Corrective measures.
- Damage repairs.
- Emergency services.
- Fines and penalties.
- Insurance premiums.
- Interruption.
- Investigation and inquiry.
- Legal
- Loss of production.
- Medical costs.
- Morale.
- Productivity.
- Recruit replacement worker.
- Repair or replacement.
- Reporting adverse incident.
- Reputation.
- Salaries.
- Startup.
- Training and retraining

Cost of Incidents - Casualty

COST TO CASUALTY

- Applying for grant.
- Cash flow and income
- Confidence.
- Disqualification for insurance.
- Healthcare costs.
- Inconvenience.
- Job hunting.
- Lost opportunities.
- Motivation.
- Pain and suffering.
- Quality of life.
- Status.
- Transportation.
- Etc.

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Chapter 12

Root Cause Analysis

Sections in this Chapter:

1. The root cause analysis process

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INTRODUCTION TO ROOT CAUSE ANALYSIS [RCA]

Rather than only addressing the SYMPTOMS of a failed management **SYSTEM,** RCA is a pro-active, systematic, analytical problem-solving technique used to identify, understand and remedy the underlying "Root Causes", weaknesses and failures. It is a study of the connections between causal factors and the incident.

RCA - Determining the Cause

RCA - DETERMINING THE CAUSE

By implementing the theories, the Investigator must:

1. Repeatedly ask "Why?" [5 to 6 times] to move past the SYMPTOMS.
2. Focus on the answers that emerge and again ask Why?
3. Dig down to uncover multiple "Root Causes".
4. Continue asking questions such as:

- WHAT dangers, hazards and risks exist?
- WHAT can be done about them?
- WHEN will something be done?
- WHICH people are affected?
- WHO is responsible?
- HOW can the problem be remedied?

RCA - Benefits

RCA - BENEFITS

The Root Cause is never a person or their Unsafe Acts.

The greatest trap of an investigator can fall into is to fail to dig deep enough to identify the real "ROOT CAUSE". RCA should:

- Uncover causes masked by layers of distractions.
- Focus on the point/s where the **SYSTEM** failed.

- Troubleshoot the **SYSTEM** to reveal weaknesses.
- Study and analyse possible causes.
- Establish HOW the incident happened.
- Determine WHAT needs to change.
- Identify the simplest or lowest cost remedies.
- Prevent similar reoccurrences.
- Predict future events before they occur.
- Recommend **SYSTEM** improvements.
- Help with forecasting and planning.
- Improve objective decision making.
- Create a Hierarchy of Needs priority template.
- Proactively solve problem.
- Move from a reactive to proactive management culture

RCA - Example

RCA - EXAMPLE
NOTE: Add your own risk-specific case studies.
When interrogating the sequence leading up to the adverse incident, ask multiple questions as to why the **SYSTEM** failed the operator and the emergency responder.
On receiving the answer, repeatedly ask the question WHY and continue to drill down until you reach a satisfactory conclusion.

Scenario - First Aider becomes the second casualty. What Happened?

- The First-Aider is admitted into ICU in a critical state of respiratory failure because of Chlorine Gas inhalation.
- Why? [Follow the reply to its logical conclusion].
- The First-Aider failed to take the necessary precautions when entering a disinfection room at a municipal water treatment plant.
- Why?
- The First-Aider was called to attend to the operator who was overcome by the Chlorine Gas fumes.
- Why?
- The employer had not adequately assessed the risk and planned accordingly.

- Why?
- The supervisor was unprepared and did not follow the emergency steps, once the alarm was raised.
- Why?
- There was no suitable PPE at the entrance to the room.
- Why?
- Their manager did not know the requirements of the General Safety Regulations.
- Why?
- In haste the First-Aider did not read the warning signs or notices before entering.
- Why?
- The First-Aider had attended a basic generic, non-risk specific Level 1 First-Aid training course which did NOT cover.

    GSR 3 [5] says "An employer shall at a workplace where a high risk substance or toxic, corrosive or similar hazardous substances are used, handled, processed or manufactured, ensure that the first aid worker contemplated in subregulation [4] is trained in the first aid procedures that are necessary for the treatment of injuries that may result from such activities, including the acute detrimental effects of exposure to such substances, and in the emergency procedures which are necessary in the case of accidental leakage or dumping of such substances".

- Why?
- Lack of supervisory monitoring and control measures.
- Why?
- The scenario had never been played out in an emergency drill.
- Why?
- The emergency callout said the operator was unconscious and the First-Aider was in a hurry to reach and resuscitate them.
- Why?
- Answer, etc.

RCA - More Questions

RCA - MORE QUESTIONS

Other questions to determine "What Went Wrong?" and "What should have happened?" could include:

- Whether a comprehensive HIRA had been conducted.
- Air quality monitoring.
- Automatic alarm system.
- Emergency rescue equipment.
- Frequency of drills.
- Inspection of PPE.
- Material Safety Data Sheets.
- Safe Work and Emergency Procedures.
- Supervisory competency.
- Etc.

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RCA - The "Fault Tree" Cause & Effect Diagram

RCA - "FAULT TREE" CAUSE & EFFECT DIAGRAM

- This useful visual technique is used to identify and cluster possible causes of a problem and effects.
- Based on "False" and "True" values, it is like the "Fishbone" or "Mind-Mapping" diagrams and techniques.
- It is a top down, logical means to "debug" and analyse **SYSTEM** failure.

Brainstorm all likely causes and list under Cause Categories such as:

1 Competency.
2 Switches and controls.
3 Materials.
4 Plant, equipment & tools.
5 Measurements / performance.
6 Methods.
7 Authority / permits.
8 Procedures / policies.
9 Supervision

Example of Fault Tree Analysis

FAULT TREE ANALYSIS - EXAMPLE
The following example demonstrates the basic process:

The Problem: "The laptop won't boot-up".

- Why?
- The battery is dead.
- Why?
- It was not charged.
- Why?
- The battery charger did not work.
- Why?
- The electricity was off.
- Why?

- The Earth-Leakage Circuit Breaker had tripped.
- Why?
- The circuit was overloaded.
- Why?
- There are too many appliances plugged into the multiplugs and extension cords.
- Why?
- The power supply was not designed to be used by so many appliances.
- Why?
- The workforce and risks have expanded.
- Why?
- A HIRA has not been conducted recently.
- Why?
- Because management are too busy.
- Why?
- Etc.

RCA - Management System Problems?

RCA - Management System Problems?
To identify Management SYSTEMs shortcomings, ask question relating to:

HUMAN FACTOR?

- Abuse or Misuse?
- Attitude?
- Behaviour?
- Boredom?
- Commitment?
- Distraction?
- Exhaustion?
- Fitness?
- Haste?
- Judgement?
- Mental?

COMMUNICATION?

- Awareness?
- Capacity?
- Competence?
- Comprehension?
- Information?
- Misunderstanding?
- Orientation?
- Supervision.
- Training?
- Understanding?

MANAGEMENT OF?

- Substance abuse?

AUTHORITY?

- Permits?
- Scope of work?
- Accountability?

PROCEDURES?

