COAL ASSETS
AUSTRALIA

GLENCORE

HSEC Procedure

Incident Investigation

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1 Purpose

This procedure aligns with and supports the Glencore Coal Assets Australia (GCAA) Standard ***HSEC – Incident***. It provides details and information for a *Lead Investigator* and the *Investigation Team* to complete an incident investigation.

The purpose of this document is to guide a *Lead Investigator* and *Investigation Team* members through the process of collecting and analysing evidence. This evidence, for any type of investigation, is used to identify contributing factors of an incident. Analysis of information will identify root cause(s) and lessons to be learnt. The intent is to use this information to complete a report for management review that includes recommended actions to prevent a reoccurrence of the incident.

The procedure is based on all initial incident or emergency response requirements being complete and the scene safe for investigators to start the investigation process. Where applicable, external authorities may be responsible for the incident scene and any investigation is to comply with restrictions and requirements put in place by these authorities.

2 Scope

This document provides the minimum incident investigation process for Glencore Coal Assets Australia and its Operations*. The requirements apply to all workers at all levels, including managers, unless specifically excluded.

This procedure is only relevant to the internal GCAA investigation aspect of an incident which is conducted after the initial response and immediate actions are complete, the area is secure and the required notifications are complete (or in progress).

Where additional requirements or obligations are identified by an Operation they are to be included in their Health, Safety, Environment and Community (HSEC) Management System and maintained to an equivalent standard.

Note

The term 'Glencore Coal Assets Australia and its operations' includes all mines, projects and administrative support services operating as part of Glencore Coal Assets Australia.

3 Document Map

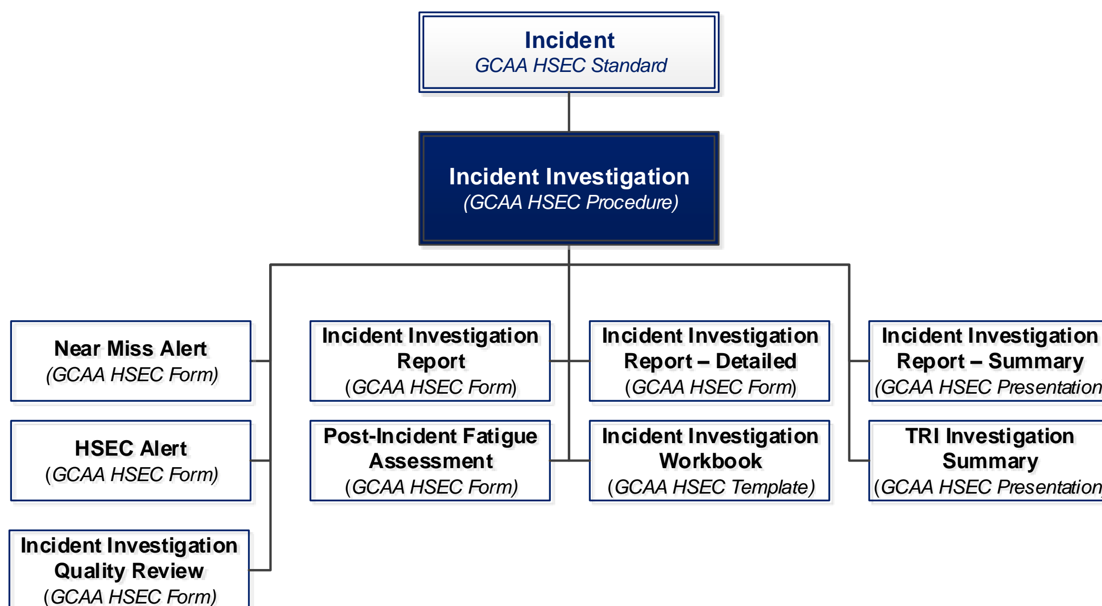

Figure 3-1 – Incident Investigation document map

4 Incident Investigation Process

The GCAA Incident Investigation process includes five main steps, as shown in ***Figure 4-1***. Each main step includes several sub steps as detailed in this procedure. Where applicable, investigation activities align with the *Incident Cause Analysis Method (ICAM)* process.

Figure 4-1 – Investigation process

5 Investigation Planning and Preparing

The investigation of an incident is to start as soon as possible after the incident has occurred. The investigation type for the relevant Risk Category is detailed in GCAA Standard ***HSEC – Incident***.

