



GROUP SAFETY STANDARD 1 INCIDENT REPORTING AND MANAGEMENT STANDARD

INDEPENDENCE GROUP NL





DOCUMENT APPROVAL FOR USE

Document owner: Head of Governance and Risk

Date first issued: 01/10/15

Prepared by: Keith Ashby

Reviewed by	Changes	Approved by	Date Effective
HSEC & Training Committee	First Version	Keith Ashby	1 October 2015
Lauren Simpson & Tricia Winyard	Corrections to SRS reporting guidance	Keith Ashby	14 December 2015
Ross Jennings, Tricia Winyard, Emilija Bradford	Corrections to incident reporting section	Keith Ashby	10 March 2016
Melayna Eggington & Rhona Wardman	Update of spill reporting guidelines	Keith Ashby	31 March 2016
Doc Control	Correction of cross referenced documents	Keith Ashby	20 June 2016
HSEC & Training Committee	Inclusion of Catastrophic Potential Incident	Keith Ashby	16 May 2017
Doc Control	Update section of spatial areas of application	Keith Ashby	25 July 2017
Jade Pratt	Addition of 'near miss' definition	Keith Ashby	1 Sept 2017
David Wells	IGO GSS6 (response to behavioural root causes of incidents) integrated into this standard.	Keith Ashby	23/11/2018

No amendments to this document may be made without the approval of the document owner.



CONTENTS

1. PURPOSE	3
2. APPLICATION	3
3. INCIDENT REPORTING PROCESS	3
4. INITIAL RESPONSE	5
4.1. Is the Incident Scene Safe?	5
4.2. First Aid	5
4.3. Is An Emergency Response Required?	5
4.4. Is the Event a Crisis?	5
4.5. Securing the Scene for Investigation	5
4.6. Should Related Works be Suspended?	5
5. REPORTING TO LINE MANGEMENT	6
5.1. What Must Be Reported?	6
5.2. Who Must Report?	6
5.3. Verbal Reporting To Line Management	6
5.4. Safety Alerts	7
5.5. Initial Incident Data Capture	8
5.6. Starting the Investigation Process	8
5.7. Safety Incident Classification	8
6. GOVERNMENT REPORTING	9
6.1. Reporting in Western Australia	9
6.2. Reporting in other jurisdictions	9
7. ENSURING A SAFE RESTART	9
8. INVESTIGATION PROCESS	9
9. INCIDENT CAPTURE IN INX	10
10. WERE THERE BEHAVIOURAL FACTORS TO THE INCIDENT?	10
11. CORRECTIVE ACTION TRACKING	10
12. COMMUNICATE OUTCOMES OF INVESTIGATIONS	11
13. INCIDENT REVIEW BY EXECUTIVE COMMITTEE	11
14. ACCOUNTABILITIES	11
15. APPENDIX 1 A: REPORTING INCIDENTS IN WESTERN AUSTRALIA	12
15.1. Reporting to the DMP	12

15.2.	Only Authorised Representatives to Report	12
15.3.	Responsibility to Ensure Reporting Is Complete	12
15.4.	Injuries to be Reported to The DMP	12
15.5.	Events to be reported to the DMP	13
15.6.	Potentially Serious Occurrence	13
15.7.	Summary of DMP Reporting Requirements	15
15.8.	DMP's Safety Reporting Systems	15
15.9.	Subsequent Confirmation by Mining Injury Report.....	15
15.10.	Monthly Status Report - WA	15
15.11.	Accident 'Log-Book' (INX)	16
15.12.	Incident Record Security	16
15.13.	Reporting to Other WA Government Agencies	16
16.	APPENDIX 1 B: REPORTING INCIDENTS IN OTHER JURISDICTIONS	17
17.	APPENDIX 2: CLASSIFICATION OF NEAR MISSES AND POTENTIAL CONSEQUENCES	18
17.1.	High Potential Incidents.....	18
17.2.	Serious Potential Incident (SPI).....	21
17.3.	Incident Classification Guidance – Non-Safety	21
18.	APPENDIX 3: CATEGORIES OF CONSEQUENCE	22
19.	APPENDIX 4: DEFINITION OF INJURY TYPES.....	23
19.1.	Criteria for Inclusion in Statistical Indicators.....	23
19.2.	Injury Classification Types.....	23
19.3.	Accountability for Decision Making Regarding Injury Classification.....	27
20.	APPENDIX 5: LOCATION OF INCIDENTS & STANDARD APPLICATION	27
21.	APPENDIX 6: SPILL MATRIX	28
22.	APPENDIX 7: RESPONSE TO BEHAVIOURAL ROOT CAUSES OF INCIDENTS	30
22.1.	OVERVIEW	30
22.2.	CLASSIFICATION OF A BEHAVIOURAL ROOT CAUSE.....	30
22.3.	GUIDANCE NOTES	32
22.4.	DISCIPLINARY ACTIONS.....	34

1. PURPOSE

The purpose of this document is to describe the Incident Reporting & Management Process at Independence Group NL (IGO).

This document has been developed to provide detailed instruction in accordance with **IGO'S Common Management System Standard 14, Incident Management**.

2. APPLICATION

This instruction applies to all persons on an IGO site, office or exploration area, including all contract workers and suppliers.

It applies to all incidents and near misses, including:

- safety, health and hygiene
- environments
- process safety (plant and equipment integrity or damage)
- production loss
- non-compliance with legal or regulatory obligations
- community, social and reputational, and
- external stakeholder complaints.

Further guidance on the spatial application of this standard is provided in Appendix 5.

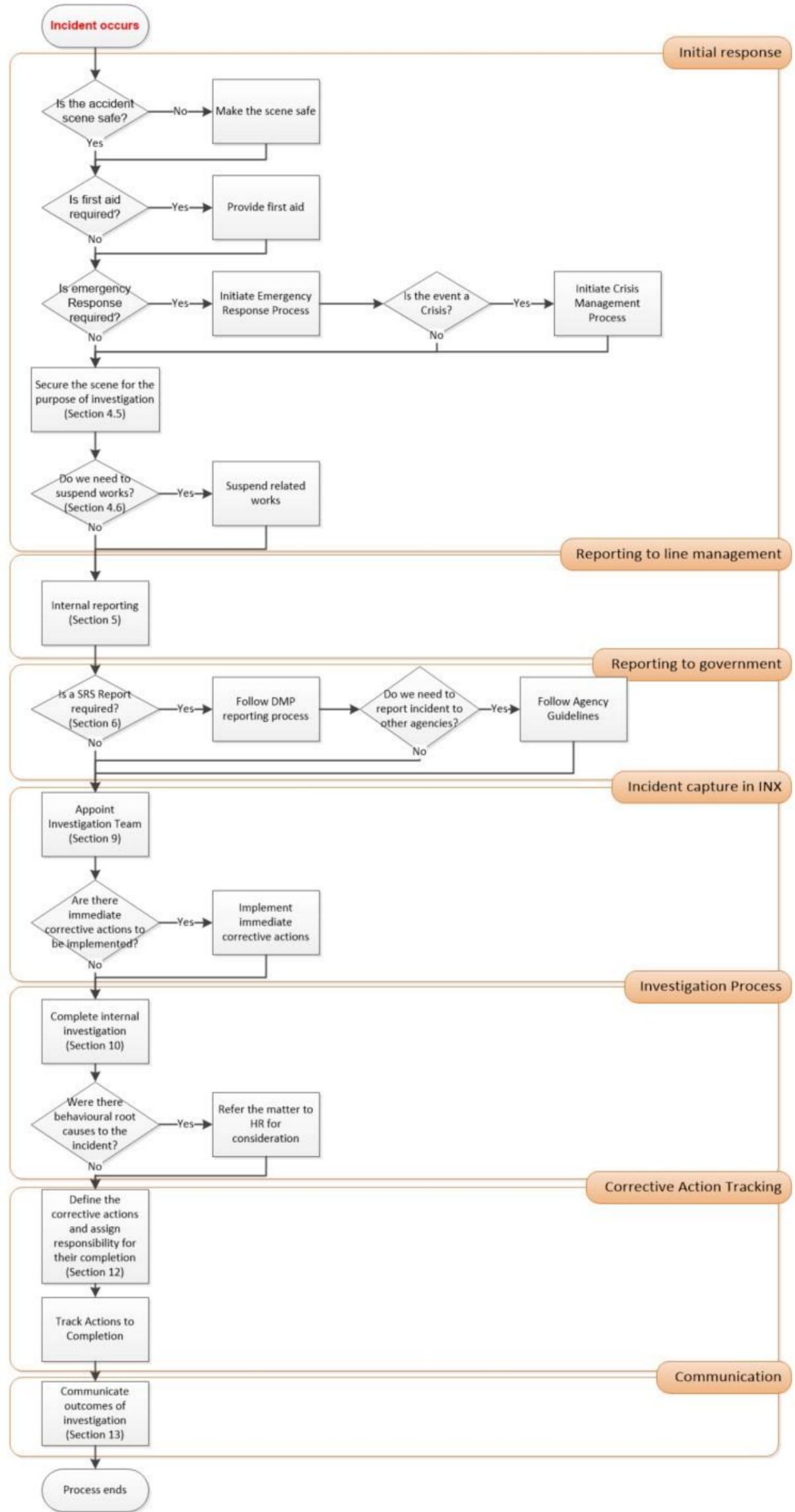
3. INCIDENT REPORTING PROCESS

The Incident Reporting & Management Standard provides a defined sequence of steps as presented in Figure 1. These steps must be followed in response to all incidents.