- Instructions?
- MSDS?
- Policies?
- procedures?
- Rules?
- Standards?
- Alarms?
- Buddy System?
- Conditions?
- Control measures?
- Discipline?
- Engineering?
- HIRA?
- Housekeeping?
- Inspections?
- Labeling?
- Maintenance?
- Planning?
- Preparation?
- Priorities?
- Purchasing?
- Quality?
- Selection and placement?
- Shifts?
- Tools Plant and equipment?
- Wear and Tear?

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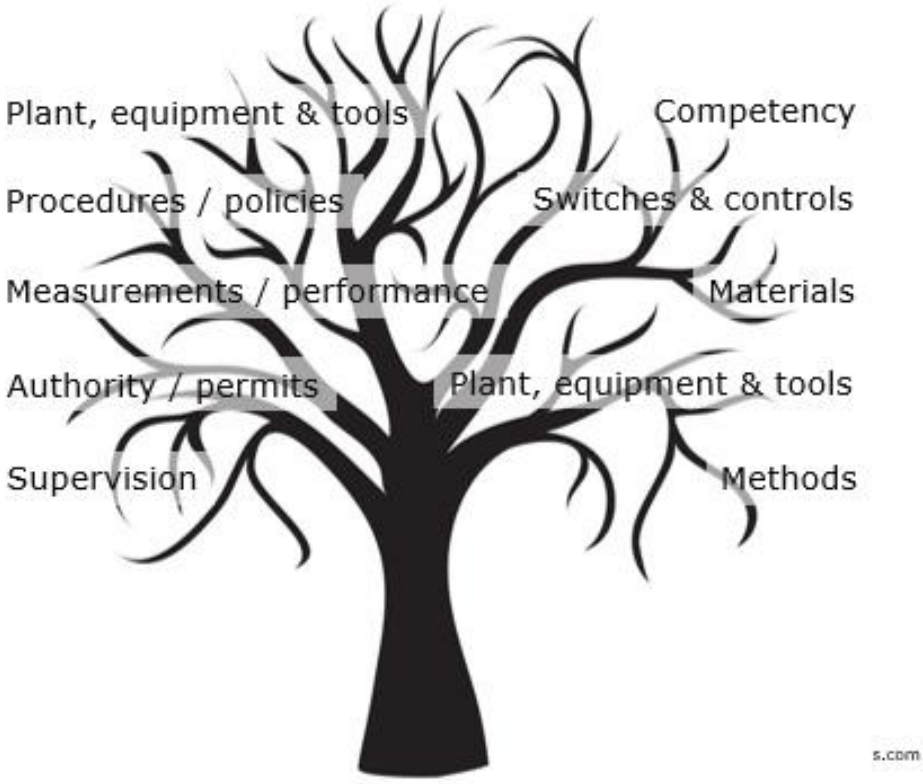

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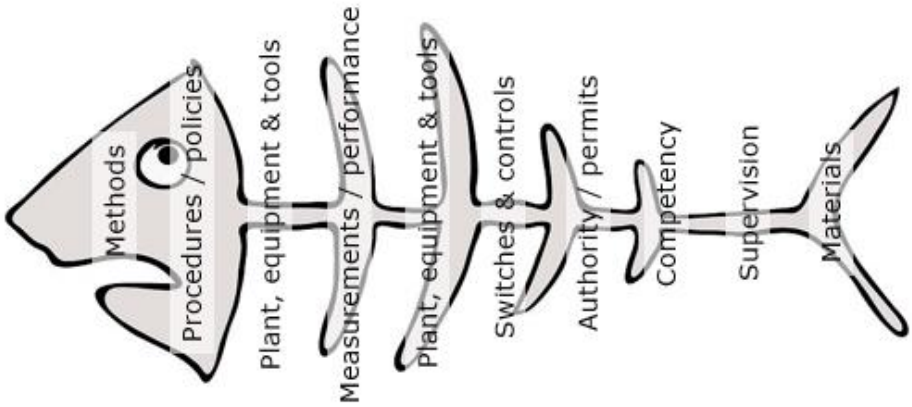

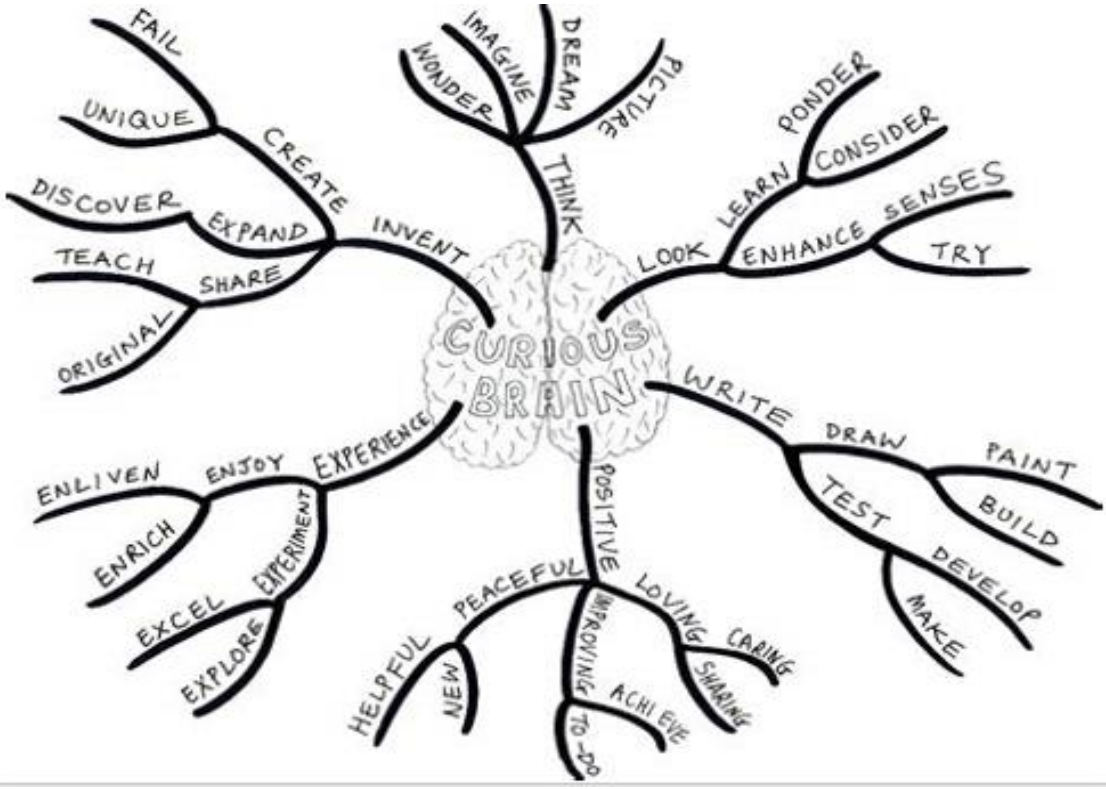

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Chapter 13

Investigation Preparation

Sections in this Chapter:

1. Investigation – Reasons
2. Investigation – for defence or prosecute
3. Investigator – Appointment
4. Investigation – tools and resources

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INVESTIGATION - REASONS

Employers have an Ethical, Legal & Financial duty to investigate incidents at work to determine why their Health & Safety **SYSTEM** may have failed.

It is important to develop, routinely communicate and audit an investigation policy.