The *Operations Manager*, or delegate, is to nominate a trained *Lead Investigator* and an investigation team for each incident as soon as possible. Minimum training requirements exist for *Lead Investigators* as detailed in ***Table 5-1***. For further training course information, refer to GCAA Register ***HSEC – GCAA Course Register***.

Investigation Type	Lead Investigator	Oversight
Basic	Line Supervisor #1	Not required
Intermediate	Line Supervisor / Nominated Lead Investigator#1	Line Manager
Detailed	ICAM Trained Investigator #1 #2	GCAA
#1 *Glencore incident Investigation (GII) course*		
#2 *ICAM Lead Investigator course plus ongoing and active participation in coaching/peer review process*		

Table 5-1 – Incident Lead Investigator requirements

Note

The Operations Manager may request a more detailed investigation based on the initial report, any discrepancies relating to the incident, or trending information.

Investigation tools and resources are provided in the *Investigation Toolkit* on the intranet.

For basic investigations, the investigation team may consist of only one or two members, depending on the incident. The relevant line supervisor (for the person involved or responsible for the area) is to lead the investigation. The level of investigation should be to a depth which identifies the contributing factors and root cause(s), relevant to the actual or potential consequence of the incident.

For intermediate investigations, the investigation team is to be structured based on the incident and the level of complexity. The Operations Manager is to nominate a suitable *Lead Investigator*. They are to determine the size and structure of the investigation team. The team is to consist of personnel directly involved or those who have knowledge of the task being performed at the time of the incident.

For detailed investigations, an ICAM trained *Lead Investigator* (*ICAM Champion*) is to lead the investigation. Detailed investigations are to follow the ICAM investigation methodology.

Detailed investigations are to include use of the *Investigation Workbook*. The *Investigation Workbook* is an Excel spreadsheet used to record evidence and is to be saved against the CMO incident event in CMO.

5.1 Investigation Objective and Scope

The objective of any investigation is to identify the contributing factors and root cause(s), and to determine corrective actions to prevent a reoccurrence of the same or similar incident.

The *Lead Investigator* is to identify:

a) The scope of the investigation, including any boundaries such as the jurisdiction and authority of the investigation team.

b) The actual and potential risk category of the incident.

c) The investigation timeframe, based on the category of the incident and any other local requirements.

d) The resources needed to complete the investigation in the identified timeframe. This includes meeting and interview rooms, administration support, and similar.

e) The investigation team size and composition, including technical experts, needed to complete the investigation.

For all investigations, the nominated *Lead Investigator* is responsible for:

a) Collecting all identified evidence.

b) Analysing the collected evidence.

c) Identifying the contributing factors and root cause(s).

d) Completing investigation report requirements (CMO or investigation report, and relevant presentations).

5.2 Incident Scene Security

As soon as possible after nomination, the *Lead Investigator* is to confirm that the incident scene is secure. Scene security is essential to the preservation of evidence and information. The scene is to remain undisturbed and secure until the relevant internal or external authority (where applicable) and the *Lead Investigator* releases the scene for access.

Access to a secure scene may be permitted if specifically authorised by the relevant internal or external authority.

6 Collecting Data

Note

- *Data collection is not to impact any scene security requirements until released, or data collection is specifically authorised, by the relevant authority.*
- *Data collection may include site information not directly restricted by the incident scene such as training records, personnel information, and other relevant records.*
- *Relevant privacy requirements are to be followed when collecting personnel information.*

The initial investigation report should be completed using GCAA Form ***HSEC – Incident Investigation Report***, or directly entered into CMO.

Once the incident scene access is authorised by the relevant authority (relevant to the type of incident), the *Lead Investigator* is to coordinate data collection to support the investigation. The Lead Investigator is responsible for complying with privacy requirements and control of any sensitive information during collection and retention. Accurate collection of information is needed and should include incident scene and witness information such as:

a) Photographs.

b) Drawings, sketches, maps and plans.

c) Personnel information (shift and roster details, personnel records (including medical information), training records, competency details, licence information, etc. as relevant).

d) Fitness for work assessment results or information, such as any drug and alcohol test results, fatigue assessment results, or similar. For post-incident fatigue assessments, the GCCA Form ***HSEC – Post-incident Fatigue Assessment*** or an equivalent is to be used.

e) Witness statements.

f) Site information such as road and inspection reports (such as Open Cut Examiner or Deputy Reports).

g) Weather forecasts and reports.

h) Sensitive receiver data or information (for example, noise monitoring devices or similar).

i) Documentation (policy, operating procedures, work instructions, work orders, forms, check lists, original equipment manufacturer documentation, and similar).

j) Vehicle or equipment monitoring information data (such as Caterpillar VIMS, in-vehicle and static monitoring, digital radio recordings, or similar).

k) Change management information (such as procedures, equipment modifications, alterations, or other relevant information).

l) Site communication information (GCOM, communication meetings, training sessions, or similar).