The following sections in this document provide guidance on the activities required to complete each step.

Figure 1: Steps to be followed after an incident

IGO's Incident Reporting & Management Process



4. INITIAL RESPONSE

4.1. Is the Incident Scene Safe?

The critical first step in assessing any incident scene is to ensure it is safe (insofar as it is safe to do so). Whilst this step may be self-evident, this question should be specifically addressed.

The normal 'Take 5' and JSA process should be followed. Refer to **IGO Safety Standard 3: Personal Risk Management: 'Take 5' & JSAs**.

4.2. First Aid

Individuals first on the scene of an incident involving an injury must, as far as is reasonably practicable, provide first aid and call for assistance.

4.3. Is An Emergency Response Required?

Does the situation constitute an emergency? An emergency response must be called if someone is seriously hurt, people are at immediate risk, or plant is endangered.

On a mine site an emergency response is initiated by calling Emergency Services by phone or radio. On an exploration site an Emergency Response is initiated by calling a) in a life-threatening situation, 000, or b) the Exploration Emergency Number 0467-066-614.

These contact details, the responsibilities of the caller, and the duties of the emergency response team are to be documented in a site specific **Emergency Response Plan**.

A site's Emergency Response Plans must conform to **IGO's Safety Standard 2: Emergency and Crisis Management Planning**.

4.4. Is the Event a Crisis?

The decision to declare an event a Crisis, and hence activate the **IGO Crisis Management Plan**, is the responsibility of the site's Registered Manager. This decision must be taken with regard to **IGO Group Safety Standard 5: Crisis Management Plan**.

4.5. Securing the Scene for Investigation

Where an accident at a site has resulted in a death, serious injury, a near miss with the potential for serious injury, or a prescribed event as defined in legislation, the place where the accident has occurred must be secured and not disturbed unless it is necessary to save a person's life or prevent injury to another person.

Note: It should be noted that a trade union representative has the right to examine an accident site given that any employee involved in an accident at a mine is a member of the same trade union. In the event that IGO is approached by a union representative for this purpose, Human Resources should be notified.

4.6. Should Related Works be Suspended?

The decision to suspend works associated with the incident is the immediate responsibility of the Job Supervisor. The Job Supervisor must suspend works if:

- a serious injury or fatality has occurred
- a reportable event occurs as defined in law (see Appendix 1)

- ongoing work may interfere with or prevent the securing of an incident scene (refer to Section 4.5)

If the Job Supervisor is uncertain he/she must speak with their Line Manager, the IGO Safety Team or the Registered Manager.

Note: In the event of a fatality, works may not recommence until both the District Inspector and IGO's Executive Committee team has given consent.

5. REPORTING TO LINE MANGEMENT

5.1. What Must Be Reported?

Any and all of the following events must be reported:

- incidents resulting in injury
- any hazard that cannot be immediately remedied. This includes health and hygiene hazards.
- near miss
- environmental incidents
- event(s) that may impact on plant and equipment integrity
- material production loss
- non-compliance with procedures, and legal or regulatory obligations
- event(s) that may adversely impact on the community, or our reputation
- theft or similar misconduct
- external stakeholder complaints.

5.2. Who Must Report?

The responsibility to report events rests with each and every individual. In practice, any person who knows of an event must take reasonable steps to verify that the event has been reported to the relevant Line Manager. To knowingly fail to report an event is regarded as a serious failure to fulfil one's duty of care, and may result in disciplinary action.

5.3. Verbal Reporting To Line Management

Whenever any of the events listed in Table 1 occur, or are likely to occur, the following **verbal notifications** must be carried out **IMMEDIATELY** as per the following chart.

Table 1: Incidents and Reporting Responsibilities

Incident type	Responsibility for reporting	Notification (the following people must be spoken to)
All incidents	Employee	Job Supervisor
Alternate Duties Injury, Medical Treatment	Job Supervisor	Department Manager and Registered Manager or Alternate. (Note: The Exploration Manager is both the Department Manager and Registered Manager for the Exploration Department in circumstances where a specified Registered Manager is not appointed to an exploration project.)
Serious Injury, Disabling injury, Serious Potential Incident	Registered Manager or Alternate	General Manager Production (Mine Sites) or General Manager New Business (for Exploration Projects) and Corporate Sustainability Manager
Electric shock	Supervisor	Register Site Electrical Supervisor or Dept Manager
Environmental incident of Major or greater consequence (see Appendix 3)	Registered Manager or Alternate	General Manager Production (Mine Sites) or General Manager New Business (for Exploration Projects) and Corporate Sustainability Manager
Any Occurrence or Serious Potential Occurrence which requires notification to the DMP	Registered Manager or Alternate	General Manager Production (Mine Sites) or General Manager New Business (for Exploration Projects)
Any incident attracting media attention or industrial action	Registered Manager or Alternate	General Manager Production (Mine Sites) or General Manager New Business (for Exploration Projects), Corporate Sustainability Manager, or Human Resources General Manager as relevant

5.4. Safety Alerts

A business-wide Safety Alert (using the template provided in IGO Templates) must be completed for all SPIs, and all incidents that result in a LTI or a more serious injury, with 24 hours of the incident occurring. An addition alert may be warranted when the investigation is complete. See Section 12.

At the discretion of site General Managers, a business-wide Safety Alert (using the template provided in IGO Templates) may be issued for other noteworthy safety incidents (eg HPIs).

5.5. Initial Incident Data Capture

All incidents must be recorded in INX. (Where there is no immediate access to INX, an **Event Notification Form** (as found in the IGO DMS) shall be completed as an intermediate step.

Responsibility for initial incident data capture in INX is with the Job Supervisor who must complete this activity by the end of the shift in which the incident occurred.

For remote exploration projects, the initial incident data capture in INX must be completed by the person designated as the 'Sched Phone Operator' as soon as practical after verbal notification of the event.

Once the incident notification page is saved, INX will automatically assign an incident number for aid reference.

5.6. Starting the Investigation Process

Investigating an incident shall commence as soon as possible after the incident has occurred. The first step is appointing an Investigation Team Leader – generally, this is the supervisor.

The Investigation Team Leader shall, in consultant with Line Management determine the size and composition of the investigation team. For incidents resulting in 'Minor' consequence (see Appendix 3 for IGO Consequence Classification Matrix), the Investigation Team Leader may require no team. However, for incidents resulting in a Critical or Catastrophic consequence expert assistance may be required. Advice in this matter should be obtained from the site HSEC Manager or equivalent.

All investigations into incidents resulting in a Critical or Catastrophic consequence must include an Elected Safety Representative. Where the incident involves a contracted company, a representative of the contractor shall be part of the investigation team.

As a minimum, Investigation Team Leaders shall be trained in, and use, the **Incident Cause Analysis Method (ICAM)**.

Formal ICAMs must be completed for all investigations into incidents resulting in an actual Critical or Catastrophic consequence, or a potential catastrophic consequence. Other incidents shall be investigated as per site procedures.

Corporate HSEC personnel must be engaged in investigations into incidents resulting in an actual catastrophic consequence.

5.7. Safety Incident Classification

At IGO, we classify safety incidents on the basis of their a) actual consequence and b) potential consequence. Actual consequence is assessed by injury type. IGO's Injury Type definitions are addressed in Appendix 4. Additionally, all safety incidents have a potential consequence. This being the worst credible potential consequence given the same event reoccurred. Refer to Appendix 4 - Classification of near misses and potential consequence.