Remember this is a FACT FINDING and not FAULT-FINDING exercise.
The investigation of incidents is critical for the following reasons:

- IDENTIFY remove or control the "Root Causes" of incidents.
- REVEAL the true situation encountered by employees at work.
- PREVENT similar incidents in future.
- DETERMINE responsibility for the occurrence of an incident.
- FULFILL the legal requirement.
- DEMONSTRATE commitment to employee's Health & Safety.
- IMPROVE the H&S Management **SYSTEM**

INVESTIGATION – FOR DEFENCE OF PROSECUTION?

It is often said that the purpose of an investigation is to "find facts, not fault".
The reality is that the prime purpose of an investigation is to determine why the Health & Safety Management **SYSTEM** failed and to take steps to prevent the incident from occurring again. Sometimes employers and employees may face disciplinary procedures or prosecution.

- Internal investigation may lead to external inquiries, where the facts may point to violation of legal or ethical practices.
- The result of the internal investigation findings may result in exposing employers and employees to criminal or civil action.
- Prosecution by the DoL and the NPA may follow a reported incident.
- Investigation teams and Health & Safety Committees must proceed judiciously to ensure they are not guilty of hiding the facts, committing fraud and defeating the ends of justice.

INVESTIGATOR – APPOINTMENT [GAR 9]

INVESTIGATOR - APPOINTMENT

In terms of GAR 9 all employers are required to appoint one or more person to investigate incidents.

- Write a selection and appointment standard and letter.
- Establish the criteria and scope of the investigation.
- Train, equip and authorise them.
- Instruct them to await and rapidly respond to incidents.
- Provide them with regular updates and retraining.

The Investigator could be:

- Employer.
- Person appointed by him or her.
- Health & Safety representative
- Member of a Health & Safety committee.
- Combination of suitable employees and or specialists.
- Independent Health & Safety consultant.

INVESTIGATION – TOOLS AND RESOURCES

The OH&S team should prepare a portable Incident Investigation Tool Kit.
The following can be stored and transported in a rugged container, together with a compact First Aid Kit:

Communication

- Two-way radio, cell phone and contact details of relevant people and emergency responders.

Containers

- Evidence and specimen envelopes or bags [plastic for wet and paper for dry samples] with labels.

Forms

- Annexure 1 investigation, Incident report / checklists, casualty and witness interview statements.

Marking of Scene

- Hi viz barrier tape and traffic cones, hi viz spray paint (various colours), chalk and chalk line.

PPE/C

- Hi-Viz Investigator Personal Protective Equipment, gloves, disposable overalls.

Recording

- Digital voice recorder, digital camera [consider use of a disposal emulsion film 24 shot "wedding" camera for tamper proof images], digital video camera, spare batteries, tripod and selfie-stick.

Stationery

- Clipboard, writing and graph paper, identification tags and labels, pens, permanent markers, duct tape, paper toweling, ruler, scissors, protractor, cable ties, exhibit number cards, etc.

Tools

- GPS, compass, high quality torch & batteries, lock-out devices and padlocks, magnifying glass, Stanley knife, tape measure, measurement tools for sound, light, temperature, distance and dimensions.

Warning

- Danger and "out of service" signs and tags, portable flashing yellow traffic lights.

Cellphone Technology.

- Consideration should be given to the use of cellphone technology in incident investigations.
- Many of the above functions can be adequately served by existing cellular features and Apps.

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Chapter 14

Investigation – Conducting Interviews

Sections in this Chapter:

1. Investigation – overview
2. Investigation – Manage the interview
3. Investigation – Interview plan
4. Investigation – Question types and Listening skills

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INVESTIGATION – OVERVIEW

The investigation is primarily about discovering why the Health & Safety Management **SYSTEM** and processes failed.

- Be objective and professional.
- Be careful not to apportion blame, assign responsibility or make judgements on the possible causes or role-players behaviour.
- To gather all the information, the Investigator needs to master the art of repeatedly asking Why? What? Where? When? Who? Etc.
- It is up to the Investigator to document the facts in a written statement, affidavit, audio or video interview as soon as possible after the incident.
- This record must include experiences, measurements, observations, opinions, photographs, sketches before, during and after the incident.
- The time and energy spent gathering information should be balanced to the level required of the investigation.
- NB casualties and witness have a constitutional right not to participate or incriminate themselves in an incident investigation.

INVESTIGATION – MANAGE THE INTERVIEW MEETING

There are several people that can contribute towards determining the cause of an incident. Compile a list of these people, follow your in-house protocols and extend an invitation to them to contribute to the investigation. They could include:

- Casualty.
- Colleagues.
- Manager.
- Specialists.
- Supervisor.
- Supplier.
- Witnesses

Request that they bring all relevant information, photographs, procedures, manuals and evidence in their possession to the interview.

An Interview Plan must be constructed, preferably with checklists, questions and desired outcomes.

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INVESTIGATION – INTERVIEW PLAN

1. **Prepare**.
   - CAUTION It is NOT the Investigators role to pass judgment.
   - EVENT Organise the interview properly, venue, resources, etc.
   - TEAM Interview by Investigator or Health & Safety Committee, HR Manager, Interpreter.
   - RECORDS Statements and recordings to be created professionally.
   - OUTCOME Facts, findings, recommendations, disciplinary steps.
   - INVITATION Role players, casualty, witness, legal representatives.
   - PERSONALITY Understand the various human temperaments.
   - CULTURE Be aware of cultural nuances.

2. **Commence**.
   - WELCOME The person being interviewed.
   - INTRODUCE The Investigator / investigation team.
   - AT EASE Adopt an amiable, non-aggressive approach.
   - REASON State the desired objective and outcome.
   - DISCUSSION Initiate free conversation.
   - TRUST Demonstrate and expect honesty during the interview.

3. **Question Time**.
   - FOCUS Keep to the subject and focus 100% on the witness.
   - ASK Closed questions [the response will be yes or no].
   - ASK Open questions [the response will be an explanation].
   - LISTEN Let them tell their own story in their own words.
   - CLARIFY Quiz if the response is vague or contradictory.
   - LEADING Don't provide words or phrases to tell their story.
   - PATIENCE Give them time to respond.

4. **Responses**.
   - PROBE Interrogate all available information and evidence.
   - DIVERSIONS Don't allow or cause distractions.
   - INTERRUPT Keep quiet while they consider or deliver their answer.

- REPEAT Provide a regular summary to gain clarity.
- DISPUTE Be alert to discrepancies in their answers.

5. **Perspective**.
   - INSIGHT Get all sides of the story.
   - SUMMARISE Obtain agreement or acknowledgement.

6. **Review**.
   - VALIDATE Read or replay their statement back to them.
   - SIGNATURE Written statements need to be signed.
   - CLOSE Thank them and explain next step

INVESTIGATION – QUESTION TYPES AND LISTENING SKILLS

Investigations - Question Types - Closed

Easy to use, “Closed-Ended” questions are answered by a forced answer with a simple "yes", "no," or “maybe”. Benefits of this technique include:

- Factual answers.
- Categorizable responses.
- Data that can be quantified and analyzed.
- Reveal significant information.
- Test understanding.
- Maintain interviewer control.
- Achieve rapid results and closure.

