Incident Management

HSEQ Operational Procedure

What this procedure describes

The prevention or reoccurrence of any incident or undesired event that causes or has the potential to cause: injury/illness, environmental, property or asset damage; or unplanned disruption to customer supply; or damage to the TasNetworks reputation.

Why it is required

- To ensure all incidents and issues are managed and investigated to determine root causes and to put into place corrective and preventative actions, and apply learnings throughout the organisation to prevent a reoccurrence and continuous improvement.
- TasNetworks is required to manage incidents and risks in accordance with the *Work Health and Safety Act 2012* and, Regulations 2012.
- The procedure supports the TasNetworks goal of Zero Harm.

Who it applies to

This procedure applies to everyone working for or on behalf of the TasNetworks.

Authorisations

Issue date	May 2017
Authorised by	HSETC Group Leader
Review Cycle	3 Years

Revision History

Date	Revision Details
December 2014	New document – based on the procedure from TasNetworks
March 2015	Appendix H – Flowchart to determine shock or electrocution incidents
April 2015	Metadata changes in The ZoNe and clarification of reporting responsibilities in section 1.4.
April 2017	Included CASA as a regulator and editorial changes to reflect changes in WorkSafe Tasmania's structure
May 2017	Changes to the definition of LTIFR. Change RMSS references to Incident Management System.
Sept 2017	Inclusion of Recordable Incident definition as agreed at the Oct 2016 Zero Harm Leadership Team Meeting.
May 2018	Addition of AJILIS EHS Incident Management blueprint design flow charts
July 2018	Inclusion of the prompt to review dashcam footage for incidents involving vehicles.

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What is an incident?

Any event that causes or has the potential to cause (near-hit) injury, illness, health impact, property loss, asset damage, environmental harm, significant loss of supply to customer(s) or material financial loss. This may include combinations of safety, environment, health, security, equipment failure and property damage.

An incident is also an exceedance of an occupational exposure limit, legal requirement or a TasNetworks Standard, procedure or rule.

Managing incidents – initial response

1.1 Taking control of the scene

The person in charge of the worksite must take control of the situation and is responsible for carrying out initial response actions. In the event that this person is unable to assume this role, another person in the working party must take over.

The person taking control of the incident must check for potential danger and Immediate Temporary Controls must be implemented to:

- Protect people from harm
- Minimise environmental impacts
- Prevent any additional equipment/property damage.

All safe steps must be taken to provide emergency rescue and treatment of any persons.

Contact appropriate emergency services as soon as practical. Always provide clear and concise information to ensure that the appropriate response is provided.

The person in charge of the worksite should remain at the incident scene to continue with the immediate response procedures.

Where injured persons need to leave the site for treatment, it is essential that someone (usually the persons Manager) accompany the injured worker to provide support and appropriate assistance.

It is important that Workers involved at the accident scene are provided with support and assistance. See Employee Assistance Program for further information.

To commence the rehabilitation process, it is appropriate that the applicable Rehabilitation Co-ordinator accompanies or meets the injured worker (this may include their immediate family) at the Medical Centre. See the Rehabilitation Policy for further information.

1.2 Police involvement

When a serious incident occurs there may be a need to involve the Police. Such incidents include:

- event of a fatality (immediately)
- when an injury results from a vehicle accident (within 24 hours) Police report required for all MAIB claims
- an worker is physically assaulted or seriously threatened by a customer (within 24 hours)
- theft
- significant vandalism
- sabotage

Where the event is a fatality, the person in charge at the scene is to notify the police immediately. For all other occurrences, the Team Leader is to contact the police and liaise to meet their requirements.

1.3 Securing the incident scene

There are both statutory requirements and TasNetworks requirements to preserve the scene of an incident. Where an incident may be notifiable, there is an injury, or was a significant incident, the scene shall be preserved.

All information relevant to the investigation must be preserved:

- do not move or remove anything, unless to make safe
- tape off the area identifying it as an incident scene
- ensure there is no interference
- identify and remove public safety risks, i.e. traffic management, pedestrian access
- retain any equipment or asset that has failed for investigation.

A scene can only be released after communication from the relevant HSETC Manager. Where required, the HSETC Manager may have to seek authorisation from the relevant statutory authority prior to releasing the scene.

Notifications

1.4 1 Hour rule

All incidents must be reported as soon as practically possible to the Team Leader and escalated where required based on risk.

The “1 Hour Rule” is a process that requires incidents to be escalated to your immediate Leader within 1 hour.

Examples of these incidents include a significant incident, medical treated injury (MTI), restricted work injury (RWI), lost time injury (LTI), fatality, reportable incident to Worksafe or Environmental Protection Agency (EPA), a near hit where an serious injury (RWI, LTI, fatality) could have occurred, asset damage such as zone transformer, major outage (long duration or large area), loss of supply to major industry or critical facility (example hospital)

or major environmental incident. In the event of this type of event, verbal notification must be provided as per Appendix D.

1.5 Notification to regulatory authorities

Where an incident meets the criteria for it to be reported to a regulatory authority, communication of the incident shall be made by, or approved by, the HSETC Manager or Principal Safety Advisor. A flow chart of the communication process is available in Appendix C.

1.6 Notification of family

Where an incident results in a worker being unable to arrive home at their usual time, it is essential that their next of kin be informed. In the event of a fatality, the Police usually perform this role. In the event of an injury, the worker's Supervisor / Team Leader will perform this role. Support for Workers performing this role is available from Rehabilitation Co-ordinator.