6.1 Data Preservation

Save all data and evidence collected as part of the investigation by uploading each attachment to the CMO incident event. Once saved in CMO, paper copies of the information do not need to be retained.

6.2 PEEPO

The *Investigation Team* is to consider each of the PEEPO categories (people, environment, equipment, procedures and organisation) at the start of the investigation to identify potential areas for the collection of evidence. Information gathered as part of the PEEPO will assist with completion of the 5 Whys analysis.

The PEEPO categories include:

a) People - includes the identification and review of applicable information (such as personnel records, work history, fatigue assessment(s), training information, time sheets, rosters, medical records, incident history records, and similar). Identify people who might have information about the event and record statements as soon as possible.

b) Environment - includes examination of the scene for information to help understand the nature of the task being conducted and the local environmental conditions (such as illumination, noise, temperature, weather, and similar). Identify the physical environment, especially any recent changes to that environment. The specific conditions at the time of the event are important, not the typical conditions.

c) Equipment - includes examination of equipment involved in the event (such as design, construction, inspections, maintenance, modifications, or similar). Consider the condition of equipment or anything that may have changed or be out of the ordinary. This could include abnormal stress, modifications, substitutions, distortions, fractures or similar situations. Identify any design flaws, mismatched components or confusing labels or markings. Confirm that the equipment was appropriate for the task being conducted.

d) Procedures and documentation - includes review of all task related documentation (includes areas such as use of documents, content, criteria, validity, status, and similar). Review the task being conducted, including the work procedures and work scheduling to determine if they contributed to the event. Examine the availability, suitability, use and supervisory requirements of documented procedures, instructions, or safe work method statements.

e) Organisation – consider the role of supervisors and managers in the incident (such as organisational culture, training programs, visible support, feedback process, and similar). Management holds the legal responsibility for the safety of the workplace and the workforce.

6.3 Written Statements and Interviews

The *Lead Investigator* is to organise the collection of statements or interviews (initial and follow up) for all personnel identified as having information relevant to the incident. An interview is the preferred method of collecting evidence, however, written statements may be necessary to gather key information due to time limitations or availability of persons.

The *Investigation Team*, through analysis of preliminary information, is to identify those persons to be interviewed.

Before completing interviews, the *Investigation Team* is to review relevant evidence, gathered as part of the PEEPO process, and prepare specific questions to ask each person. The specific questions to be asked during the interview process should be targeted around the person's involvement and to obtain additional information for analysis.

6.3.1 Written Statements

Written statements may be obtained immediately following an incident to determine an initial timeline of events and key information. Review of this information may identify the need for interviews or additional statements.

The *Lead Investigator* is to provide guidance for completing written statements, which should include:

a) Name of person and contact details.

b) Date and time of statement.

c) Date and time of the incident.

d) Summary of events before, during, and after the incident.

e) Sketch or drawing of details (if needed).

f) Any other information relevant to the incident.

The information is to be retained as part of the incident investigation evidence.

6.3.2 Interview Techniques

The quality and quantity of information collected during an interview can directly relate to the techniques and skills used during the interviews. The interviewer should consider:

a) Showing empathy to the interviewee, including consideration of body language, active listening, and non-verbal communication.

b) Preparing for the interview so all known information is reviewed and available during the interview.

c) Visiting the scene of the incident (where possible) as part of the interview.

d) Conducting interviews individually, not as part of a group.

e) Locating the scene of the interview away from distractions or work activities that can interrupt or distract from the questioning.

f) Making the interviewee feel as comfortable as possible.

g) Asking the interviewee if they want a representative present during the interview.

h) Holding the interview in a location that provides privacy and is not intimidating.

i) Following up with the interviewee to ask if they would like to add any additional information.

During interviews, the interviewer is to monitor and consider the emotional condition of the person being interviewed and stop for breaks where needed, or if necessary reschedule the interview.

Note

- *A representative is there only to provide support and not to provide answers on behalf of the interviewee. This should be clarified by the interviewer at the start of the interview.*
- *Consider the use of a scribe to allow the interviewer to maintain contact with the interviewee and focus on the objectives of the interview.*

The interviewer is responsible for recording details of the interview, or delegation of the task. This is to include as a minimum:

a) Date and time of the interview.

b) Name of persons involved in the interview.

c) Location of the interview.

d) Subject(s) of discussion.

e) Specific questions and responses.