Closed Questions start with:
Are? Can? Could? Did? Do? Does? Have? Is? May? Shall? Should? Were? Will? Would?

The Investigator must have a clear understanding of the subject matter otherwise ignorance may:

- Create a negative frame of mind.
- Discourage conversation or concerns.
- Inhibit flow of information

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Investigations - Question Types - Open

"Open Questions" are exploratory in nature and require thought and explanation.
They result in richer information and data than responses from **"Closed Questions"**.
A balanced use of "Closed Questions" can start the conversation and summarize progress, followed by "Open Questions". It gets the person thinking and talking.
Start "Open Questions" with What? Who? Why? When? Which, Where and How?, etc.

This technique allows for:

- Effective interview.
- Complete story.
- Develop the conversation.
- Exposing understanding or lack thereof.
- Personal insights.
- Proof of commitment, care and concern.
- Realization of the extent of the **SYSTEM** defects.
- Rich qualitative data.
- Spontaneous answers.
- Steering the dialogue.
- Unique or unexpected facts.

If responses are slow in coming, ask them to ask you "Open Questions".

The drawbacks of "Open Questions" include:

- The lack of statistical significance needed for objective conclusions.
- Extensive time and effort to process the information

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Investigations - Listening Skills

Listening.
Listening is the central component of interpersonal communication and an active process that extracts meaning from verbal and nonverbal communication.

"Active Listening" when applied skillfully:

- Used in counseling, interviews, investigations and conflict resolution.
- Avoids misunderstanding.
- Builds trust.
- Changes viewpoints and values.
- Considers the detail of what is said.
- Decreases disciplinary action.
- Enables the listener to mature emotionally.
- Enhances outcomes.
- Improves cross-cultural understanding.
- Involves all the senses.

"Passive Listening" focuses on the general overall story.

"Reflective Listening" is where the listener clarifies understanding by repeating what they have just heard.
"Non-Verbal Listening" is listening with your eyes and observing the person's conduct and body language throughout the interview.

1. **Understanding**.

Understanding both the message and meaning of what is said is critical.
Language, accents, terminology, misinterpretation are all hindrances to gain an appreciation of what transpired prior to, during and after the incident.

2. **Distractions and Barriers**.

Barriers to effective listening include:

- Attention span.
- Digital or technological devices.

- Disruptive body language.
- Emotions and grievances.
- Hunger or fatigue.
- Judgmental attitude.
- Psychological or physical incapacity.
- Terminology and language.

3. **Clarity**.
   - Adopting a fixed position will derail the process. Stay open-minded.
   - Both parties to paraphrase the other's words by stating what was heard.
   - Care must be taken to not turn the interview into a lecture.
   - Focus the attention on the other person.
   - Interaction adds action to the passive process.
   - Probe to uncover the facts.
   - Third party and hearsay information are acceptable at this stage.

4. **Memory - Retention and Recall**.

Outlook and the ability to recall information differs from person to person. Consideration must be given to the following:

- Appreciation of logic, chronology, SYSTEMs and strategy.
- Different meanings to the same statement.
- Physical and mental state of the listener.
- Activity the person was involved with at the time.
- Work experience and technical background of the parties.
- Ability to extract the details of the incident.

Investigations - Hearsay Evidence

Hearsay testimony in NOT accepted in a court of law.

"He said, she said" is an example of hearsay evidence or testimony.

- A "hearsay" statement is made by a person [the third party], to an onlooker or listener [first party], who repeats it to another [second party] as a statement of fact.

- As the third party is not available to verify the information or undergo cross-examination, this “hearsay” evidence is normally not admissible.
- Conversational “hearsay” can however direct an Investigator to other verifiable information.
- It should not be discarded until the inquiry forms part of a disciplinary or criminal proceeding.

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Investigations - Concluding the Interview

INVESTIGATIONS - CONCLUDING THE INTERVIEW

Don't end the interview abruptly. A brief summary is essential:

- Take time to recap.
- Review the information gleaned.
- Ask if there is information they would like to add.
- Avoid sharing any judgment or procedural conclusions.
- Tell them there may be further inquiries.
- Thank them and end the interview

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Chapter 15

Investigations – Taking Statements

Sections in this Chapter:

1. Investigation – purpose and types
2. Investigation – statement considerations - practical
3. Investigation – statement considerations – legal
4. Investigation – witness selection
5. Investigation – witness input
6. Investigation – signatures
7. Incident caste study

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INVESTIGATION – PURPOSE AND TYPES OF STATEMENTS

Record and preserve an accurate account of the incident.

- Determine what happened.
- Essential analysis to prevent similar incidents.
- Secure evidence in the event of a prosecution.
- Put witness off from changing their version.
- Reminder for future reference.
- Avoid misunderstanding.
- May be required by legal counsel or insurance company

INVESTIGATIONS - STATEMENT CONSIDERATIONS - PRACTICAL

- Assist hearing or visually impaired people.
- Avoid making witness feel like an accused or whistleblower.
- Witness must be emotionally and mentally capable.
- Determine witness literacy levels.
- Encourage witness to simply state the facts.
- Ensure they comprehend English.
- Follow a format that is easy to read.
- Interview as soon as possible after the incident.
- Record their story in the “first person” as it happened.
- Use a spell and grammar check like www.grammarly.com.
- Record in writing on a word processor or by audio or video recording

INVESTIGATIONS - STATEMENT CONSIDERATIONS - LEGAL

- A statement is not “sworn under oath” and states their observations.
- An affidavit is “sworn under oath of perjury”, as a truthful statement.
- Can implicate the employer and employee.
- Recorded with witness’s knowledge and consent.
- The DoL Inspector may take another statement

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INVESTIGATIONS - WITNESS SELECTION

- Witness/s - Casualty, complainant.
- All people involved in or with the incident.
- Employer and employee representatives.
- Interpreter or translator.
- Subject matter specialists.
- Supervisor or manager

INVESTIGATIONS - WITNESS INPUT

Statements must include:

- Full names, employee, identity, passport or visa / work permit numbers.
- Position, title, job description, work experience, training.
- Organisation name, activities, industry category, department
- Supervisor, Manager H&S Rep.
- Home address, age, gender, contact details.
- Chronological activities prior to, during and after the incident.
- Day, date, time, shift.
- Work instructions, procedures, task at hand.
- Witness's observations, experiences, feelings.
- Plant, machinery, equipment used.
- Position, location, activities at the time.
- Assumed causes.
- Obvious consequences.
- Recommended preventative remedies.
- Introduction of diagrams, sketches, photos and evidence.
- Declaration that the Statement is a true and accurate record.