Incident investigation and reporting

Within 48 hours of a significant incident occurring, the General Manager responsible for the incident is to convene an Incident Action Panel. The scope of this panel is to:

- Gather immediate data available (interviews, photos/dashcam footage, documents, etc)
- Assess severity potential
- Determine if there may be outside interest: e.g. WorkSafe Tasmania WST, media/political
- Determine if and what Immediate Temporary Controls are to be implemented to prevent re-occurrence
- Communicate immediate learnings and controls
- Confirm the makeup of the investigation team.

The team is to be made up of a core group of positions, as well as any optional personnel that would be required based on the scope of the incident.

Core group:

- General Manager
- Group Leader
- Team Leader
- HSETC Manager/ Advisor
- Worker health &safety representatives (HSR)

Optional Personnel may include:

- Legal Counsel
- Technical Expert

- Group HSETC Representative

The panel is to communicate the key aspects of the incident and the critical Immediate Temporary Controls using the Red Alert Form. This should be done for immediate learnings resulting from the initial finding of an investigation that affect the business operation and the safety of public and workers.

The Red Alert is to be issued by the owner of the TasNetworks business unit that the incident has the potential to affect. In most cases this will be a General Manager or Chief Operating Officer. This Significant Incident Advice is to be cascaded down through the levels of the business units ensuring that all personnel receive this advice prior to any task potentially affected by the incident is performed.

1.7 Incident reporting (internal)

All incidents must be recorded in the Incident Management System (IMS).

1.7.1 Notification

Supervisors / Team Leaders are responsible for ensuring that the report has been entered and that appropriate information has been provided. The incident report shall include all relevant information, be factual and without emotive bias.

The information provided should outline the sequence of events and be clear and concise. It is important that all information is included, and that it does not rely on any other document to be able to be understood. Appendix D outlines the process flow for the investigation process.

Where there is asset loss or damage, the Supervisor / Team Leader at the location of the event is responsible for ensuring that the report has been notified in IMS. For example:

- A pole fails at Queenstown, responsibility of the Team Leader for Queenstown.
- Electrical damage to customer's premises / equipment, responsibility of the person attending e.g.; Electrical Inspector, Field Operator, or Line worker.

1.7.2 Review Event

Incidents are to be reviewed by the team leader that owns the incident. Some examples are below:

- A pole fails at Queenstown, responsibility of the Asset Team that manages overhead assets.
- Worker slips on an uneven surface and sprains their ankle, responsibility of the Team Leader that the worker reports to.

1.7.3 Notifying and recording times

There are specific timeframes for Notifying and Recording incidents in IMS:

	Significant Incident	Others
Notified in IMS	End of Shift	Within 1 working days
Recorded in IMS	Following Work Day	Within 2 Working Days

In addition to the above requirements, all incidents are required to be recorded by close of business on the last day of the month

1.8 Incident reporting (external)

There are statutory requirements for reporting particular types of incidents to Government Agencies.

- WorkSafe Tasmania WST – If a person is killed or suffers serious bodily injury, any workplace injury or illness which involves admission to hospital a *"dangerous incident"* occurs or there is a serious electrical accident, these types of incidents must be reported by the quickest available means to WST by the HSETC Manager or their delegate. For the purpose of investigation, WST will then determine if the incident resides with WST or Electrical Standards and Safety.
- Police – When an incident occurs there may be a need to involve the Police. See 5.1.2
- Australian Transport Safety Bureau (ATSB) – aviation related wire strikes under the Transport Safety Investigation Act 2003
- Civil Aviation Safety Authority (CASA) – CASA is responsible for regulating and overseeing the maintenance, enhancement and promotion of civil aviation safety.

HSETC Manager or their delegate will provide external reports as necessary on receipt of incident notifications from the business.

1.9 Restricted events and incidents

The Manager or Team leader will be responsible for selecting this function in the IMS. Once selected this will restricted the event and it will only be able to be viewed and managed by persons with administration rights e.g. HSETC, Legal, and People and Performance. These events are classified in more detail under the "Personal Information Protection Act"

Restricted definition can relate to:

Personal information specific to an individual.

- Information about your health or a disability. It also includes any personal information collected while you are receiving a health service.

- Information that includes residential address, postal address, date of birth and gender of an individual.

- Information relating to termination of the employment, discipline of individuals, performance or conduct of the individual in carrying out the duties or functions of employment,

Legal Professional Privilege events.

- Under common law, legal professional privilege protects from disclosure the contents of all oral and written communications passing between a lawyer (solicitor or barrister) and their client (and in some instances a third party) which refer to the lawyer/client relationship and which are confidential in character.

    - These reports are commissioned by the Manager of Legal Services at TasNetworks Pty Ltd and are provided for the purpose of seeking and providing legal advice about the event or incident and any findings relating to the same.

Investigation

The purpose of investigating an incident is to identify its cause, so that appropriate remedial actions can be put in place to prevent recurrence.

Any incident can be investigated regardless of severity.

As a minimum, the following types of incidents must be investigated:

- Significant Incidents
- Lost time Injuries
- Restricted Work Injuries
- Medical Treatment Injuries
- Reportable Incidents

The Group Leader will determine if a full Root Cause Analysis (RCA) is required and assign the investigation to the Group Leader.

1.10 Investigation team

Group Leaders will appoint a lead investigator with regard for the need to ensure unbiased opinions and facilitate the appointment of subject matter experts and collation technical data. Consequently an appropriate Investigation lead may also be someone external to the workgroup. The remainder of the investigation team will then be appointed by the Event Manager and details of roles and responsibilities included in the IMS and on the investigation report template. This will automatically trigger process flow in SAP.

Investigation Team members will be selected on their knowledge and skills in relation to the particulars of the incident. As a minimum the Investigation Team should include a knowledgeable person from the workgroup where the incident occurred and a Health Safety Representative.