6. GOVERNMENT REPORTING

6.1. Reporting in Western Australia

Guidance on statutory reporting in Western Australia is presented in Appendix 1.

6.2. Reporting in other jurisdictions

Guidance on statutory reporting in other jurisdictions is presented in Appendix 2.

7. ENSURING A SAFE RESTART

Following an incident, work may only restart subject to:

- release of the incident scene by line management (and the DMP or other statutory body as relevant). Individuals should seek confirmation of this from their Supervisor if they are unsure.
- completion of the required corrective actions
- completion of the normal 'Take 5' and JSA process as described in **IGO Safety Standard 3: Personal Risk Management: 'Take 5' & JSEAs**.

8. INVESTIGATION PROCESS

The standard incident investigation methodology used by all IGO is ICAM. All incidents, irrespective of the investigation level shall be investigated using ICAM. The scale and intensity of effort shall be proportionate to the significance of the incident. In overview, the investigation process must:

- Establish the facts, complete for-cause testing, complete data collection including information on People, Environment, Equipment, Procedures and Organisation – PEEPO.)
- Collect witness statements where a) the actual consequence is "Major", 'Critical' or 'Catastrophic' (as per the IGO Consequence Matrix), and b) the potential consequence is assessed as 'Catastrophic'.

Note: For incidents that result in an actual 'Critical' or 'Catastrophic' consequence, or a 'Catastrophic' potential consequence, statements shall be recorded verbal statements that are subsequently transcribed. Recorded statements shall be made subject to the consent of the interviewee.

- establish the sequence of events
- identify contributing factors (Apply the '5 whys' methodology)
- review the adequacy of the existing controls and procedures
- review existing risk assessments, if any
- report findings on root cause(s). If the incident is determined to have behavioural root causes, guidance on the disciplinary response to be considered is addressed in Appendix 7.

- rate the actual and potential severity of the incident in accord with Appendix 3: Categories of Consequence
- provide recommended corrective or preventative actions to the incident
- identify key lessons for communication.

Overall responsibility for the timely completion of an investigation lies with the Department Manager responsible for the area in which the incident has occurred. Investigations must be completed as quickly as possible after an event and within the time periods prescribed in Table 2.

Table 2: Completion periods for investigations

Severity of Consequence	Investigation Completion Period
1. Minor	Within 48 hours of an event
2. Significant	Within 96 hours of an event
3. Major	Within 9 days of an event
4. Critical	Within 27 days of an event
5. Catastrophic	As soon as is practicable after the event.

Note: Incidents and near misses that have a ‘Critical or Catastrophic’ actual or potential consequence level are to be reported to the General Manager Operations and the Sustainability Manager as soon as practicable, and within 24 hours of occurrence.

Note: Incidents and near misses that have a ‘Critical or Catastrophic’ actual or potential consequence may require investigation under legal privilege. Refer to the Sustainability Manager or IGO Legal Counsel.

9. INCIDENT CAPTURE IN INX

At completion of the investigation, the associated data, analysis and corrective actions must be captured in INX. Refer to the IGO Safety team for further information.

10. WERE THERE BEHAVIOURAL FACTORS TO THE INCIDENT?

To aid in the determination of the type of behavioural root causes involved in an incident, refer to **IGO Group Safety Standard 6 – Response to Behavioural Root Causes of Incidents**.

11. CORRECTIVE ACTION TRACKING

Corrective actions must be tracked to completion using the INX system. All corrective actions must be subject to a defined completion date. As determined by Line Management, some actions will require verification of completion.

12. COMMUNICATE OUTCOMES OF INVESTIGATIONS

The outcomes of investigations are shared across the organisation to the extent permissible and subject to legal requirements. The IGO safety team is responsible for coordinating the sharing of such information.

A business-wide **Safety Alert** (using the template provided in IGO Templates) must be completed for all SPIs and other noteworthy incidents, and all incidents that result in a LTI or more serious injury. Typically, a business-wide Safety Alert should be issued following the completion of the investigation. However, if the matter relates to a risk that may expose people to immediate harm, an interim Safety Alert may be appropriate.

13. INCIDENT REVIEW BY EXECUTIVE COMMITTEE

In the event of incidents of Critical or Catastrophic Consequence, or incidents of potentially catastrophic consequence (ie SPIs), the responsible department manager shall present the investigation findings and corrective actions to the Executive Committee (ExCo).

The IGO safety team is responsible for maintaining and sharing:

- a set of key performance indicators, appropriate to the incident categories noted in this standard, are communicated to the ExCo and the IGO Board of Directors.
- an annual review and data analysis of incidents and near misses for the incident categories to identify trends and common lessons.

14. ACCOUNTABILITIES

Table 3 defines key accountabilities and responsibilities in relation to this document.

Table 3: Roles and Responsibilities

Role	Responsibility
Everyone on the IGO site	Responsibility to report events rests with each and every individual on site. Any person who knows of an event must take reasonable steps to verify that the event has been reported to Line Management. To knowingly fail to report an event is regarded as a serious failure to fulfil one's duty of care and hence may result in disciplinary action.
Job Supervisor	It is the responsibility of the Job Supervisor to notify his line manager of any incident, and
Investigation Team Leader	Must coordinate the investigation to the appropriate level and engage investigation team members.
Department Manager	It is the responsibility of the Department Manager to ensure investigations and the associated corrective actions are completed in a timely manner. This specifically includes data capture in INX. Note: The Exploration Manager is both the Department Manager and Registered Manager for the Exploration Department in circumstances where a specified Registered Manager is not appointed to an exploration project.

Registered Manager	The Registered Manager is responsible for ensuring that statutory reporting is completed and ExCo is notified. Must approve any a business-wide Safety Alert before it is issued.
Site HSEC Manager or equivalent	The HSEC Manager must ensure reporting and investigations are facilitated and that the incident reporting and management process is followed.

15. APPENDIX 1 A: REPORTING INCIDENTS IN WESTERN AUSTRALIA

15.1. Reporting to the DMP

The Department of Mines and Petroleum (DMP) has issued a guideline regarding incident reporting in line with the *Mines Safety and Inspection Act 1994* (MSI Act 1994) and the *Mines Safety and Inspection Regulations 1995*. IGO staff will comply with this guideline.

Refer to:

www.dmp.wa.gov.au/documents/Factsheets/MSH_G_AccidentIncidentReporting.pdf

15.2. Only Authorised Representatives to Report

Only authorised representatives of IGO shall report incidents to the DMP. Authorised representatives specifically include Registered Managers and HSEC Managers.

15.3. Responsibility to Ensure Reporting Is Complete

Ultimate responsibility for reporting incidents rests with the site General Manager. However, Department Managers and their alternates are immediately responsible for ensuring reporting is completed as required.

15.4. Injuries to be Reported to The DMP

A report to the District Inspector of the DMP shall be made if:

- a person suffers an injury as a result of an accident and is unable to perform the work being done at the time of the accident, or
- if requested by the injured person, or the secretary or local representative of a trade union of which the person is a member.

Where the injury appears to be serious, the District Inspector should be notified by phone as soon as possible. Determining the seriousness of an injury may require a judgement by the Registered Manager, but if there is any possibility that the injured person will be disabled for two weeks or more, a report should be made without delay.

Where the District Inspector cannot be contacted directly, a direct verbal report should be made to the regional inspectorate office during office hours or, to any serving inspector for the region, outside office hours, if required.

Where the injury does not appear to be serious, but is still reportable as defined in Section 5.5 of this document, a direct verbal report or a notifiable incident report is not required. The notification should be given at the end of the month that the incident occurs in a **Mining Injury Report** via SRS.

15.5. Events to be reported to the DMP

The following events are listed under the MSI Act 1994 as occurrences to be reported:

- serious or potentially serious injury (including fatality)
- extensive subsidence, settlement or fall of ground or any major collapse
- earth movement caused by a seismic event
- outbreak of fire above or below ground
- breakage of a rope, cable, chain or other gear by which persons are raised or lowered
- inrush of water
- dust ignition below ground
- presence or outburst of potentially harmful or asphyxiant gas
- accidental, delayed or fast ignition or detonation of explosives
- explosion or bursting of compressed air receivers, boilers or pressure vessels
- electric shock or burn or dangerous occurrence involving electricity
- poisoning or exposure to toxic gas or fumes where persons are affected
- loss of control, failure of braking or steering of heavy earthmoving equipment
- catastrophic potential incidents (SPIs) (see 15.6 and 17.2)
- incidents affecting registered or classified plant or equipment.