INVESTIGATIONS - SIGNATURES

- Give the witness an opportunity to review the statement.
- To be signed by the person making the statement, a witness and the interviewer.
- Provision of dates, time and place the statement was signed

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Incident Case Study - Continued

Work in groups of 2 - 4 learners
Complete the form with available information

- Appointment of Incident Investigator Letter
- **Investigation Case Study Worksheet**
- **Casualty / Witness Statement Template**
- **Annexure 1 "Recording & Investigation of Incidents" Form**

Interaction between the Trainer & learners
Discuss the findings & opinions on a flipchart
Submit your case study for evaluation at the end

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Chapter 16

The Investigation – 9 Steps

Sections in this Chapter:

1. Investigation – the 9 steps
   - STEP 1 - Assemble the Investigation Team.
   - STEP 2 - Visit the Scene.
   - STEP 3 - Gather the Information.
   - STEP 4 - Collect Evidence and Exhibits.
   - STEP 5 - Take Statements and or Affidavits.
   - STEP 6 - Isolate and identify the “Root Cause/s”.
   - STEP 7 - Make Recommendations.
   - STEP 8 - Complete the Documentation / Record Keeping.
   - STEP 9 - Develop and Implement the Corrective Action Plan

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INVESTIGATION – THE 9 STEPS

The following basic steps will guide you through the investigation:

STEP 1 - Assemble the Team

As we saw, the law demands that all Section 24 and GAR 8 incidents must be investigated by an appointed person or team.
Investigations are best conducted by a group of experienced people who represent both employer and employees.
Where prosecution is likely, special attention must be paid to ensuring thoroughness of the observations, findings, recording and recommendations.
The investigation team could consist of:

- OHaSA Section 8, 16.1 & 16.2 Management Appointees.
- Appointed Investigator/s.
- Health & Safety Committee members & Reps.
- HR professional.
- Legal Advisor / Attorney.
- OH&S professional.
- First aider and emergency responder.
- Approved Inspection Authorities.
- Specialists with knowledge in the fields of:
  Administration, Chemistry, Construction, Electricity, Engineering, Environment, Finance, Maintenance, Mechanical, Medicine, Nuclear Physics, Occupational Medicine, Occupational Hygiene, Production, Quality-control.

Relevant appointments need to be made in advance by the employer and on recommendation of the Health & Safety Committee.

STEP 2 - Visit the Scene

Effective incident scene control and examination requires the:

- Treatment of the casualties.
- The scene shielded from spectators and possibility of tampering.

- Safety ensured with barriers, lockout, PPE, etc.
- Systematic, disciplined approach.
- Control and coordination by the Supervisor and Health & Safety Rep.
- Use of essential observation, recording and collection techniques.
- Application of physical evidence collection skills.
- Preservation of uncovered evidence.
- Basic knowledge of forensic science.
- Methodical collection and recording of evidence.
- Information to reach the investigation team.
- Physical and mental stamina and determination of the Investigator.

STEP 3 - Gather the Information

Keep an open mind and search for anything that may have contributed to the incident, in these groupings:

- PLACE: Organisation, Layout, Maintenance, Cleaning, Conditions.
- TIME: Date, Chain of Events, Chronological Order.
- ROLE PLAYERS: Casualty, Witnesses, Supervision, Visitors.
- ACTIVITIES: Actions, Work, Workflow, People, Behaviour, Position.
- AUTHORITY: Permits, Access, Licenses.
- ARRANGEMENTS: Materials, Tools, Equipment, Substances, Source.
- ASSESSMENT: HIRA, Dates, Details of Danger, Hazard, Risk.
- COMMUNICATION: SYSTEMs, Effectiveness.
- COMPETENCY: Training, Experience, Preparedness, Suitability.
- CONSEQUENCE: Injuries, Death, Disease, Damage, Disruption, etc.
- DISTRACTIONS: Sidetracked, Non-related issues, Urgency.
- ENVIRONMENT: Layout, Scenario, Weather, Situation.
- INCIDENT: Occurrence, Accident, Event.
- INFLUENCES: Chance, Coincidence, Pressure.
- INFORMATION: Data, Statistics, Statements, Measurements.
- OTHER: Unusual, Different, Difficulties, Shortcoming
- RECORDS: Plans, Drawings, Photos, Video.
- SAFETY: Procedures, SYSTEMs, Equipment.

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Re-enactment or Reconstruction

Do not put anyone at risk!

- An investigation may result in a recommendation that an onsite incident re-enactment or reconstruction be staged.
- A conclusive HIRA should be conducted to determine the feasibility of the recommendation.
- CAUTION: A re-enactment or reconstruction of the incident MUST NOT be considered if the risks of a repeat of the sub-standard practices encountered in the incident could result in a duplication of that incident.
- In the event of that possibility, a VR [Virtual Reality] interactive simulation, animation or theatrical re-enactment could be commissioned.
- It must be limited to situations where information cannot be obtained by any other means.
- Bear in mind that the event may result in additional emotional trauma.

Objective

- Ensure the details have been accurately collected, communicated and understood.
- Clarify key facts and timelines.
- Demonstrate exactly what happened.
- Detect System Failure.
- Identify Unsafe Acts and/or Unsafe Conditions.
- Provide obscure insights.
- Resolve conflicts in witness testimony.
- Review Control Measures.

Participants.

- Investigation team, casualty, witnesses and managers.
- An autonomous Health & Safety consultant to halt the re-enactment if necessary.
- Engineers to analyze the injury mechanisms and dynamics.
- Medical professionals to diagnose the injuries and diseases.

Records.

- Diagrams.
- Photographs.
- Statements.
- Timelines.
- Video.
- Record of who made or took them.

STEP 4 - Collect Evidence & Exhibits

Collect all the evidence or exhibits for later examination or incident reconstruction.

The DNA Project is a valuable resource of information and guidelines. Visit www.dnaproject.co.za

Considerations when collecting and handling physical, documentary or biological evidence or exhibits including:

Collection and Recovery.

- Tag and number each item or sample.
- Photograph each item while still in original position.
- Take care not to damage or alter any exhibit.
- Names of individuals involved with the collection.
- Authorised collection, recovery, retention and disposal.
- Accurate and comprehensive records.
- Detailed description of the evidence or exhibits; articles, substances, materials, equipment, samples, etc.
- Time, date and place of recovery.
- Available for DoL Investigator.
- Pack fragile items well.

Handling and Storage.

- Sealed according to required protocol.
- Maintain integrity of exhibits.
- Removal, retention, preservation, examination and transfer records.
- Location and method of final storage.

- Needs to be presented by a witness or Investigator at the inquiry.
- Technical reports to be provided by Authorised Inspection Authority

STEP 5 - Interview and Take Statements

This step was discussed in:

- Part 13 - Conducting Interviews
- Part 14 - Taking Written Statements

STEP 6 - Identify the Cause

This step was discussed in:

- Part 10 - Causes of Incidents

Using the systematic RCA techniques, the Investigator will arrive at logical and informed conclusions.

STEP 7 - Make Recommendations

As previously discussed in:

- Part 02 - Introduction to OH&S Management

The Hierarchy of Control will provide measures to mitigate or eliminate the risks, rendering the workplace or process safe and healthy. It is up to the Health & safety Committee to ratify and make the necessary recommendations.

The priority rating is as follows:

1. Remove.
2. Replace.
3. Redesign.
4. Regulate.
5. Educate.
6. Supervise.
7. PPE and PPC.

STEP 8 - Complete the Documentation / Record Keeping

As required by the Act, Regulations and organisation's policies:

- The originals must be handed to the employer and Health & Safety Committee.