1.11 The investigation

The investigation is to be completed within:

- 5 working days for potential significant incidents or incidents where team members are reallocated duties; or
- within 21 working days for those with less potential of the event occurring from the time of notification unless an extension is granted (e.g. where external expert advice is required).

Depending on the complexity of the investigation, an application can be made to extend the investigation timeframe. An application must be made to the HSETC Manager outlining why the investigation will take longer and the expected completion date. If the application is acceptable, the HSETC Manager will approve the application and extend the expected completion date in IMS.

TasNetworks Incident Investigation template is available on the Zone.

1.12 Investigation report approval

Once completed, the investigation report is to be review and approved by the appropriate Manager.

For Significant Incidents, the incident is to be approved by the senior manager in that business unit (General Manager or Chief Operations Officer as applicable).

1.13 Completion of the investigation

The approved and complete investigation is to be completed into IMS by the Lead Investigator. The following must be created/ updated to match the completed and approved investigation report:

Main Pages:

- Incident Description (What Happened)
- Risk Assessments (Actual Severity and Potential Risk Assessment)

Investigation Workbench:

- Root Cause
- Investigation team members
- Any attached documents

Actions:

All actions are to be entered into IMS, including those that are already complete. The actions shall be discussed and agreed with the recipient prior to them being entered into IMS.

1.14 Action Management

Actions in IMS are assigned to a person and have an expected completion date. If an action is not going to be complete within the assigned completion date, the person responsible is to seek approval from the Group Leader to have the action completion date extended. If the application is suitable, the Group Leader will extend the action date to the agreed date.

General Managers must ensure that Controls and Remedial Actions are completed and implemented within their business unit within the specified time period.

1.15 Audit

Members of the HSETC Team who are involved with a Significant Incident investigation must lodge an audit in the HSETC Audit schedule to be completed three months after the final Significant Incident corrective action is closed.

They are to lead the audit to determine effectiveness and identify residual issues.

Rehabilitation

Injured Workers will be managed and supported in accordance with the Workers Rehabilitation and Compensation Act 1988, and TasNetworks Rehabilitation Policy which can be found in the Health pages on the Volt.

Further information is available in the Workers Compensation Administrative Manual AE-OHS-SYS-PRO-14.

Safety, health and environment committee structure

TasNetworks has in place a Safety, Health and Environment system structure which enables information to be shared upwards and downwards throughout the organisation. The structure is as follows:

~~**IRT –** This team will review all significant incidents or those that include RWI's, LTI's or have potential for wide implications within TasNetworks.~~

HSETC Team - will review and discuss incidents relevant to that Division. Divisional teams are encouraged to share information gained from incidents with other Divisional Teams.

Workgroup Teams - Workgroup teams will regularly discuss incidents particular to that workgroup and relevant information on other incidents as appropriate.

Training

Workers in the business require training in this process. The training requirements are listed below:

- **Worker -** Shall be trained in Incident Management
- **Supervisor/Team Leader/Manager -** Shall be trained in Incident Management and the appropriate investigation technique being used, as defined by this standard.
- **Investigation Specialists (Nominated lead investigators)-** Shall be trained in Incident Management and the appropriate investigation technique being used, as defined by this standard.
- **Training Records -** Training records are to be maintained by the TasNetworks Training Centre against an individual's records.

Responsibilities in relation to this procedure

1.16 The TasNetworks board and senior management

'Officers' under the WHS Act include directors and secretaries of the Board and some senior managers. Officers must exercise *due diligence* to ensure that TasNetworks manages risks identified during work. This ensures TasNetworks puts appropriate controls in place to eliminate, or where not reasonably practicable, minimise the risk resulting from a hazard.

- When in charge of a worksite; take control of the situation and carry out initial response actions.
- Ensure that incidents, as prescribed in section 35 of the *Work Health and Safety Act* 2012, are reported to WorkSafe Tasmania (serious accidents, fatality or dangerous incidents).
- Report dangerous incidents, serious electrical accidents and reportable environmental incidents to TasNetworks management and Board.
- Ensure that Investigation Controls and Corrective Actions have been implemented within the specified period of time for their Division.
- Review and approve Significant Incidents prior to circulation

1.17 Managers, supervisors and team leaders

- When in charge of a worksite; take control of the situation and carry out initial response actions.
- Advise the General Manager of significant incidents.
- Advise TasNetworks Crisis Management Team in the event of a fatality or other crisis.
- Initiate incident investigation within 4 working days of the incident occurring.
- Ensure that training is provided for people involved in the Managing Incidents process within 3 months of this procedure being implemented and that an appropriate training record is kept and maintained.

- Ensure that all investigations and corrective actions are completed within the required timeframe.
- When in charge of a worksite; take control of the situation and carry out initial response actions.
- Appoint a Lead Investigator and the Investigation Team and ensure that investigations are completed on time.
- Ensure that all corrective actions are completed within the required timeframe.
- When in charge of a worksite; take control of the situation and carry out initial response actions.
- Advise their manager of significant incidents. Follow the 1 Hour Rule.
- Notify family when a worker has been seriously injured.
- Initiate Worker Support as described in TasNetworks Trauma Management Guidelines.
- Ensure that incident reports have been entered into IMS.
- Assume the role of Lead Investigator when appointed by the Group / Group Leader. The Lead Investigator will ensure that the investigation report has been entered into IMS and where delegated by the Group / Group Leader will select investigation team members as required. The team should include the safety representative and in the interests of continual improvement, involve people from other Divisions.
- Advise the appropriate Rehabilitation Co-ordinator of the potential for a time lost injury as soon as is practically possible. In all other instances the Rehabilitation Co-ordinator must be advised within 24 hours of a worker being injured.
- Provide Rehabilitation Co-ordinators with a copy of the accident and investigation reports for events where Workers have been injured.
- Discuss incidents particular to that workgroup and relevant information on other incidents as provided by the Divisional HSETC Team.
- In other instances, the Rehabilitation Co-ordinator must be advised within 24 hours of a worker being injured.
- Workers Compensation Claim Form and Medical Certificate are forwarded to the Rehabilitation Coordinator immediately upon receipt.