The information is to be retained as part of the incident investigation evidence.

6.3.2.1 Questioning Technique

When questioning interviewees, consider the following techniques:

a) Ask open ended questions to obtain as much information as possible. Let the interviewee do most of the talking during the conversation.

b) Ask the interviewee: 'who, what, why, when, where, and how' for each relevant PEEPO category.

c) Follow-up the question, where relevant, with; 'if not, why not'.

d) Concentrate on the actual events of the incident, not what normally happens.

e) Make certain that the person being interviewed uses their own words.

f) Ask the interviewee to explain:

  i. The sequence of events and their actions.

  ii. Existing or desirable risk controls for the task.

  iii. Any similar incidents or near misses.

  iv. Experience of the people involved.

  v. If any training was provided to the people involved.

  vi. Supervision or guidance provided for the task.

  vii. Any physical limitations or health issues.

  viii. Any stress or time pressures.

g) Ask the interviewee for their opinion of how to prevent future incidents.

6.3.3 Interview Types

Two interview types are used during data collection:

a) Initial interviews – the first contact with a person of interest, sometimes conducted at the scene of the incident.

b) Follow-up interviews – the second interview (or sometimes more) with identified persons of interest, if needed.

6.3.3.1 Initial Interviews

The *Lead Investigator* is to coordinate initial interviews with all identified persons of interest as soon as possible after the incident.

An initial interview is the first contact with the interviewee and will assist with:

a) Verifying facts.

b) Establishing the timeline of events.

c) Identifying:

  i. Additional information or details.

  ii. Additional persons of interest.

  iii. Persons not relevant to the investigation.

  iv. Persons for follow-up interviews.

6.3.3.2 Follow-up Interviews

Follow-up interviews are not mandatory but may be necessary to clarify or verify information against collected evidence and information. A follow-up interview is especially important where evidence is contradictory or requires clarification. The *Lead Investigator* is to determine if any follow-up interviews are needed.

Preparation for a follow-up interview includes the review of evidence and having that information available during the interview, if needed.

6.4 Organising and Verifying Information

As evidence and information is collected, the *Investigation Team* is to organise the information into logical groups and a timeline of events. This will assist with the verification of evidence and in identifying any conflicting information.

The *Lead Investigator* is to identify the most suitable structure or framework of the information, relevant to the incident.

During data and information collection, the *Lead Investigator* is to verify information and cross check where possible. This includes reviewing physical evidence against witness statements and looking for any discrepancies or errors.

6.4.1 Recording Evidence

Warning

When collecting and recording information, Privacy Principals are to be maintained to protect the confidentiality of personal information. Refer to the Human Resources Department for additional guidance or information.

On completion of the investigation, record all information and evidence against the incident event in CMO.

If no *Evidence Log* is used, evidence file naming should indicate the date of collection and the subject of the evidence (for example: truck 23 LHS01 20170812, or witness statement BH 20170812).

An *Evidence Log* provides a record of all information collected as part of the investigation. If an evidence log is used, the start of the filename for each item of evidence is to include the *Evidence Log* entry, as shown in the example in ***Figure 6-1***. The *Evidence Log* is to be recorded against the incident event in CMO and is part of the *Investigation Workbook*.

Evidence Log

Reference	Brief Description	Details
121	Truck 23 LHS photo 1	Incident location - left hand side photo 1 - detail of
122	Truck 23 LHS photo 2	Incident location - left side wide angle photo 2 - det
123	Truck 23 LHS photo 3	Inc
124	Truck 23 RHS photo 4	Inc
125	Truck 23 RHS photo 5	Det ... photo 5 - det
126	Haul truck VIMS data	Truck 23 VIMS 17 Jul 2017

123 - Truck 23_LHS_photo3.jpg 5,048 KB 4/2/2015 8:21 AM

file name example

Figure 6-1 – Evidence log example showing the reference number showing link to the file name in the folder

6.4.2 Establishing a Timeline

For basic and intermediate investigations, a timeline format is provided in GCAA Form ***HSEC – Incident Investigation***. Arrange the sequence of significant events into pre-event, event, and post-event. This structure and information is to be used as the basis of the 5 Whys analysis method at a later stage.

For detailed investigations, use the timeline format provided in the *Investigation Workbook*.