In any these events, the District Inspector for the region should be immediately notified. Notification should be submitted in a notifiable incident report via SRS but, if the responsible manager considers that the incident is serious, the written notification should be preceded by a phone call.

Notification must be provided regardless of whether injury occurred, and/or whether or not there was any damage to property.

15.6. Potentially Serious Occurrence

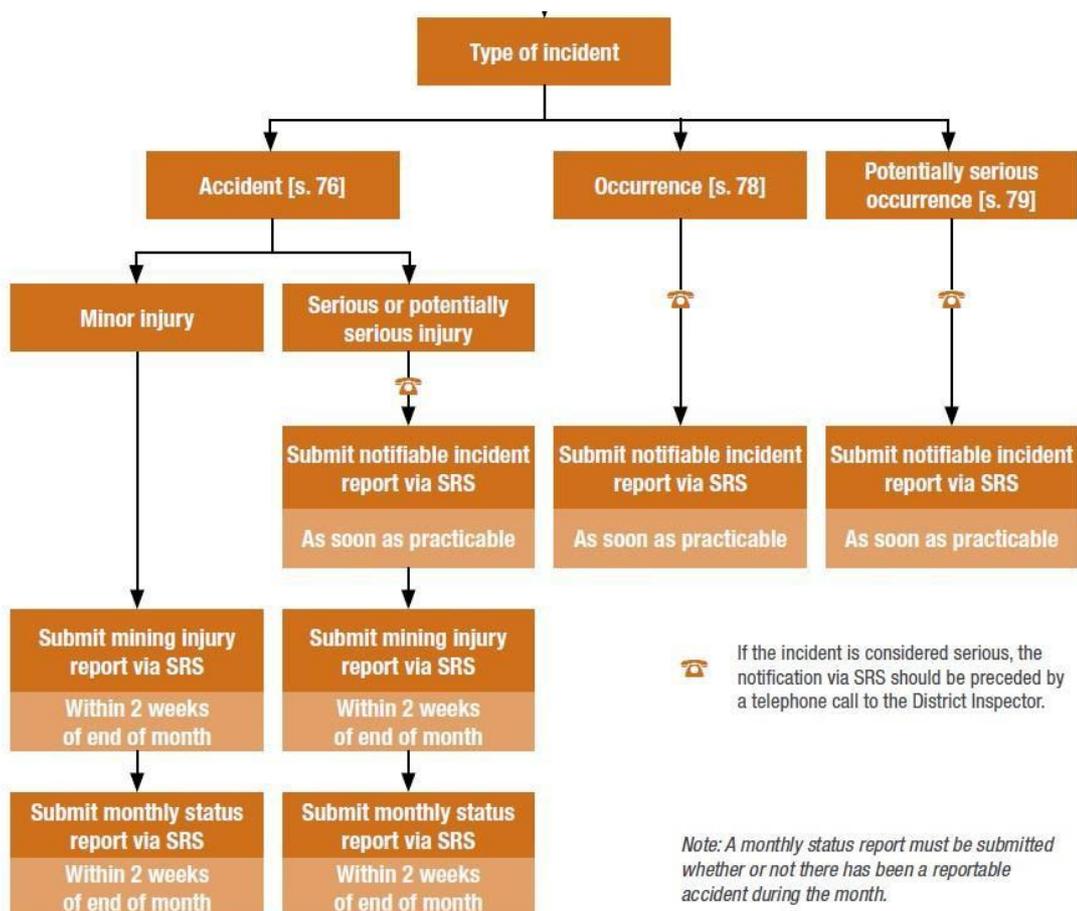
The MSI Act 1994 refers to the concept of a Potentially Serious Occurrence; this being defined as any event at a mine or exploration site that the Register Manager considers has the potential to cause serious injury or harm to health, even though no injury or harm has in fact occurred, but it is not included in the circumstances listed above as an occurrence.

Note: A Potentially Serious Occurrence is either a Serious Potential Incident (SPI) or High Potential Incident (HPI) as be IGO's incident classification process. For the purposes of interpreting this requirement, reference must be made to IGO's Occupational Health and Safety Definitions Appendix 2.

Note: If an SPI occurs it must be reported both verbally and by the SRS to the District Inspector for the region in which the mine or exploration lease is situated. This must be done as soon as is practicable after the facts are known.

Note: As requested by the District Inspector, a detailed written report of the incident must also be provided to the District Inspector.

15.7. Summary of DMP Reporting Requirements



15.8. DMP’s Safety Reporting Systems

The DMP must be notified by phone immediately and details confirmed in writing as soon as practicable via an SRS notifiable incident report.

Only authorised representatives of IGO shall report incidents to the DMP via the SRS. This requires a login and password, which would be provided by the Site Safety Team.

A site-based ‘company administrator’ will be appointed and registered for SRS access to enable reports to be submitted to Resources Safety, Department of Mines and Petroleum, WA.

15.9. Subsequent Confirmation by Mining Injury Report

At the end of the month following a serious injury, the Registered Manager must send a completed Mining Injury Report via SRS confirming the information reported in the **Notifiable Incident Report**.

15.10. Monthly Status Report - WA

The site HSEC Manager, or equivalent, must submit a monthly status report for each calendar month.

This must be submitted via SRS as soon as practicable after the end of each month (usually within two weeks). The report must be submitted whether or not there has been a reportable accident during the month.

The report includes details of any time lost or changes of work status because of injuries from previous months, and company and contractor employee statistics.

Specific reporting requirements include:

- the names of employees who have been injured in previous months and are still off work, or have not returned to their duties (as they were being performed at the time of the accident) by the start of the month being reported
- the number of days lost for each employee and his or her work status
- the average number of company and contractor employees and total hours worked by company and contractor employees that month
- hours worked as defined by the Mines Safety and Inspection Levy Regulations 2010.

The information in the report provides data for analysis by Resources Safety, and is used to generate industry performance indicators.

15.11. Accident ‘Log-Book’ (INX)

IGO sites are obliged to keep an ‘accident logbook’ of the type approved by the State Mining Engineer. In practice, the accident logbook used at IGO is the INX system. IGO is also required to ensure that any accident that occurs on site is recorded in the accident logbook (INX) without delay.

INX must be available for inspection at all reasonable times.

Persons authorised by the MS I Act 1994 to inspect or make requests of information contained in INX are:

- an inspector
- a safety and health representative for the mine
- a representative of a trade union that has members employed at the mine
- anyone else authorised by the State Mining Engineer.

15.12. Incident Record Security

Access to INX incident records, particularly personal injury data, must be restricted. For personnel, other than those authorised by the Registered Manager, this information must be available as ‘read only’ to disallow deletions or additions.

15.13. Reporting to Other WA Government Agencies

Department of the Environmental Regulation – WA

Under Section 72 of the Environmental Protection Act 1986 IGO is required to notify the CEO of the Department of Environmental Regulation (DER) regarding the discharge of waste or pollutant spills that are likely to cause pollution, material environmental harm or serious environmental harm. Discharges may be a consequence of an emergency, accident or malfunction.

It is a requirement that the DER CEO is notified as soon as practicable by either verbal or electronic notification, followed by written notification as soon as practicable after the discharge has occurred. Regulation 5K of the Environmental Protection Regulations 1987 prescribes the details of the discharge and its impact which are required to be reported to the CEO. The prescribed details are:

- the time and the address of the premises on or from which the discharge occurred and a map of the premises showing the location of the discharge;
- if the discharge of the waste was a result of the operation of equipment or otherwise, the name of the person operating the equipment or otherwise responsible for the discharge of the waste
- the composition of the waste
- the quantity of the waste discharged
- whether or not the discharge caused pollution and, if so, the nature and extent of the pollution
- the action taken by the occupier of the premises to minimize the effect on the environment of the discharge of waste
- whether or not the waste involved in the discharge has been removed, dispersed, destroyed, disposed of or otherwise dealt with, and if so, the manner in which the waste was removed, dispersed, destroyed, disposed of or otherwise dealt with.

Further guidance for reporting to DER can be found; <http://www.der.wa.gov.au/your-environment/reporting-pollution>

When determining the severity and consequence of an environmental incident, the IGO Consequence Assessment Table (Appendix 3) should be used. For incidents classified Major (2) and above the Environment Department should be contacted to determine which regulatory agencies may need to be informed.

Spills are classified in accord with Appendix 5.