1.18 IMS administrators

- Review incident investigation reports to ensure compliance with this procedure and ICAM methodology.
- For Significant Incidents:
- Send a copy of the report to Legal Services for Review (Where required)
- Send a copy of the reviewed report to the General Manager for Approval
- Distribute the approved incident report to all relevant areas of the business
- For other incidents, distribute report to appropriate areas of the business
- Ensure that personnel records in IMS are up to date
- Assist Workers with IMS related queries in their area of coverage.
- Provide support to Workers and Group Leaders with IMS related queries.
- Administer the IMS system.

1.19 Health, safety, environment and quality

- Determines Notifiable Incidents and notifies them to the appropriate regulatory body such as WorkSafe Tasmania or the Environmental Protection Agency. The HSETC manager may delegate these duties to a HSETC Team Leader or Advisor.

1.20 Health and safety manager

- Ensure that reports relating to serious electrical incidents and equipment or plant failure, which is commonly used within the electricity industry, are reported to the ENA.

1.21 Injury Management Specialist

- File a copy of the incident report for their records.
- File a copy of the investigation report for their records.
- Work closely with supervisors / team leaders to provide assistance as required.
- Work closely with ill or injured Workers and their families to assist with the return of the worker to productive employment.
- Prepare a Return to work program for an injured worker with an injury rated as a RWI or LTI.

1.22 Health and safety representatives

- Participate on incident investigation and issue resolution teams as required.

1.23 HSETC team members

- Upon completion of a Significant Incident investigation, schedule an audit in the HSETC audit schedule for 3 months after the completion of the final corrective action to confirm effectiveness of implemented controls. The audit can be lodged with the Quality Assurance Risk Manager.
- Lead audits of Significant Incident Corrective Actions to confirm effectiveness and identify residual issues.

1.24 Workers (including staff at all levels)

- Act responsibly and appropriately when an incident occurs.
- When in charge of a worksite; take control of the situation and carry out initial response actions.
- Report all incidents immediately to their Team Leader / Supervisor. Follow the 1 Hour Rule.
- Not release any details or information to any member of the media without prior approval from Manager Corporate Affairs.

- Notify incidents in IMS where the worker has access to a computer. Where no access is available within the Notification timeframes, an incident recording form can be submitted to the Team Leader for Notifying in IMS.

When required, workers are responsible for:

- Completing Workers Compensation Claim form
- Forward Workers Compensation Claim form and Medical Certificate to Supervisor
- Participate in the development of a return to work plan
- Adhere to the requirements of the return to work plan.

How everyone contributes to managing health safety and environmental matters in general is provided in TasNetworks Responsibilities procedure.

References

Legislation
• *Work Health and Safety Act 2012* • Work Health and Safety Regulations 2012
• How to Manage Work Health and Safety Risks, Code of Practice, Safe Work Australia
TasNetworks Documents
• TasNetworks Enterprise Agreement • TasNetworks Environmental Handbook

Glossary

Dangerous Incident – an incident in relation to a workplace that exposes a worker or any other person to a serious risk to a person's health or safety emanating from an immediate or imminent exposure to:

- an uncontrolled escape, spillage or leakage of a substance; or
- an uncontrolled implosion, explosion or fire; or
- an uncontrolled escape of gas or steam; or
- an uncontrolled escape of a pressurised substance; or
- electric shock; or
- the fall or release from a height of any plant, substance or thing; or
- the collapse, overturning, failure or malfunction of, or damage to, any plant that is required to be authorised for use in accordance with the regulations; or
- the collapse or partial collapse of a structure; or
- the collapse or failure of an excavation or of any shoring supporting an excavation; or
- the inrush of water, mud or gas in workings, in an underground excavation or tunnel; or
- the interruption of the main system of ventilation in an underground excavation or tunnel.

DPIPWE – Is the Government Authority responsible for environmental management – Department of Primary Industries, Parks, Water and Environment.

~~**ESS –** Is the Electricity Standards and Safety, which is a Division within WST, whose function is to regulate the electrical aspects of workplace safety.~~

HSE – Health Safety and Environment

HSETC – Health Safety Environment and Technical Competence

HSR – A person elected in accordance with the WHS Act 2012 to represent workers in a workgroup on work health and safety matters. This person will also represent workers on environmental and sustainability matters.

ITC's – Immediate Temporary Controls are actions that are to be taken to prevent an incident occurring or prevent re-occurrence.

Incident – Any event that has the potential to cause injury, illness, health impact, property loss, asset damage, environmental harm, significant loss of supply to customer(s) or material financial loss. This may include combinations of safety, environment, health, security, equipment failure and property damage.

An incident is also an exceedance of an occupational exposure limit, legal requirement or a TasNetworks Standard

Investigation Methodology – A systematic methodology used for the investigation of an incident. The current approved investigation methodology is ICAM (Incident Causation Analysis Methodology). Alternative methodologies can be approved by the HSETC Manager on a case by case basis.

~~**IRT –** The Incident Review Team is a forum and sub-team, comprised of Divisional Representatives, Chairperson and a Minutes Taker for the purpose of reviewing incidents and investigations.~~

JRA – Job Risk Analysis

Loss – Includes financial loss, theft, damage to property, vandalism, fire, and any injury to a member of the public or damage to private property resulting from TasNetworks activities.