- Provide a copy to the witness if requested.
- An archive copy must be kept for the statutory period

STEP 9 - Develop and Implement the Corrective Action Plan

Health & Safety Committee recommendations must be attended to by the employer with these considerations:

- Role players or their representatives should be involved.
- A senior investigation custodian to be appointed to ensure finalisation.
- High priority actions should be implemented immediately.
- Priorities should be guided by probability, frequency and severity.
- Progress reports should be reviewed regularly.
- Risks must be mitigated to an acceptable level or the work must stop.
- Appraised financial losses to be submitted.
- Casualty and witness counseling form.
- Revise Safe Work Procedures.
- Update training curriculum.

The Corrective Action Plan should follow the reliable SMART [Specific, Measurable, Attainable, Relevant and Time-Frames] format:

- SPECIFIC: focus on precise areas of improvement.
- MEASURABLE: allow for measurable progress and further analysis.
- ATTAINABLE: be realistic, based on available resources and existing limitations.
- RELEVANT: align with other business objectives.
- TIME-FRAME: have a cutoff date.

NOTE: Remember to communicate the results of the investigation to all involved.

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DEFINITIONS, TERMINOLOGY & GLOSSARY

Definitions, Terminology & Glossary - Common Terms.

"**act**" [OHaSA] Occupational Health & Safety Act [Act 85 of 93] and includes any regulation.
"**biological monitoring**" [OHaSA] means a planned programme of periodic collection and analysis of body fluid, tissues, excreta or exhaled air in order to detect and quantify the exposure to or absorption of any substance or organism by persons.
"**chief executive officer**" [OHaSA], in relation to a body corporate or an enterprise conducted by the State, means the person who is responsible for the overall management and control of the business of such body corporate or enterprise.
"**COIDA**" Compensation for Occupational Injuries & Diseases Act, 1993 [Act No. 130 of 1993].
"**compensation commissioner**" [GAR] means the Compensation Commissioner appointed under Section 2 of the COIDA.
"**consequence**" means any Injury, Damage, Death, Destruction, Disability, Disease, Disruption, Disturbance, Etc.
"**damage**" to plant, machinery, equipment, property or production.
"**deponent**" a person who makes a deposition or affidavit under oath.
"**DoL**" Department of Labour.
"**employee**" [OHaSA] means, subject to the provisions of subsection [2], any person who is employed by or works for an employer and who receives or is entitled to receive any remuneration or who works under the direction or supervision of an employer or any other person.
"**employer**" [OHaSA] means, subject to the provisions of subsection [2], any person who employs or provides work for any person and remunerates that person or expressly or tacitly undertakes to remunerate him, but excludes a labour broker as defined in section I [1] of the Labour Relations Act, 1956 [Act No. 28 of 1956].
"**first-aid**" means emergency treatment provided to an injured or ill person before professional medical assistance arrives.
"**GAR**" General Administrative Regulations.
"**GMR**" General Machinery Regulations.
"**GSR**" General Safety Regulations.
"**Health & Safety committee**" [OHaSA] means a committee established under section 19.
"**Health & Safety equipment**" [OHaSA] means any article or part thereof which is manufactured, provided or installed in the interest of the health or safety of any person.
"**Health & Safety representative**" [OHaSA] means a person designated in terms of Section 17 [1].

"**Health & Safety standard**" [OHaSA] means any standard, irrespective of whether or not it has the force of law, which, if applied for the purposes of this Act, will in the opinion of the Minister promote the attainment of an objective of this Act.
"**healthy**" [OHaSA] means free from illness or injury attributable to occupational causes.
"**HIRA**" Hazard Identification & Risk Assessment.
"**inspection authority**" [OHaSA] means any person who with the aid of specialized knowledge or equipment or after such investigations, tests, sampling or analyses as he may consider necessary, and whether for reward or otherwise, renders a service by making special findings.
"**Inspector**" [OHaSA] means a person designated under section 28.
"**lost time injury**" A recordable or a medically confirmed injury or disease that requires an employee to perform alternative work, or that prevents them from carrying out their normal duties on the following day/s.
"**machinery**" [OHaSA] means any article or combination of articles assembled, arranged or connected and which is used or intended to be used for converting any form of energy to performing work, or which is used or intended to be used, whether incidental thereto or not, for developing, receiving, storing, containing, confining, transforming, transmitting, transferring or controlling any form of energy.
"**major incident**" [OHaSA] and [MHIR] means an occurrence of catastrophic proportions, resulting from the use of plant or machinery, or from activities at a workplace.
"**mandatary**" [OHaSA] includes an agent, a contractor or a subcontractor for work, but without derogating from his status in his own right as an employer or a user.
"**medical surveillance**" [OHaSA] means a planned programme or periodic examination [which may include clinical examinations, biological monitoring or medical tests] of employees by an occupational health practitioner or, in prescribed cases, by an occupational medicine practitioner.
"**MHIR**" Major Hazard Installation Regulations
"**near miss**" also referred to as a "close call", is an unplanned uncontrolled incident that has the potential to cause injury, disease or other consequence.
"**near miss**" [MHIR] means any unforeseen event involving one or more hazardous substances which, but
for mitigating effects, actions or SYSTEMs , could have escalated to a major incident;
"**NPA**" National Prosecuting Authority formerly the Attorney-General.
"**occupational health**" [OHaSA] includes occupational hygiene, occupational medicine and biological monitoring.

"**occupational hygiene**" [OHaSA] means the anticipation, recognition, evaluation and control of conditions arising in or from the workplace, which may cause illness or adverse health effects to persons.
"**occupational injury**" [COIDA] means a personal injury sustained as a result of an accident.
"**occupational medicine**" [OHaSA] means the prevention, diagnosis and treatment of illness, injury and adverse health effects associated with a particular type of work.
"**OHaSA**" Occupational Health & Safety Act [Act 85 of 93].
"**organism**" [OHaSA] means any biological entity which is capable of causing illness to persons.
"**plant**" [OHaSA] includes fixtures, fittings, implements, equipment, tools and appliances, and anything which is used for any purpose in connection with such plant.
"**PPE / PPC**" Personal Protective Equipment or Clothing specifically designed to protect employees from injury or exposure to health hazards.
"**premises**" [OHaSA] includes any building, vehicle, vessel, train or aircraft.
"**prescribed**" [OHaSA] means prescribed by regulation.
"**properly used**" [OHaSA] means used with reasonable care, and with due regard to any information, instruction or advice supplied by the designer, manufacturer, importer, seller or supplier.
"**reasonably practicable**" [OHaSA] means practicable having regard to-
[a] the severity and scope of the hazard or risk concerned;
[b] the state of knowledge reasonably available concerning that hazard or risk and of any means of removing or mitigating that hazard or risk;
[c] the availability and suitability of means to remove or mitigate that hazard or risk; and
[d] the cost of removing or mitigating that hazard or risk in relation to the benefits deriving therefrom.
"**regulation**" [OHaSA] means a regulation made under section 43.
"**safe**" [OHaSA] means free from any hazard.
"**scene**" means the place or setting where the incident took place.
"**SHE**" means Safety, Health and Environmental matters.
"substance" [OHaSA] includes any solid, liquid, vapour, gas or aerosol, or combination **thereof**.
"**unsafe act**" means employee behaviour or practice that is contrary to common sense or Health & Safety instructions or practices that did or could lead to a workplace incident.
"**unsafe conditions**" means objects, equipment, environment or circumstances found in the workplace that are unsafe, unhealthy or constitute a hazard.
"**user**" [OHaSA] in relation to plant or machinery, means the person who uses plant or machinery for his own benefit or who has the right of control over the use of plant or machinery, but does not include a lessor of, or any person employed in connection with, that plant or machinery.