Depending on the outcome of the environmental incident, additional regulatory agencies may need to be notified, including DMP and Department of Parks and Wildlife (DPaW). The Environment Department is responsible for notifying all regulatory agencies as required.

16. APPENDIX 1 B: REPORTING INCIDENTS IN OTHER JURISDICTIONS

Refer to IGO's Head of Governance & Risk.

17. APPENDIX 2: CLASSIFICATION OF NEAR MISSES AND POTENTIAL CONSEQUENCES

A Near Miss is defined as an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.

At IGO, as part of the standard investigation process, near miss incidents must be evaluated and classified based on their 'worst credible potential consequence' using the IGO Categories of Consequence Matrix (Appendix 3).

For safety, related incidents, consequence is defined in terms of injury types. As a result, the worst credible potential consequence should be regarded as the injury that is most likely to occur given the same event occurred numerous times. IGO's Injury Type definitions are addressed in Appendix 4.

An incident for which the worst credible potential consequence is determined to be a fatality or permanently disabling injury shall be classified as a **Serious Potential Incident**.

An incident for which the worst credible potential consequence is determined to be a Serious Injury (a LTI of greater than 2 weeks), or a permanent partial disabling injury, shall be classified as a **High Potential Incident**.

All other safety related incidents which are assessed to have lesser consequences, shall be classified as a **Near Miss**.

It is accepted that the evaluation of the potential consequences of a safety incident is inherently subjective. However, the following matters must be considered:

- The level of damaging energy that was released or potentially released in the incident
- The potential for this energy to impact on a person
- The number of additional controls, checks or processes that would have needed to fail and so result in impacts on people

Note: Some incident types must automatically be classified as either a HPIs or SPIs as per Section 17.1. The choice between classifying such incidents as an HPI or a SPI shall rest with the relevant GM.

17.1. High Potential Incidents

High Potential Incidents include:

1. all incidents for which the worst credible potential consequence is assessed as being a Serious Injury (a LTI of greater than 2 weeks), or a permanent partial disabling injury, and
2. those incidents automatically defined as High Potential Incidents (HPIs) below.

Incidents that must classified as HPIs are:

- For general incidents:
 - a work-related incident causing a person to become unconscious

- an incident causing an unplanned emergency evacuation of the entire mine
- For mobile plant and equipment:
 - a vehicle having more than two wheels go over the crest of a protection bund or windrow
 - a vehicle tipping or rolling onto its side or roof
 - a heavy vehicle (HV) impacting a light vehicle (LV) due to the HV operator not being aware of the LV's presence (irrespective of speed)
 - any incident where the operator of a LV or HV falls asleep at the wheel and the vehicle runs off the road or is involved in a collision (irrespective of speed), either on site or on work-required travel off-site
 - any collision between HVs where under slightly different circumstances the cabin of either vehicle could have been impinged
 - any incident or near miss where a pedestrian was struck or very nearly struck by a moving vehicle
 - a parked vehicle rolling towards people or in the proximity of people
 - an in-service failure of a vehicle's entire braking or steering system.
- For fire and explosion:
 - a fire underground (including glowing embers) which:
 - ◆ cannot be immediately extinguished by personnel on the scene; or
 - ◆ occurs in an unattended area; or
 - ◆ is in proximity to flammable or explosive materials (in storage or in transport)
 - a person burnt by an open flame, hot steam or hot water resulting in hospital admission
 - an unplanned ignition of explosives
 - an unplanned ignition or explosion of gas or dust.
- For falling objects:
 - an object or load falling uncontrollably from height into an area normally accessible to persons
 - in service failure of, or damage to, scaffolding affecting its structural integrity, exposing people to risk
 - where a person is found working at heights without critical control fall protection
 - where a person falls and is suspended by fall restraint or fall arrest equipment
 - where a person is found within any exclusion zone (with an associated fatality risk) without the prescribed critical controls in place

- an unprotected and unattended open hole or missing section of walkway/handrail where
- a person could fall more than 2m
- a person falling into water or other liquid deeper than 1.5m, without a personal flotation device on, or while working alone.
- For Geotech, inrush and ventilation:
 - a failure of ground support or reinforcement in an area where persons could have potentially been present
 - a fall of ground which prevents a person from exiting any work area (i.e. entrapment), or interrupts mine ventilation
 - uncontrolled presence of an atmosphere containing less than 19% oxygen in an accessible work area
 - an incident which required personnel to put on self-rescue breathing devices due to an irrespirable atmosphere or fire
 - an inrush of water, mud, paste or similar with the potential to result in harm to a person.
- For electric shock:
 - Any electric shock that required medical treatment (see definition of MTI)
- For uncontrolled energy:
 - a person becoming entangled in moving or rotating equipment and requiring assistance to be extracted
 - failure of isolation procedures resulting in a situation where a person was exposed to the potential energy source, and where it was likely that the equipment could have been energised or started while the person was exposed
 - contact with energised overhead power lines
 - failure to use the required permit and follow correct procedure for confined space, hot work, working around power lines, HV switching, or other high-risk activity requiring a permit.
- For plant failure:
 - a catastrophic or major structural failure of plant
 - damage to, or failure of haulage or winding or lifting equipment that had potential to result in significant impact to a person
 - catastrophic failure of a pressure vessel.
- For aviation
 - a load dropped from an aircraft or helicopter in a populated area

- loss of control of a load during helicopter sling loading, i.e. swinging in the proximity of people during hookup / positioning.
- Security
 - in-flight shut down of an engine or critical flight system in an aircraft security
 - theft or other loss of explosive
 - unauthorised discharge of a firearm, or use of a weapon, within the site-controlled boundaries.

Note: In INX, HPIs have a potential consequence of 'critical'.

Note: Some HPIs may be reportable to the authorities as per local law.

17.2. Serious Potential Incident (SPI)

Serious Potential Incidents (SPIs) are incidents where the likely potential outcome is a fatality, permanent disabling injury, or irreversible or widespread health impacts. Usually there are no critical controls remaining to prevent impact to people, and the actual outcome is dependent on chance.

Note: In INX, SPIs have a potential consequence of Catastrophic.

Note: In WA, SPIs must be reported to the DMP. See Section 15.6

17.3. Incident Classification Guidance – Non-Safety

For incidents with other potential outcomes (i.e. besides safety), the consequence table of the IGO risk matrix is used to determine the investigation level. Actual or likely potential outcome is referenced against the definitions in this table.