LTIFR – Lost Time Injury Frequency Rate as per AS1885.1-1990. *Or see Workplace Injury and Disease Recording Standard "Resource Kit" for more detail.*

–3.5 Lost-time injuries/diseases—those occurrences that resulted in a fatality, permanent disability or time lost from work of one day/shift or more.

–3.10 Cases of recurring injury or disease should be recorded and cross-referenced to the original record but not counted as a separate occurrence unless there was a separate identifiable incident associated with the recurrence.

Medical Certificate - Is a worker's compensation medical certificate issued by an accredited medical practitioner.

MTIFR – Medical Treatment Injury Frequency Rate

Near Hit – An incident, which did not but could have, resulted in harm to people, damage to property or the environment or loss to process.

Notifiable incident means an incident that must be notified to WorkSafe Tasmania by the "the fastest possible means" including:

- the death of a person; or
- a *serious injury or illness* of a person; or
- a *dangerous incident*.

Power System – Comprises all equipment associated with the generation, transmission or distribution of electricity. This includes civil, mechanical and electrical assets.

Recordable incident – is a Medical Treatment Injury (MTI) (an injury or disease that resulted in a treatment given by a physician or other medical personnel under standing orders of a physician). A recordable incident also includes one or more of the following first aid treatments:

- Using a non-prescription medication at non-prescription strength (for medications available in both prescription and non-prescription form, a recommendation by a physician or other licensed health care professional to use a non-prescription

medication at prescription strength is considered medical treatment for recordkeeping purposes);
- Administering tetanus immunizations (other immunizations, such as Hepatitis B vaccine or rabies vaccine, are considered medical treatment);
- Cleaning, flushing or soaking wounds on the surface of the skin;
- Using wound coverings such as bandages, Band-Aids, gauze pads, etc.; or using butterfly bandages (other wound closing devices such as sutures, staples, etc., are considered medical treatment);
- Using hot or cold therapy;
- Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc. (devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment for recordkeeping purposes);
- Using temporary immobilization devices while transporting an accident victim (e.g., splints, slings, neck collars, back boards, etc.);
- Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister;
- Using eye patches;
- Removing foreign bodies from the eye using only irrigation or a cotton swab;
- Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means;
- Using finger guards;
- Using massages (physical therapy or chiropractic treatment are considered medical treatment for recordkeeping purposes); or
- Drinking fluids for relief of heat stress.

Rehabilitation Co-ordinator – Trained members of TasNetworks personnel who assist ill or injured Workers to return to productive employment and who provide support to the supervisors / managers of those ill or injured Workers.

Return to Work program – A program of work activities specifically developed to manage the rehabilitation of injured Workers.

IMS - TasNetworks electronic incident and risk management system. Its functions include incident reporting and investigation, audit and action management and risk assessment and register functions.

Serious Electrical Incident – An accident involving:
- electrocution; or
- electric shock serious enough to cause temporary or permanent disability or to require medical attention; or
- Electricity that produces a burn serious enough to cause temporary or permanent disability or to require medical attention.

Refer to Appendix H – Flowchart to determine notification requirements for shock or electrocution incidents.

Serious Injury or Illness – serious injury or illness of a person means an injury or illness requiring the person to have:

- immediate treatment as an in-patient in a hospital; or
- immediate treatment for:
    - the amputation of any part of his or her body; or
    - a serious head injury; or
    - a serious eye injury; or
    - a serious burn; or
    - the separation of his or her skin from an underlying tissue (such as de-gloving or scalping); or
    - a spinal injury; or
    - the loss of a bodily function; or
    - serious lacerations; or
- medical treatment within 48 hours of exposure to a substance.

Stress Related Injury/ LTI- For a stress-related injury to be considered an LTI:

- Event that lead to worker stress be recorded in IMS; and
- It's reasonable that an event at work triggered the injury; and
- Stress is assessed by an Accredited Medical Practitioner and issues a workers compensation medical certificate; and
- If medical certificate states one full shift or greater off work.

Significant Incident – An incident that has a credible potential consequence of Major or Severe as assessed in the consequence table in the TasNetworks Risk Management Framework:
http://projectzone.tnad.tasnetworks.com.au/business-projects/nis-program/r19workprogram/supporting/Risk%20Framework/TasNetworks%20-%20Risk%20Management%20Framework%20FINAL.DOCX
vWorkSafe – Is the Government Authority responsible for workplace health and safety – WorkSafe Tasmania.

Worker – A worker is someone who carries out work for TasNetworks. It includes Workers, outworkers, apprentices, trainees, students gaining work experience, volunteers, contractors or subcontractors and their Workers.

Appendix A – Incident Severity Classifications

This document lists the Incident Severity and Injury Classification definitions, as well as some examples that serve as a guide to the type of injury/incident that may fit into each classification. These examples are a guide only and it is not an exhaustive or definitive list.