6.4.3 Detailed Investigation Evidence Log

The *Investigation Team* is responsible for recording and maintaining information in the *Evidence Log* which is a tab in the *Investigation Workbook*. As a minimum, save a copy of the *Evidence Log* worksheet into CMO by uploading the spreadsheet to the CMO incident event.

7 Evaluating Information

The *Investigation Team* is to assess and evaluate all collected evidence and information relating to the incident. Where gaps or inconsistencies are identified, complete further investigation to resolve the issues before identifying the root cause.

7.1 Identifying the Contributing Factors and Root Causes

The *Lead Investigator* is to coordinate the analysis and identification of the root cause(s) and contributing factors of the incident to identify findings. Two methods of analysis are used:

a) 5 Whys – for basic and intermediate investigations.

b) ICAM – for detailed investigations.

7.1.1 5 Whys

5 Whys is a questioning technique used to explore the cause and effect relationships underlying a particular problem. The primary goal of the technique is to determine the root cause(s) of a defect or problem derived from the incident timeline. The 5 in the name reflects the number of iterations typically needed to resolve the problem, and is indicative only. An example is provided in ***Table 7-1***.

Step	Example	Notes
Identify the problem or incident	The vehicle will not start.	*The problem statement*
Why?	The battery is dead.	*First why*
Why?	The alternator is not functioning.	*Second why*
Why?	The alternator belt has broken.	*Third why*
Why?	The alternator belt was well beyond its useful service life and was not replaced.	*Fourth why*
Why?	The vehicle was not maintained according to the recommended service schedule.	*Fifth why - a root cause*
Why?	Replacement parts are not available because of the extreme age of the vehicle.	*Sixth why*
Actions - to prevent a reoccurrence	Start maintaining the vehicle according to the recommended service schedule.	*Possible fifth Why solution*
	Source alternative parts.	*Possible sixth Why solution*

Table 7-1 – 5 Whys example questions

Note

The 5 Whys analysis is only to be completed once the incident timeline has been established.

7.1.2 ICAM Investigation and Analysis

ICAM is an analysis methodology that sorts the findings of an investigation into a structured framework. The specific objectives of an ICAM investigation are to:

a) Establish the relevant and material facts surrounding the event.

b) Prevent the investigation from being restricted to only the errors and violations of personnel.

c) Identify underlying or latent causes of the event.

d) Review the adequacy of existing controls and procedures.

e) Recommend corrective actions.

f) Detect developing trends that can be analysed to identify specific or recurring problems.

g) Prevent the investigation from apportioning blame or liability. Where a criminal act or an act of wilful negligence is discovered, the information will be passed to the appropriate authority.

h) Meet relevant statutory requirements for incident investigation and reporting.

The *Investigation Team* is to use the *Investigation Workbook* to record and analyse investigation information.

The *Lead Investigator* is to develop a detailed report using the *GCAA Investigation Detailed Report* template and the *Investigation Summary Report* using the *GCAA HPRI Presentation* or Glencore *Fatality Presentation*.

Note

Both formats of the Investigation Report (detailed and summary) are to be kept in alignment. If a change is made to one format during review the other format is to be updated to reflect the same information.

7.2 Verify Findings

For all investigations, the *Lead Investigator* is to review the findings and verify that they align with the objectives of the investigation.

8 Recommended Actions

Note

All actions identified from an investigation are only recommendations until reviewed and approved, relevant to the type of investigation.

For all investigations, the *Investigation Team* is to make recommendations based on their findings. The relevant management team is to review the recommendations and create corrective actions, relevant to the type of investigation. Corrective actions are to be targeted at the prevention of a reoccurrence of the incident.

SMART goals include:

a) Specific – target a specific area for improvement.

b) Measurable – quantify or suggest an indicator of progress.

c) Assignable – specify who will do it.

d) Realistic – state what results can realistically be achieved, given available resources.

e) Time-related – specify when the result(s) are to be achieved.

Develop all actions as SMART goals. Include sufficient information and detail so the action can be read as a stand-alone task when entered into CMO.

Before finalising recommended actions, the *Lead Investigator*, with input from the management team where necessary, is to review all actions to confirm each action:

a) Is written in SMART format.

b) Can be read as a stand-alone task when entered in CMO.

c) Will address the contributing factors and root cause(s), for corrective actions.

d) Can be assigned to a specific person.

e) Can be implemented by the assigned person.

Once each action has been reviewed, record the action associated with the incident in CMO and assign to the nominated person.