18. APPENDIX 3: CATEGORIES OF CONSEQUENCE

		Type of Consequence					
		Health	Safety	Environment	Community & Reputation	Financial Loss or Exposure	Compliance
Severity of Consequence	5 - Catastrophic	<ul style="list-style-type: none"> Chronic exposure of numerous employees to elevated levels of Class A carcinogen or similarly hazardous material resulting in disease Widespread outbreak of infectious disease. 	<ul style="list-style-type: none"> Fatality Permanently disabling injury 	<ul style="list-style-type: none"> Widespread environmental damage. Extinction or credible risk of species extinction. Destruction or credible risk of destruction of listed ecosystem 	<ul style="list-style-type: none"> Very serious widespread social impacts causing site closure Irreparable damage to highly valued structures/items/locations of cultural significance Government or police intervention in operations Operations/production stopped by community action Prolonged or national media focus on the company's activities or impacts Community fatality as direct consequence of IGO's actions 	<ul style="list-style-type: none"> loss of >\$100M cash flow loss of > 25% market capitalisation 	<ul style="list-style-type: none"> Prosecution resulting in imprisonment of company officer, or Suspension of operating licence of a mine
	4 - Critical	<ul style="list-style-type: none"> Chronic exposure of numerous employees to elevated levels of Class A carcinogen or similarly hazardous material - no symptomatic disease Localised outbreak of infectious disease among numerous employees. Numerous employees demonstrate symptoms of industrial disease (eg functionally significant hearing loss) 	<ul style="list-style-type: none"> Serious Injury (LTI of greater than 2 weeks) Permanent partial disability 	<ul style="list-style-type: none"> Environmental damage extending beyond IGO's land tenure. Material threat to listed species Destruction or credible risk of destruction of listed biological communities 	<ul style="list-style-type: none"> Ongoing serious social issues Significant damage to structures/items of cultural significance Significant infringement/disregard of cultural heritage Aggressive action causing restrictions on operations Protestors on IGO property External arbitration required Limited short term national media focussing on the company activities or impacts Community fatality where IGO is seen as having some responsibility (e.g. contractor hauling our product from site). 	<ul style="list-style-type: none"> between \$10M to \$100M loss of between 15% and 25% market capitalisation 	<ul style="list-style-type: none"> Prosecution of the business for breach of law, or Material non-compliance with the law as identified by a company officer requiring disclosure and for which no immediately remedy is available, or Breach of Code of Conduct, or Breach of Critical Safety Control
	3 - Major	<ul style="list-style-type: none"> Chronic exposures that require an extended period (> 2 weeks) of alternate duties to alleviate symptoms. 	<ul style="list-style-type: none"> Lost time injury (LTI) 	<ul style="list-style-type: none"> Extensive unapproved environmental damage within IGO's property boundaries (>10 ha). Credible threat to listed species or ecosystems Nuisance impact (e.g. dust, noise) to neighbours resulting in complaint(s) or investigation by regulator 	<ul style="list-style-type: none"> Ongoing social issues Minor damage to structures/items of cultural significance Infringement/disregard of cultural heritage/sacred locations Strong community complaints/reaction: threat to operations; small scale protests near operating sites Isolated national media on the event Local media attention 	<ul style="list-style-type: none"> between \$500k to \$10M attributable loss of market capitalisation but <15% 	<ul style="list-style-type: none"> Regulators issue corrective action directives, or Material non-compliance with the law as identified by company officer for which no immediately remedy is available (> 1 month), or Major non-compliance with company policy or procedures.
	5 - Significant	<ul style="list-style-type: none"> Exposures that require a short period (<2 weeks) of alternate duties to alleviate symptoms. 	<ul style="list-style-type: none"> Injury requiring medical treatment (MTI) and/or Injured person required to complete alternative or restricted work duties (RWI) 	<ul style="list-style-type: none"> Significant environmental impact (between 1 and 10 ha) within IGO property. Impact to flora/fauna localised and contained (single animals and plants) 	<ul style="list-style-type: none"> Minor social/cultural impact Damage or loss of minor community asset Minor infringement of cultural heritage No media coverage or some isolated local media discussion 	<ul style="list-style-type: none"> between \$20K to \$500K 	<ul style="list-style-type: none"> Statutory non-compliance identified by company officer requiring more than a month to remedy, or Statutory non-compliance identified by company officer requiring external disclosure Non-compliance with company policy or procedures, requiring more than a month to remedy.
	1 - Minor	<ul style="list-style-type: none"> Working conditions or impacts causing discomfort or physical strain that may result in industrial disease (eg continuous exposure to vibration) immediately alleviated by changes in work method 	<ul style="list-style-type: none"> First aid or minor supportive treatment 	<ul style="list-style-type: none"> Minor environmental impact (<1ha) within IGO property Impact to flora/fauna localised and contained (single animals and plants) 	<ul style="list-style-type: none"> Communication of complaint or concern (letters, emails, social media, telephone calls, etc) from external party. 	<ul style="list-style-type: none"> <\$20K 	<ul style="list-style-type: none"> Statutory non-compliance identified by company officer for which an immediate remedy is available, or Non-compliance with company policy or procedures.

19. APPENDIX 4: DEFINITION OF INJURY TYPES

19.1. Criteria for Inclusion in Statistical Indicators

Before considering the issue of injury type classification, a decision must be made as to whether or not the injury should be included in IGO's injury recording and reporting system (INX), i.e. whether the injury or illness is "work related". Work related activities are those where IGO can set safety, health and environmental standards, and can supervise and enforce their application. If an event or exposure in the work environment either caused or significantly contributed to an injury or illness, or significantly aggravating a pre-existing condition, then the case is considered work related.

If an injury or illness does not meet the above criteria as being work related, then the incident should not be recorded in a way that it will appear in the statistical indicators. However, details of the incident should be retained for information.

Work related means injuries and illnesses resulting from events or exposures occurring at IGO controlled sites, unless an exception specifically applied. See definition of non-worked related injury.

Note: Although an injury is eligible for Workers' Compensation it does not automatically mean that it is included in the injury statistics.

19.2. Injury Classification Types

Fatality

Loss of life

Permanently Disabling Injury

A Permanently Disabling Injury is an injury that results in a person being totally and permanently disabled (as defined in Western Australian Law) as assessed by a physician to the extent that they are no longer able to work.

Lost Time Injury (LTI)

An injury or illness that results in the employee or contractor being unable to attend work on the next calendar day after the day of the injury, or any day subsequent to that. If a suitably qualified medical professional advises that the injured person is unable to attend work on the next calendar day after the injury, regardless of the injured person's next rostered shift, a Lost Time Injury (LTI) is deemed to have occurred.

Days lost are calculated by the number of days the individual was rostered to work but was unable to. (For example, in the month of November there are 30 calendar days. But a person is rostered to work only 20 out of that. So, you must report the 20 days to DMP and not the 30. In short, the reportable days should not include any R&R, Annual leave or any other Non-Injury related leave. This calculation will also be the case for individuals on alternate duties, when days are calculated for reporting it is based on their rostered days.) Time spent travelling to/from medical evaluation and for evaluation/diagnosis does not of itself create a lost time injury (see guidance notes), but is included in days lost if the injury becomes classified as an LTI or a Restricted Work Injury (RWI).

Time lost solely as a result of an injury occurring in a remote location does not justify an injury that would have been a MTI or MI in other circumstances being reclassified as an LTI.

Serious Injury (SI)

A Serious Injury (SI) is an LTI where:

- the injured person is off work for more than two calendar weeks, or
- involves unconsciousness arising from inhalation of fumes or poisonous gases, or asphyxiation due to lack of oxygen or displacement of oxygen by an inert gas, or
- results from an accident, including fuming, arising from the use of explosives or blasting agents.

Restricted Work Injury (RWI)

A Restricted Work Injury is a work-related injury that results in the injured person being unable to fully perform his or her ordinary occupation any time after the day or shift on which the injury occurred, regardless of whether or not the person is rostered to work, and where alternate or light duties are performed, or hours are restricted. A person with a Restricted Work Injury is unable to perform one or more of their routine functions for a full working day or more due to restrictions directed and certified by advice from a physician or licensed health care professional (including site nurses). The RWI classification does not apply to “voluntary” restrictions imposed by the supervisor or area manager, or a reduction in efficiency/productivity.

Note: a RWI that is also a Serious Injury equates to a Disabling Injury (DI) in DMP Resources Safety performance terminology.

An RWI has not incurred when there are no medically required restriction, but the person is placed on “precautionary duties” to enable time to monitor the injury for change, or while awaiting diagnosis. This period can be no longer than four days, and there must be improvement to the injury and capability during that time. Health reviews must occur regularly during the 4 days and if an individual is not considered fit at the end of 4 days a medical review with a physician must be organised. Should medical restrictions be required these should be dated back to the day after injury.

An employee’s routine functions are those activities the employee regularly performs at least once per week.

Medical Treatment Injury (MTI)

An injury that either requires treatment by, or under the specific order of, a medical practitioner, or could be considered as being one that would normally be treated by a medical practitioner.

MTIs include:

- insertion of sutures, and/or the use of glue where it is used in lieu of sutures (i.e. used for wound adhesion rather than cosmetic purposes or to maintain the cleanliness of the wound)
- treatment of fractures or other internal injuries
- treatment of bruises by drainage of blood
- treatment of second or third-degree burns
- surgical debridement
- treatment of infection (other than the application of non-prescribed topical medications or antibiotics prescribed only for precautionary purposes)
- removal of foreign bodies embedded in eye, or requiring removal from the eye by means other than irrigation or removal with cotton swab
- removal of foreign bodies from a wound (other than the eyes) by means other than irrigation, tweezers, cotton swabs or other simple means

- use of prescription-only medications (except a single dose administered on the first visit for minor injury or discomfort, or medications used solely for diagnostic purposes)
- any work injury that results in a loss of consciousness.

The following, by themselves, do not constitute MTIs:

- visits to physicians or other licensed health care professional solely for observation or counselling
- the conduct of diagnostic procedures, such as X-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes (e.g. eye drops to dilate pupils etc.)
- visits to physicians or other licensed health care professionals solely for therapy as a preventative measure (e.g. physiotherapy or massage as preventative therapy, tetanus or flu shots)
- placement of wound adhesive glue only for maintenance of cleanliness or cosmetic purposes.