Health and Safety Incident Severity

CLASSIFICATION	INCIDENT DESCRIPTION	EXAMPLES
NEGLIGIBLE	▪ Minor injury / first aid ▪ Medical treatment injury ▪ Short term reversible health effects ▪ Minor irritation or transient effects reversible after exposure stops ▪ Customer complaint ▪ Low speed vehicle incident less than 30 km/h	▪ Incident that leads to first aid treatment ▪ Work Related threats / abuse ▪ Reverse vehicle into a sign post
MINOR	▪ Vehicle incident at less than 60 km/h ▪ Restricted Work Injury ▪ Lost time injury <5 days – loss of a full shift or requiring hospitalisation	▪ Laceration requiring stitches ▪ Illnesses such as skin irritation or food poisoning ▪ Electric shocks more than 50V AC or 120V DC
MODERATE	▪ Vehicle incident at 60 – 80 km/h ▪ Lost time injury > 5 days – temporary life-altering injury ▪ Long term irreversible health impacts	▪ Chronic back / repetitive sprain injury ▪ Work-related mental illness ▪ 5% loss of movement after breaking ankle ▪ Burns requiring medical treatment of more than 5 days
MAJOR	▪ Vehicle incident at 80 – 100 km/h • Fatality or permanent life-altering injury • Single exposure leads to a terminal illness	▪ Car accident on a main highway ▪ Cancer caused by exposure to a substance/chemical ▪ Electrocution
SEVERE	• Multiple Fatality or permanent life altering injuries • Vehicle incident at more than 100 km/h	

Injury Classification

CLASSIFICATION	INCIDENT DESCRIPTION	EXAMPLES
First Aid Injury	▪ Minor injury that required first aid treatment, whether by a "First Aider" or any other person ▪ Single treatment only	▪ Minor laceration requiring a Band-Aid ▪ Bruising due to a bump ▪ Discomfort or minor irritation while using a cleaning chemical
Medical Treatment Injury	▪ Injury requiring assessment or treatment by a medical practitioner	▪ Laceration requiring stitches ▪ Illnesses such as skin irritation or food poisoning ▪ Electric shocks less than 50V AC or 120V DC
Restricted Work Injury	▪ Injury where a medical practitioner has prescribed limitations on: o The duties that can/cannot be performed or o The time that a person can spend at work	▪ Chronic back / repetitive sprain injury ▪ Work-related mental illness ▪ Injury that requires modified duties or temporary reassignment to another job
Lost Time Injury	▪ An injury where a medical practitioner prescribes at least 1 full shift away from work as a direct result of the injury.	▪ Substantial Burns ▪ Back injury that does not allow person to attend work ▪ Injury that requires surgical correction or hospitalisation
Fatality or Permanent Life Altering Injury	▪ An injury or illness resulting in a loss of life or ▪ An injury that has significant impact on the quality of life of an individual, to the extent that their life is permanently altered.	▪ Electrocution ▪ Severe burns ▪ Asbestosis ▪ Paraplegia ▪ Amputation ▪ Blindness ▪ Hearing loss

ENVIRONMENTAL INCIDENTS

<table>
<tr><th>CLASSIFICATION</th><th>INCIDENT DESCRIPTION</th><th>INCIDENT SEVERITY</th></tr>
<tr><td>NEGLIGIBLE</td><td>
<u>Spills:</u>
<table>
<tr><th>Onto / Into:</th><th>Land</th><th>Waterway / Stormwater
(non-drinking)</th><th>Drinking Supply</th></tr>
<tr><td>PCB-free</td><td>< 20 L</td><td>see 'Minor'</td><td>see 'Moderate'</td></tr>
<tr><td>PCB-contaminated</td><td>see 'MEDIUM'</td><td>see 'HIGH'</td><td>see 'Major'</td></tr>
</table>
<u>Other:</u>

Incident contained on TasNetworks property (e.g. depots, enclosures etc.).
Incident involving single non-threatened flora or fauna.
Loss or uncontrolled sediment storage.
Customer complaint (e.g. noise, veg clearing, emissions, etc.

</td><td>

Negligible localised impact.
Estimated clean-up & disposal cost less than $5,000
Incident not escalated to external authority and/or 3rd party.
Complaint not escalated to external authority and/or 3rd party.
Complaint not escalated to TasNetworks Senior Management.
No breach of legislation.
No legal implications.
No media coverage.

</td></tr>
<tr><td>MINOR</td><td>
<u>Spills:</u>
<table>
<tr><th>Onto / Into:</th><th>Land</th><th>Waterway / Stormwater
(non-drinking)</th><th>Drinking Supply</th></tr>
<tr><td>PCB-free</td><td>20 – 1000 L</td><td>0 – 50 L</td><td>see 'Moderate'</td></tr>
<tr><td>PCB-contaminated</td><td>< 20 L</td><td>see 'HIGH'</td><td>see 'Major'</td></tr>
</table>
<u>Other:</u>

Incident involving multiple non-threatened flora or fauna.
Loss or uncontrolled sediment storage or dewatering >10 tonne from worksites.
Less than (<) 1kg loss of SF_6 to atmosphere.

</td><td>
Incident reportable to external authorities

Significant localised impact.
Remediation work / follow-up action required.
Estimated remediation & disposal cost between $5,000 & $20,000
Incident reportable to 3rd party – no action / no litigation.
Local media coverage / community attention.
Non-compliance with legislation:

Infringement Notice (IN) – monetary penalty unlikely

</td></tr>
</table>

<table>
<tr><th>CLASSIFICATION</th><th>INCIDENT DESCRIPTION</th><th>INCIDENT SEVERITY</th></tr>
<tr>
<td>MODERATE</td>
<td>
<u>Spills:</u>
<table>
<tr><th>Onto / Into:</th><th>Land</th><th>Waterway / Stormwater
(non-drinking)</th><th>Drinking Supply</th></tr>
<tr><td>PCB-free</td><td>1000 – 10,000 L</td><td>50 – 1000 L</td><td>0 – 100 L</td></tr>
<tr><td>PCB-contaminated</td><td>20 – 1000 L</td><td>0 – 100 L</td><td>see ‘Major’</td></tr>
</table>
<u>Other:</u>

Impact to single individual of threatened fauna species (e.g. grey goshawk, wedge-tailed eagle, sea eagle, other).
Removal of vegetation outside of the TasNetworks vegetation easement specifications.
Damage to Indigenous / European heritage (including trees) without permit.
0 – 5% destruction of threatened species, habitat or community.
Non-reporting of >100 tonnes of vegetation cleared under the Forest Practices Code.
Inappropriate management of a Controlled Waste.
Conducting Unauthorised work in a National Park or other protected place.
Greater than (>) 1kg loss of SF_6 to atmosphere.