Note

Operations are to manage corrective actions and any new risks that could be introduced as a result of implementing actions arising from incident investigations through the change management process. This is to consider document revisions, training, and the communication of changes to relevant personnel and affected stakeholders.

8.1 Types of Actions

There are two types of actions relevant to incident investigations:

a) Corrective actions which address the root cause(s) of an incident.

b) Other actions which are non-contributory to the incident.

8.1.1 Corrective Actions

Corrective actions refer to actions that directly address the root cause(s) of an incident. There should be at least one corrective action for an incident investigation.

For a detailed investigation, corrective actions are to address, as a minimum, absent and failed defences, and organisational factors.

8.1.2 Other Actions

Throughout the investigation process, other actions may be identified that are considered to be non-contributory to the root cause(s) of the incident but are considered important to address as part of continuous improvement.

8.2 Department Review and Approval

The next up *Line Manager* from the *Lead Investigator* is to complete a review of the incident event. Review and approval is to verify quality and accuracy of information, as relevant to the incident and role:

a) Investigation details and data collection.

b) Injury details (where applicable).

c) Potential risk is correctly identified.

d) Consequence category (actual) is correctly assigned.

e) Assigned actions and due dates are assigned to the relevant person and the timeframe is appropriate for each action.

9 Investigation Reporting

Reporting requirements are detailed in GCAA Standard ***HSEC – Incident***. The *Lead Investigator* is to complete all required reports and submit for review in the required timeframes. Minimum reporting includes:

a) Basic Investigation - GCAA Form ***HSEC – Incident Investigation Report***, or directly entered into CMO.

b) Intermediate investigation - GCAA Form ***HSEC – Incident Investigation Report***, or directly entered into CMO. An Investigation TRI Summary Presentation (if TRI). Additional investigation and reporting may be required at the direction of the *Operations Manager*.

c) Detailed Investigation – HPRI:

   i. *Investigation Summary Report Presentation* (using the GCAA template).

   ii. *Investigation Detailed Report* (using the GCAA template).

d) Detailed Investigation – Category 4 or 5:

   i. *Glencore Report Summary Presentation* (using the Glencore template).

   ii. *Investigation Detailed Report* (using the GCAA template).

10 Document Information

Relevant legislation, standards and other reference information are to be regularly reviewed and monitored for updates and should be included in the site management system. Related documents and reference information in this section provides the linkage and source to develop and maintain site compliance information.

10.1 Terms and Definitions

Terms and definitions are detailed in the GCAA Guideline ***HSEC – Definition Guideline***.

10.2 Related Documents

Table 10-1 lists internal documents directly related to or referenced from this document.

Number	Type	Title
GCAA-625378177-9992	CGAA HSEC Standard	Incident
GCAA-625378177-13717	GCAA Guideline	GCAA HS Definition Guideline
GCAA-625378177-10439	GCAA Form	Incident Investigation Report
GCAA-625378177-13822	GCAA Register	GCAA Course Register
GCAA-625378177-15279	GCAA Form	Post-incident Fatigue Assessment
GCAA-625378177-10439	GCAA HSEC Form	Incident Investigation Report
GCAA-1299732908-24	GCAA Template	Incident Investigation Report - Summary
GCAA-1299732908-25	GCAA Template	Incident Investigation Report - Detailed
GCAA-1299732908-48	GCAA Template	Near Miss Alert
GCAA-1299732908-23	GCAA Template	HSEC Alert
GCAA-1299732908-50	GCAA Template	TRI Investigation Summary
GCAA-625378177-10438	GCAA HSEC Form	Incident Investigation Quality Review
GCAA-625378177-13822	GCAA Register	GCAA Course Register

Table 10-1 – Related documents

10.3 Reference Information

Table 10-2 lists reference information directly related to the development of this document or referenced from within this document.

Reference	Title
Safetywise	ICAM Lead Investigator Training
RIIWHS301	Conduct safety and health investigations
Safetywise	ICAM Pocket Investigation Guide

Table 10-2 – Reference information

10.4 Change Information

Full details of the document history are recorded in the document control register, by version. ***Table 10-3*** provides a summary of the current change.

Version	Date	Change Summary
3.0	10 May 2018	Total rewrite of document to align with updates to the GCAA HSEC Incident Standard, investigation training, and CMO requirements.
2.0	14 July 2016	Republished by Migration Script.
1.0	24 October 2016	Refer to change management for details.

Table 10-3 – Change information