"**witness**" a person who makes a statement that is not under oath.
"**work**" [OHaSA] means work as an employee or as a self-employed person, and for such purpose an employee is deemed to be at work during the time that he is in the course of his employment, and a self-employed person is deemed to be at work during such time as he devotes to work as a self-employed person.
"**workplace**" [OHaSA] means any premises or place where a person performs work in the course of his employment.
NOTE. Feel free to add relevant terms in use at your organisation.

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TEMPLATE - ANNEXURE 1

OCCUPATIONAL HEALTH AND SAFETY ACT, 1993
(ACT NO 85 OF 1993)

REGULATION 9 OF THE GENERAL ADMINISTRATIVE REGULATIONS

RECORDING AND INVESTIGATION OF INCIDENTS

A. RECORDING OF INCIDENT

1. Name of employer _____

2. Name of affected person _____

3. Identity number of affected person _____

4. Date of incident _____ 5. Time of incident _____

6. Part of body affected

Head or Neck	Eye	Trunk	Finger	Hand
Arm	Foot	Leg	Internal	Multiple

7. Effect on person

Sprains or strains	Contusion or wounds	Fractures	Burns	Amputation
Electric shock	Asphyxiation	Unconsciousness	Poisoning	Occupational Disease

8. Expected period of disablement

0-13 days	2-4 weeks	?4-16 weeks	?16-52 weeks	?52 weeks or permanent disablement	Killed

9. Description of occupational disease _____

10. Machine/process involved/type of work performed/exposure** _____

11. Was the incident reported to the Compensation Commissioner and Provincial Director?

12. Was the incident reported to the police? *	Yes	No
13. SAPS office and reference _____	Yes	No

* to be completed in case of a fatal incident
** in case of a hazardous chemical substance, indicate substance exposed to

---

B. INVESTIGATION OF THE ABOVE INCIDENT BY A PERSON DESIGNATED THERETO

1. Name of Investigator _____

2. Date of investigation _____

3. Designation of Investigator _____

4. Short description of incident

_____
_____
_____
_____

5. Suspected cause of incident

_____
_____
_____
_____

6. Recommended steps to prevent a recurrence

_____
_____
_____
_____

_____ _____
Signature of Investigator Date

C. ACTION TAKEN BY EMPLOYER TO PREVENT THE RECURRENCE OF A SIMILAR INCIDENT

Signature of Employer

Date

D. REMARKS BY HEALTH AND SAFETY COMMITTEE

Remarks:

Signature of Chairperson of Health & Safety Committee

Date

TEMPLATE - INVESTIGATOR APPOINTMENT LETTER

[Insert Your Letter Head]

A P P O I N T M E N T O F I N C I D E N T I N V E S T I G A T O R

in terms of the Occupational Health & Safety Act (Act 85 of 1993 as Amended) and General Administrative Regulation 9

I, _____ [full name and designation], declare I am authorised in terms of Section 16 (1) and or (2) and subject to the control and directions of our Chief Executive Officer, to appoint:

Complete Specialized Retail Solutions (PTY) Ltd

_____ _____

[Full name and designation] [Area of responsibility / Department / Section]

F U N C T I O N S A N D D U T I E S

"As appointed Incident Investigator, and in terms of Regulation 9 (2) you are required to investigate all Section 24, Regulation 8 and Regulation 9 (1) incidents in your area of responsibility within 7 days from the date of the incident. You are further required to finalise the investigation as soon as is reasonably practicable, or within the contracted period in the case of contracted workers".

In addition to your Section 14 duties, and on receiving a report of an incident, you are to meticulously, proficiently and professionally perform the following activities:

- Actively advance the investigative process.
- Visit the scene.
- Gather the relevant information.
- Collect evidence and exhibits.
- Take statements and or affidavits.
- Identify the "root cause/s" for the incident.
- Make recommendations to the employer.
- Complete the documentation / record keeping.
- Develop and implement a corrective action plan.
- Other duties that may be assigned to you

A C C E P T A N C E O F A P P O I N T M E N T

I, _____ [full name and designation], accept this appointment and declare I will diligently implement the relevant sections of the Act and Regulations as required of me.

_____ _____

[Signature of authorised person] [Signature of appointee]

Complete Specialized Retail Solutions (PTY) Ltd

from
____ dd ____ mm ____ yyyy
[period of validity]

to
____ dd ____ mm ____ yyyy
[period of validity]

Signed on
____ dd ____ mmm ____ yyyy

Signed at
_____
_

+27 21 001 7600
www.csrsza.com
Director: Mrs M Roodman

Proud Subsidary of GLOBAL CSRS

3 High Street, Bellville, 7530, Cape Town, South Africa
Reg. No: 2014/266320/07
VAT No: 4030289328
CSD No: MAAA0957908
FP&M SETA: FPM21/PRPACC-065
SAIOSH: 44587218

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Template - Investigation Case Study

Based on the pseudo incident described in my book "The One Minute **SAFETY** Manager":

1. Conduct a comprehensive investigation 2. Determine the Root Causes 3. Make recommendations to the Employer and Health and Safety Committee and 4. Complete the compulsory information required in GAR Annexure 1
2.

A. Recording of Incident.

1. Name of employer.
2. Name of affected person.
3. Identity number of affected person.
4. Date of incident.
5. Time of incident.
6. Part of body affected.

TRAINER GUIDELINES

Ankle, Arm lower, Arm upper, Armpit, Back, Bones, Breast, Buttocks, Calf, Cheek, Chin, Ear, Elbow, Eye, Eyebrow, Eyelid, Face, Finger, Foot, Forearm, Forehead, Gum, Hand, Head, Heel, Hip, Jaw, Knee, Knuckle, Leg lower, Leg upper, Lip, Mouth, Muscle, Nail, Neck, Nose, Chest, Palm, Rib, Sexual organ, Shin, Shoulder, Skin, Stomach, Thigh, Throat, Thumb, Toe, Tongue, Tooth, Waist, Wrist, **OTHER**

7. Effect on person sprains or strains.
7. Summary:
8. Expected period of disablement.
9. Description of occupational disease.

TRAINER GUIDELINES

Occupational diseases and disorders stemming from:

Pneumoconiosis-Fibrosis, Parenchyma of the Lung, Pleural Thickening, Bronchopulmonary Disease, Byssinosis, Occupational Asthma, Allergic Alveolitis, Erosion of the Tissues of the Oral Cavity or Nasal Cavity, Dysbarism, Including Decompression Sickness, Barotrauma or

Osteonecrosis, Allergic or Irritant Contact Dermatitis, Mesothelioma of the Pleura or Peritoneum, Malignancy of the Lung, Skin, Larynx, Mouth Cavity or Bladder, Malignancy of the Mucous Membrane or the Nose or Air Sinuses, Malignancy of the Lung, Angiosarcoma of the Liver, Malignancy of the Bladder, Leukaemia, Tuberculosis of the Lung, Brucellosis, Anthrax, Q-Fever, Bovine Tuberculosis V Hearing Impairment, Hand-Arm Vibration Syndrome (Raynaud's Phenomenon), Overstraining of Muscular, Tendinous Insertions, Other

9. Summary:
10. Machine/process involved/type of work performed/exposure**.
10, Summary
11. Was the incident reported to the Compensation Commissioner and Provincial Director?
12. Was the incident reported to the police? *
13. SAPS office and reference.