</td>
<td>
Incident reportable to external authorities

Severe localised impact with long-term effects, or wide spread impact.
Significant remediation work and follow up required.
Estimated remediation & disposal cost between $20,000 and $1,000,000
Incident reportable to 3rd party – potential litigation.
State-wide media coverage.
Non-compliance with legislation:

Infringement Notice (IN) – monetary penalty likely.

</td>
</tr>
</table>

<table>
<tr><th>CLASSIFICATION</th><th>INCIDENT DESCRIPTION</th><th>INCIDENT SEVERITY</th></tr>
<tr>
<td>MAJOR</td>
<td>
<u>Spills:</u>
<table>
<tr><th>Onto / Into:</th><th>Land</th><th>Waterway / Stormwater
(non-drinking)</th><th>Drinking Supply</th></tr>
<tr><td>PCB-free</td><td>10,000 – 20,000 L</td><td>1000 – 2,000 L</td><td>100 – 500 L</td></tr>
<tr><td>PCB-contaminated</td><td>1000 – 5,000 L</td><td>100 – 500 L</td><td>0 – 100 L</td></tr>
</table>
<u>Other:</u>

Impact to multiple individuals of threatened fauna species (e.g. grey goshawk, wedge tailed eagles, sea eagles, other) or their nests.
Clearing of multiple threatened flora species without appropriate permits.
5 – 10% destruction of threatened species, habitat, or community.
Destruction of Indigenous / European heritage sites, items or artefacts.
Removal of protected or significant trees, listed on government registers.
Work occurring in a National Park or other protected place without authorisation and leading to significant impact.

</td>
<td>
Incident reportable to external authorities

Local area permanently affected or severe impact wide spread.
Major remediation work and long term follow up required.
Estimated cost of remediation > $1,000,000.
Damage to World Heritage Area; RAMSAR Wetland
Impact on listed migratory species.
Impact / damage to Commonwealth listed threatened species or listed ecological community.
Incident reportable to 3rd parties – litigation certain.
Widely reported in the media (national coverage) with major, lasting damage to brand and corporate reputation.
Non-compliance with legislation:

Infringement Notice (IN)
Significant monetary penalty
TasNetworks / staff liable for criminal charges, possible imprisonment.

</td>
</tr>
<tr>
<td>SEVERE</td>
<td>
<u>Spills:</u>
<table>
<tr><th>Onto / Into:</th><th>Land</th><th>Waterway / Stormwater
(non-drinking)</th><th>Drinking Supply</th></tr>
<tr><td>PCB-free</td><td>> 20,000 L</td><td>> 2,000 L</td><td>> 500 L</td></tr>
<tr><td>PCB-contaminated</td><td>> 5,000 L</td><td>> 500 L</td><td>> 100 L</td></tr>
</table>
<u>Other:</u>

Greater than (>) 20% of threatened species, threatened species habitat, or threatened vegetation community destroyed.

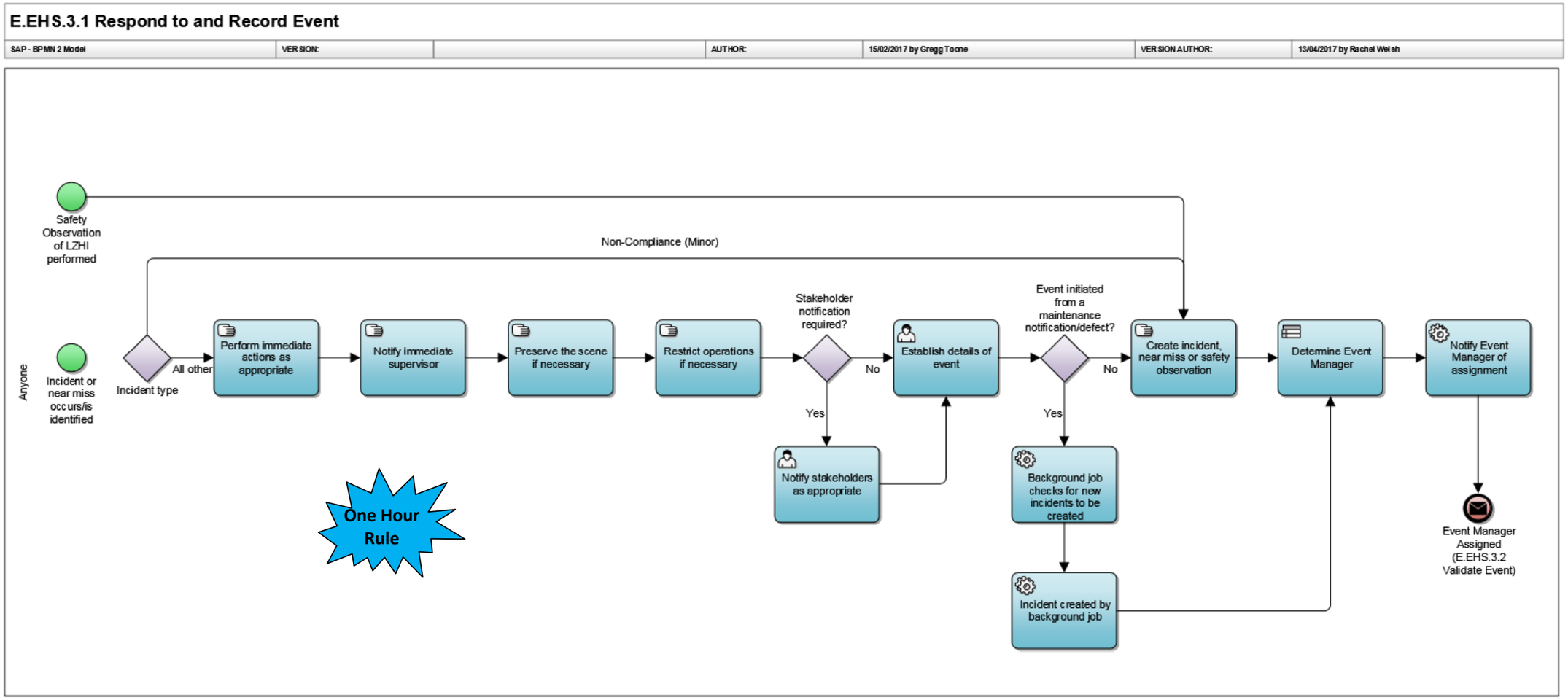
</td>
<td>
Incident reportable to external authorities