First Aid Injury (FAI)

An injury that can be managed by first-aid treatment only. First-aid is defined as treatment that falls within the scope of recognised first-aid protocols, regardless of who administers the treatment. First- aid treatment means:

- visit(s) to a health care provider for the sole purpose of observation or diagnosis;
- diagnostic procedures, including x-rays or the use of prescription medications solely for diagnostic purposes
- use of non-prescription medications including antiseptics, and administration of a single dose of prescription medication on the first visit for a minor injury or discomfort
- simple administration of oxygen
- administration of tetanus/diphtheria shot(s) or booster(s)
- cleaning, flushing or soaking wounds on skin surface
- use of wound coverings such as bandages, gauze pads, etc.
- use of hot and cold therapy e.g. compresses, soaking, whirlpools, non-prescription creams/lotions for local relief except for musculoskeletal disorders
- use of any elastic bandages and other common first aid kit equipment
- drilling of a nail to relieve pressure for subungual hematoma
- use of eye patches
- removal of foreign bodies embedded in the eye if only irrigation or removal with cotton swab is required
- removal of splinters or foreign material from areas other than the eyes by irrigation, tweezers, cotton swabs or other simple means
- the administering of antibiotics as a precautionary measure where no infection is present

- use of temporary immobilising instruments when moving a patient (i.e. neck brace, etc.)
- ingestion of liquids to relieve heat stress.

No Treatment Injury

A 'no treatment injury' occurs where an employee seeks to take the precautionary step of reporting an injury for which no treatment can be or is given. If any treatment of any type is given, including rest, the injury must be reported as a First Aid Injury.

Non-work related Injury

An injury or illness is not generally to be considered as work related if (from OSHA guidance material):

- occurred during travel to and from the normal place of work (commuting)
- the injury or illness occurs outside working hours and they are not associated with deficiencies in equipment or management controls for which the reporting company is responsible
- at the time of the injury or illness, the employee was present in the work environment as a member of the general public rather than as an employee
- the injury or illness involves signs or symptoms that surface at work but result solely from a non- work-related event or exposure that occurs outside the work environment
- the injury or illness results solely from voluntary participation in a wellness program or in a medical, fitness, or recreational activity such as blood donation, physical examination, flu shot, exercise class, or sport. (Activities/examinations required by the company or by legal regulations are not included in this exemption)
- the injury or illness is solely the result of an employee eating, drinking, or preparing food or drink for personal consumption (whether bought on the employer's premises or brought in). For example, if the employee is injured by choking on a sandwich while in the work environment, the case would not be considered work related. Note: If the employee is made ill by ingesting food contaminated by workplace contaminants (such as lead), or gets food poisoning from food supplied by the employer, the case would be considered work related
- the injury or illness is solely the result of an employee doing personal tasks (unrelated to their employment) at the work place outside of the employee's assigned working hours
- the injury or illness is solely the result of personal grooming, self-medication for a non-work-related condition, or is intentionally self-inflicted
- the illness is the common cold or flu. However, in the case of other infectious diseases such as tuberculosis, brucellosis, and hepatitis C, employers must evaluate reports of such illnesses just as they would any other type of injury or illness
- there is not a clear connection to a specific work activity or work environment
- the work place or work task did not cause, contribute to or significantly aggravate the injury or occupational illness
- the outcome is inconsistent with the reported event.

19.3. Accountability for Decision Making Regarding Injury Classification

The final accountability for a decision regarding injury classification rests with the Resident Manager of the site (or their equivalent). It is expected that this accountability will be delegated for routine situations to the HSEC Manager on site at that site. It is strongly advised that this day-to-day responsibility be with one person only to ensure consistency in injury classification.

If there is any debate regarding the classification, the issue should then be referred to the Sustainability Manager.

20. APPENDIX 5: LOCATION OF INCIDENTS & STANDARD APPLICATION

As general guidance, IGO's Incident Reporting & Management Standard applies to:

- all incidents that occur within IGO's property or workplaces,
- all incidents on IGO owned mining, exploration and related tenements,
- all injuries and security incidents affecting IGO's employee's whilst working irrespective of their location,
- any incident involving the spill or release of IGO's products or wastes in public or third party owned spaces,
- any incident wherein an IGO employee's actions (whilst working), or the activities of the operational parts of the business, cause a physical impact or harm to third parties, and
- any traffic accident resulting in injury to a DIDO employee or contractor where their travel time exceeds 3 hours (including travel to remote exploration areas).

21. APPENDIX 6: SPILL MATRIX

Spill Matrix		Spill Volume (Litres)			
		<1	1 to 10	10 - 100	>100
Chemical		<1	1 to 10	10 - 100	>100
Hydrocarbon		<10	10 - 100	100 - 1,000	>1,000
Process Liquor/Tailings		<100	100 - 1,000	1,000 - 10,000	>10,000
Contaminated/hypersaline water (TDS >150,000)		<1,000	1,000 - 10,000	10,000 - 100,000	>100,000
Saline water (TDS 40,000 - 150,00)		<10,000	10,000 - 100,000	100,000 – 200,000	>200,000
Brackish Water (TDS 5000 – 40000)		<100,000	100,000 – 200,000	200,000 – 300,000	>300,000
Receiving Environment	Bund or impervious surface	Not reportable	Not reportable	Minor	Minor
	Compacted surface (hardstand, road or work/production area)	Not reportable	Minor	Minor	Significant
	Permeable (but disturbed) surface, drainage channel or standing water	Minor	Minor	Significant	Major
	Flowing water or undisturbed surface	Minor	Significant	Major	Critical
	Sensitive ecosystem (undisturbed vegetation, groundwater)	Significant	Major	Critical	Catastrophic

Category Level	Internal Notification	External Notification
Minor	Line Manager, Department Manager	None
Significant	Site GM	Dependent on severity - notify DER/DMP
Major	Site GM, COO,	Notify DER and DMP within 24 hours
Critical	Site GM, Exco	Notify DER and DMP within 24 hours
Catastrophic	Site GM, Exco, Board	Notify DER and DMP within 24 hours



22. APPENDIX 7: RESPONSE TO BEHAVIOURAL ROOT CAUSES OF INCIDENTS

22.1. OVERVIEW

All significant investigations on IGO sites shall be completed in accord with the Incident Cause Analysis Method (ICAM) (refer to Section 8). This process will result in an assessment of the human factors, also referred to as behavioural factors, if any, which constituted one or more root causes of an incident.

The process for responding to these behavioural root causes is to be completed in a stepwise fashion as presented below (Section 22.2).

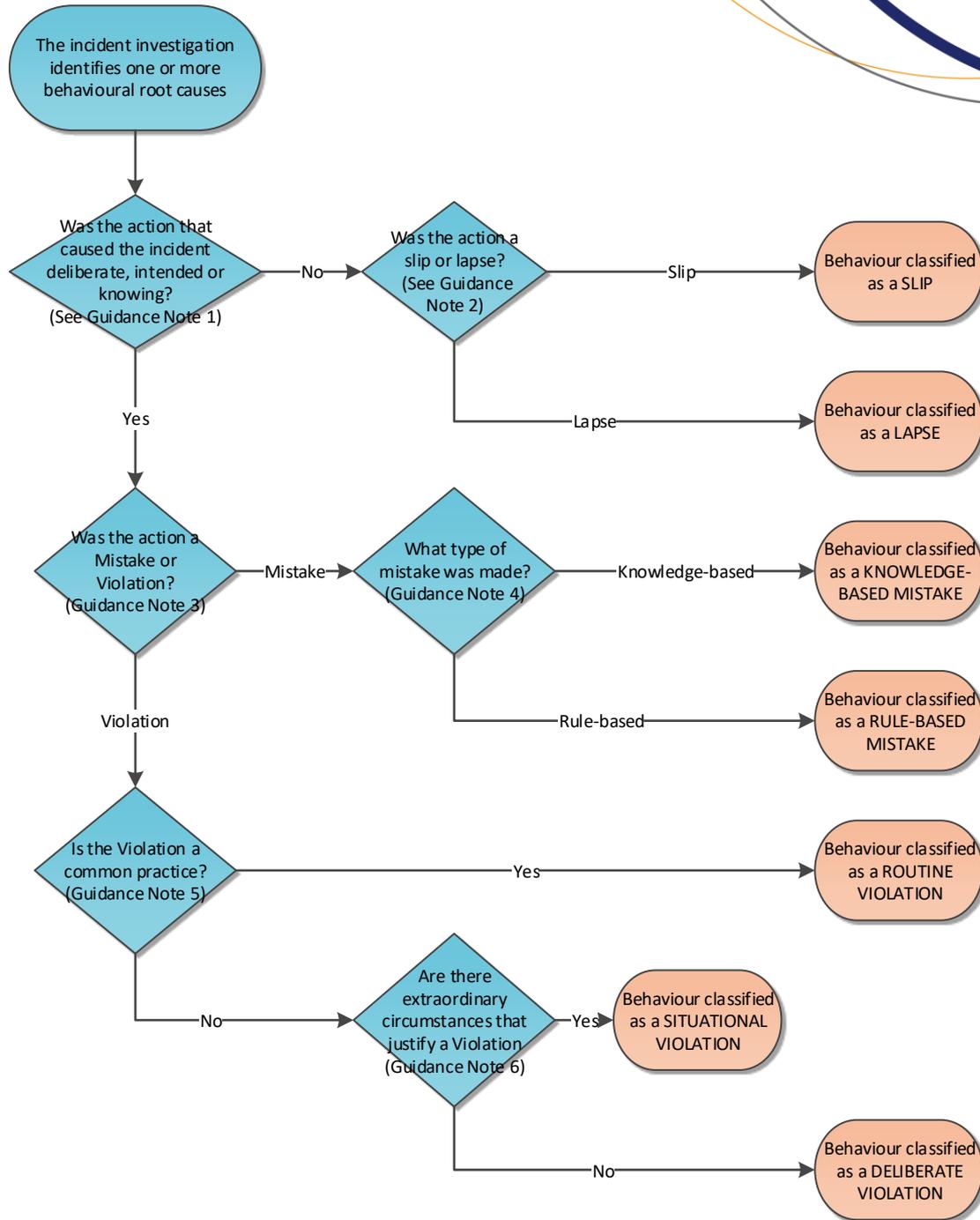
22.2. CLASSIFICATION OF A BEHAVIOURAL ROOT CAUSE