B. Investigation of the Above Incident by a Person Designated Thereto.

1. Name of Investigator.
2. Date of investigation.
3. Designation of Investigator.
4. Short description of incident.

TRAINER GUIDELINES

The Incident resulted one or more of these elements:

Bite, Sting, Caught In, Caught By, Caught Between, Collapse, Crushed, Buried, Engulfed, Crash, Collisions, Impact, Cuts, Laceration, Amputation, Electrocution, Explosion, Falls From, Falls To, Slip, Trip, Fire, Incineration, Flood, Sunk, Deluge Hyperthermia, Hypothermia, Involuntary Intoxication, Overexertion, Strains, Radiation, Poisoning, Contamination, Allergic Reaction, Rupture, Spill, Emissions, Pollution, Leak, Struck Against, Struck By, Suffocation, Inhalation, Other

4. Summary:
5. Suspected cause of incident.

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TRAINER GUIDELINES

UNSAFE ACTS leading up to the incident could have been caused by an inappropriate:

MINDSET / ATTITUDE Assistance or advice not sought, Being over confident, Fail to engage with the supervisor, Flawed decision making, Emotional or mental distractions, Pre-task risk assessment overlooked, Underestimating the task or team **CONDUCT,** Distracting or quarrelling, Fooling around, Misbehaviour, Taking shortcuts **OBSERVATION,** Neglect to monitor and observe, Operating without authority, permission or permits **HANDLING,** Improper lifting, manual handling, Loading or placement, Stacking and storing **PLANT, TOOLS AND EQUIPMENT,** Incorrect use, Operating at improper speed, Performing "unprofessional" repairs, Servicing equipment in motion, Using defective equipment **POSITION,** Taking up an improper position or posture, PPE, Incorrect use or lack of PPE **WORK PERMIT,** Permit not obtained, Rules and procedure not followed **SAFETY DEVICES,** By-passed, removed or made ineffective **SECURE,** Failure to secure or lock-out, Failure to place barriers **TRAINING,** Operating without training, Starting with incomplete instructions, **TRANSPORT,** Motorised transport abuse **WARNINGS,** Failure to place warning signs **OTHER**

TRAINER GUIDELINES

OTHER FACTORS the incident could have been caused by the absence, defective, excessive, exposure, failure, inadequate, lack, poor, substandard or unsuitably of:

AUTHORITY Permits, Scope of work, Accountability **HUMAN FACTOR,** Abuse or Misuse, Attitude, Behaviour, Boredom, Commitment, Distraction, Exhaustion, Fitness, Haste, Judgement, Mental, Substance abuse **COMMUNICATION,** Awareness, Capacity, Competence, Comprehension, Information, Misunderstanding, Orientation, Supervision, Training, Understanding **MANAGEMENT** Alarms, Buddy System, Control measures, Discipline, Engineering, HIRA, Housekeeping, Inspections, Labelling, Maintenance, Planning, Preparation v Priorities, Purchasing, Quality, Selection and placement, Shifts, Tools Plant and equipment, Wear and Tear **PROCEDURES,** Instructions, MSDS, Policies, procedures, Rules, Standards, Other

TRAINER GUIDELINES

UNSAFE CONDITIONS leading up to the incident could have been caused by the absence, defective, excessive, exposure, failure, inadequate, lack, poor, substandard or unsuitably of:

Atmosphere, Confined Spaces, Congestion, Overcrowding, Diseases, Excavations, Shafts, Openings, Underground, Guards Rails, Supports, Barriers, Heights, Aloft, Housekeeping, Lighting, Noise, Personal Protective Equipment, Platforms, Scaffolding, Structures, Repetitive Motion, Storage, Supervisory Control, Tools, Plant, Equipment, Ventilation, Warning Signs, Devices, SYSTEMs, Weather, Work Procedure, Instructions, Other

TRAINER GUIDELINES

The disease could have been caused by exposure to:

BIOLOGICAL Bacteria, Fungi, Parasitic, Virus **CHEMICALS,** Dusts, Fibres, Fumes, Gases, Liquids, Mists, Smoke, Solids, Vapour **ERGONOMIC,** Lifting, Musculoskeletal, Posture, Repetitive motion, Stretching **PHYSICAL,** Electromagnetism, Lighting, Noise, Radiation, Temperature, Vibration **PSYCHOSOCIAL,** Behavioural, Fatigue, Mental, Stress, Workload **OTHER**

5. Summary:
6. Recommended steps to prevent a recurrence.

TRAINER GUIDELINES

Repetition of incidents of this nature can be mitigated or eliminated by:
Remove the Danger, Hazard and Risk, Replace, Redesign the Layout, Plant, Machine or Process, Regulate, Educate, Supervise, Issue PPE and PPC, Other

6. Summary:

C. Action Taken by Employer to Prevent the Recurrence of a Similar Incident.

C. TRAINER GUIDELINES

Repetition of incidents of this nature can be mitigated or eliminated by:

Remove the Danger, Hazard and Risk, Replace, Redesign the Layout, Plant, Machine or Process, Regulate, Educate, Supervise, Issue PPE and PPC, Other

1. Signature of employer.
2. Date.

D. REMARKS BY HEALTH & SAFETY COMMITTEE.

1. Remarks.
2. Signature of Chairperson of Health & Safety Committee.
3. Date

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Template - Statement of Incident

Title of Incident	Register Number

Witness Details:

I,			[Full Names]
And am ☐ male ☐ female	and	years of age.	
I reside at			[Full address]
My Cell no is		My email address is	
I am a citizen of	☐ Identity ☐ Passport ☐ Work Permit Number:		
I work for	[Organisation] in the		[Section]
I have held the position of		and gained the work experience since:	
My relevant qualification and training includes:			
My primary job description is:			
My primary work activities include:			
My Manager is:	My Supervisor:	My H&S Rep.	

Incident Details

On the ☐ day ☐ night of	[Date] and at	[Time]
I was ☐ on duty ☐ off duty and busy with:		
When I saw / heard / felt / experienced / discovered the following:		

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[Describe the chronological activities / observations prior to, during and after the incident in detail]
• Name and details of casualties
• Name and details of witnesses / contractors
• Position, location, activities at the time of the incident:
• Work instructions, permits, licenses and authority pertaining to the activity / task:
• Nature of Injury, Danger, Death, Disability, Damage, Delays, Destruction, Disruption
• Plant, machinery, equipment, tools, substances in use at the time
• Assumed cause/s of the incident
• Recommended preventative remedies.
• Diagrams, sketches, photos and other evidence.
• Etc.

Witness / Investigator Declaration

I declare the information in this statement is to the best of my knowledge a true and accurate representation of this incident.

_____ _____

_ _

[Signature Witness] [Signature of Investigator]

_____ _____

_ _

[Date] ____ dd ____ mmm ____ yyyy [Signed at Place]

Complete Specialized Retail Solutions (PTY) Ltd

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