All behavioural root causes must be classified. Figure 1 defines the decision-making process to be used to classify behavioural root causes.

Guidance to answering the questions posed in the flowchart is presented in Section 22.3: Guidance Notes.



Figure 1: Behavioural root cause classification



22.3. GUIDANCE NOTES

Guidance Note 1: The question ‘Was the action that caused the incident deliberate, intended or knowing?’ should be answered without regard to the persons intended outcome. The focus is solely on the action. Could the action have occurred in advertently or was it deliberate?

Consider some examples.

- 1) *A person walks down a set of steps, misjudges the size of the last step, and stumbles causing injury. The action causing the incident is the stumble. Clearly the action was unintended.*
- 2) *Access to a hazardous area is restricted by a gated safety fence. The gate is closed. A person opens the gate and enters the area. The action of opening the gate is an example of a deliberate, intended or knowing action – irrespective of the person’s expectations of the outcome.*
- 3) *Access to a hazardous area is restricted by a gated safety fence. The gate is open. A person enters the area. In this example, in the absence of any other knowledge, it is indeterminate as to whether or not the action (i.e. being in the hazardous area) was deliberate, intended or a knowing action. Here the person should be given the benefit of the doubt; i.e. it should be assumed that the action was not deliberate.*

Guidance Note 2: ‘Was the action a Slip or a Lapse?’

When an appropriate action is carried out incorrectly, the error is classified as a slip. When the action is simply omitted or not carried out, the error is termed a lapse.

Slips are generally physical actions caused by an attention failure or circumstances where the individual’s actions are largely automatic or sub conscious. A Slip is a ‘skill-based’ error wherein one misjudges a physical action or fails to pay attention during the completion of a physical action. Slips also include perceptual confusion, interference errors (distractions), reversal of action sequencing, mis-ordering and or mistiming.

Consider an example.

A person walks down a set of steps, misjudges the size of the last step, and stumbles causing injury. The step leading to the stumble is classified as ‘slip’ – a misjudged physical action.

Lapses are typified as memory failures, inattention or reduced intentionality.

Guidance Note 3: Was the action a Mistake or Violation?

Mistakes: A mistake occurs when someone thinks they know what they are supposed to do but don’t. Mistakes include the application of poorly understood or misunderstood knowledge or rules. Consequently, a mistake is deemed to have occurred when a person did what he/she intended to do based on their misguided knowledge or misunderstanding of the rules, thus causing a poor outcome.

Within this context, safety rules include all workplace instructions, safety work procedures and risk assessment leading to prescriptions for task management (eg JSEAs etc) *Note: if the rules are not credible, inconsistent and unclear, the root cause is not behavioural, but rather a systems or process error. The investigation needs to revisit this matter.*

Violations: Violations occur when someone achieves an outcome as a consequence of non-adherence to the rules or in a manner contrary to their knowledge of the generally expected behaviour.

Note: in circumstances where the execution of the task (leading to the incident) required the individual to have training or specific competencies, and this training or competency assessment was not completed, the behaviour leading to the incident cannot be regarded as a violation.

Guidance Note 4: What type of mistake was made?

Mistakes take one of two forms; knowledge-based mistakes and rule-based mistakes.

Knowledge-based mistakes arise when in skill is inadequately learnt, or as a consequence of 'confirmation bias' (seeing or hearing what one expects, rather than what has actually occurred) or selectively (eg tunnel vision).

In the absence of explicit knowledge, people seek to solve a problem by relying on their memory of the rules. A failure to remember the rules is a **rule-based mistake**. *Note: Rule-based mistakes occur either as a consequence of the misapplication of a 'good' rule or the application of a bad or inappropriate rule. Given the investigation reveals the latter, the root cause is not behavioural but rather a systems or process error. The investigation needs to revisit this matter.*

Guidance Note 5: Is the Violation a common practice?

In answering the question 'Is the Violation a common practice?' one must consider whether or not other members of the work team also commit the same violation of the rules or behave in the same manner. If in fact there is an alternate arrangement to the specified rule that is commonly employed, or the behaviour is generally accepted practice, then this is referred to as a **Routine Violation**.

Consider the following example. The site has a rule that states that 'nobody shall climb over fixed handrails'. An employee is injured as a consequence of climbing over a hand rail and falling. The investigation finds that the action of climbing over the hand rail is common practice amongst the injured employee's workmates – then the action is classified as a Routine Violation.

Guidance Note 6: Are there extraordinary circumstances that justify the Violation?

In answering this question one must examine the possibility that there were circumstances that justified the violation; i.e. the person had no choice because to follow the rules would have genuinely imperilled them. This is referred to as a **Situational Violation**. Situation violations do not warrant disciplinary action.

Consider the following example. The site has a rule that states that 'nobody shall climb over fixed handrails'. An employee is injured as a consequence of climbing over a hand rail and falling. The investigation finds that the action of climbing over the hand rail was motivated by a fire thus preventing any other means of egress – in this case the action is classified as a Situation Violation.

Given that the violation is neither routine nor situational, then it must be classified as a **Deliberate Violation**. A Deliberate Violation is characterised by the individual deliberately or knowingly acting in a manner contrary to the rules or the generally accepted behaviour.

Consider the following example. The site has a rule that states that 'nobody shall climb over fixed handrails'. An employee is injured as a consequence of climbing over a hand rail and falling. The investigation finds that the action of climbing over the hand rail was deliberate, contrary to the rules and the commonly expected behaviour. Given this, there were no exceptional circumstances to justify the action and hence the action is classified as a Deliberate Violation.

22.4. DISCIPLINARY ACTIONS

Where an investigation identifies behavioural root causes to an incident, the decision to pursue disciplinary action shall be determined by the responsible Department Manager in consultation with HR.

All disciplinary action shall be undertaken in accord with IGO's Counselling and Discipline Procedure. Within this context, and in respect of behaviours that have led to an incident, the decision as to an appropriate level of disciplinary action, if any, should be made with regard to the type behaviour determined by the process outlined in Sections 22.2 and 22.3

Whilst all disciplinary action needs to be determined on the basis of the facts arising from the investigation, it is also important that there is an underling rationale and a consistency of approach. Given this, Figure 2 presents a matrix based on the behaviour classification to aid the decision-making process. Using Figure 2, the Department Manager shall be responsible for making the initial determination of the need, if any, to take disciplinary action.

Where dismissal of an IGO employee is contemplated, both the Registered Manager and Organisational Capability Manager must be consulted and approve the action.

Note: The process outlined in this document (ie Figure 2) is subordinate to IGO's Counselling and Discipline Procedure. Further, this procedure does not limit the discretion of management in making a final determination on the appropriate course of action.



Figure 2