Large area permanently affected.
Significant impairment of ecosystem function.
Remediation work on a scale that significantly affects profitability of TasNetworks, and/or costs to consumers.
Incident reportable to 3rd parties – litigation certain.
Extensive national and some international coverage in media.
Permanent damage to TasNetworks brand.
Non-compliance with legislation:

Infringement Notice (IN)
Significant monetary penalty
Likely criminal prosecution, imprisonment for TasNetworks / staff

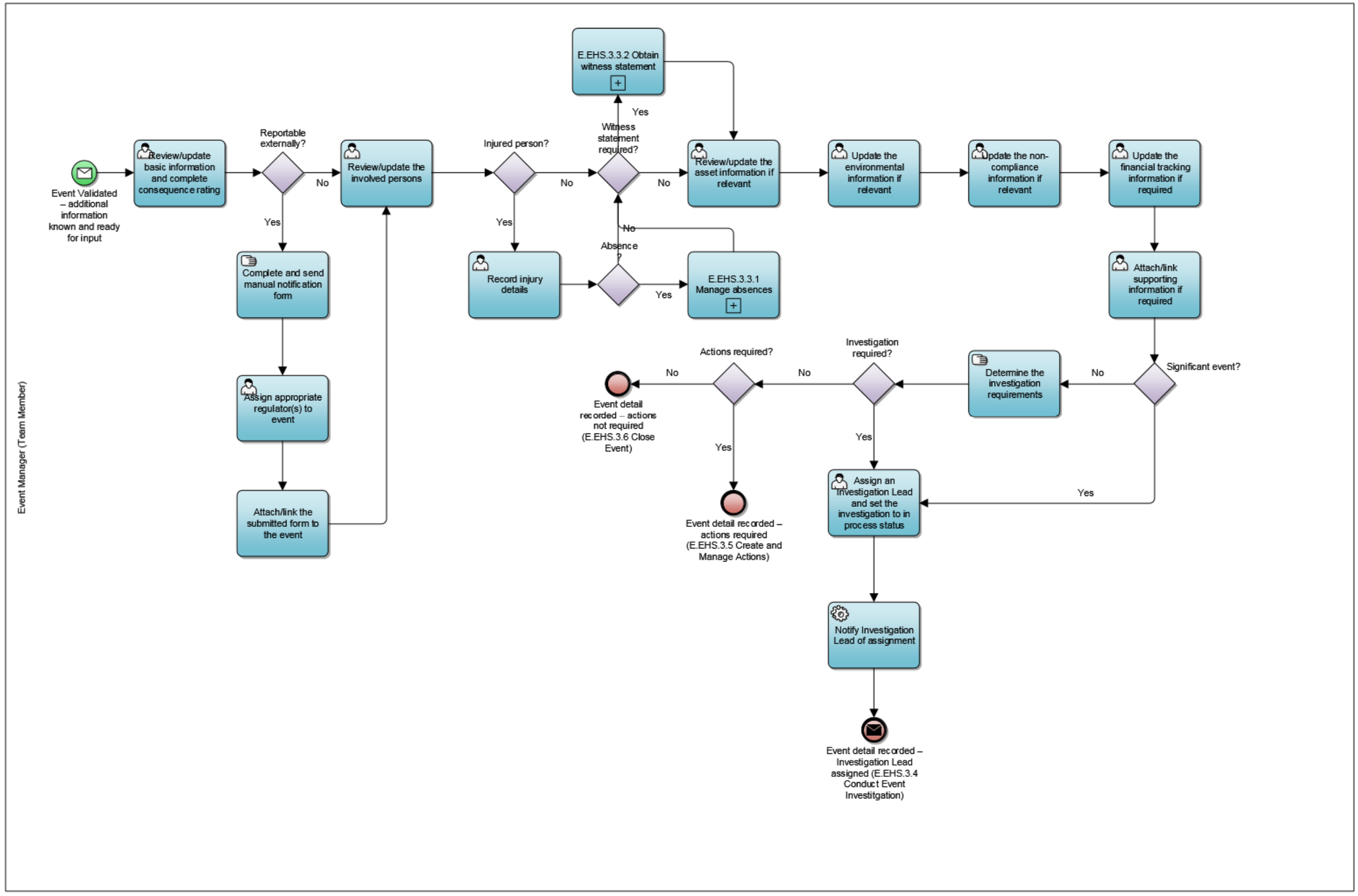
</td>
</tr>
</table>

Appendix B – Respond and record an event

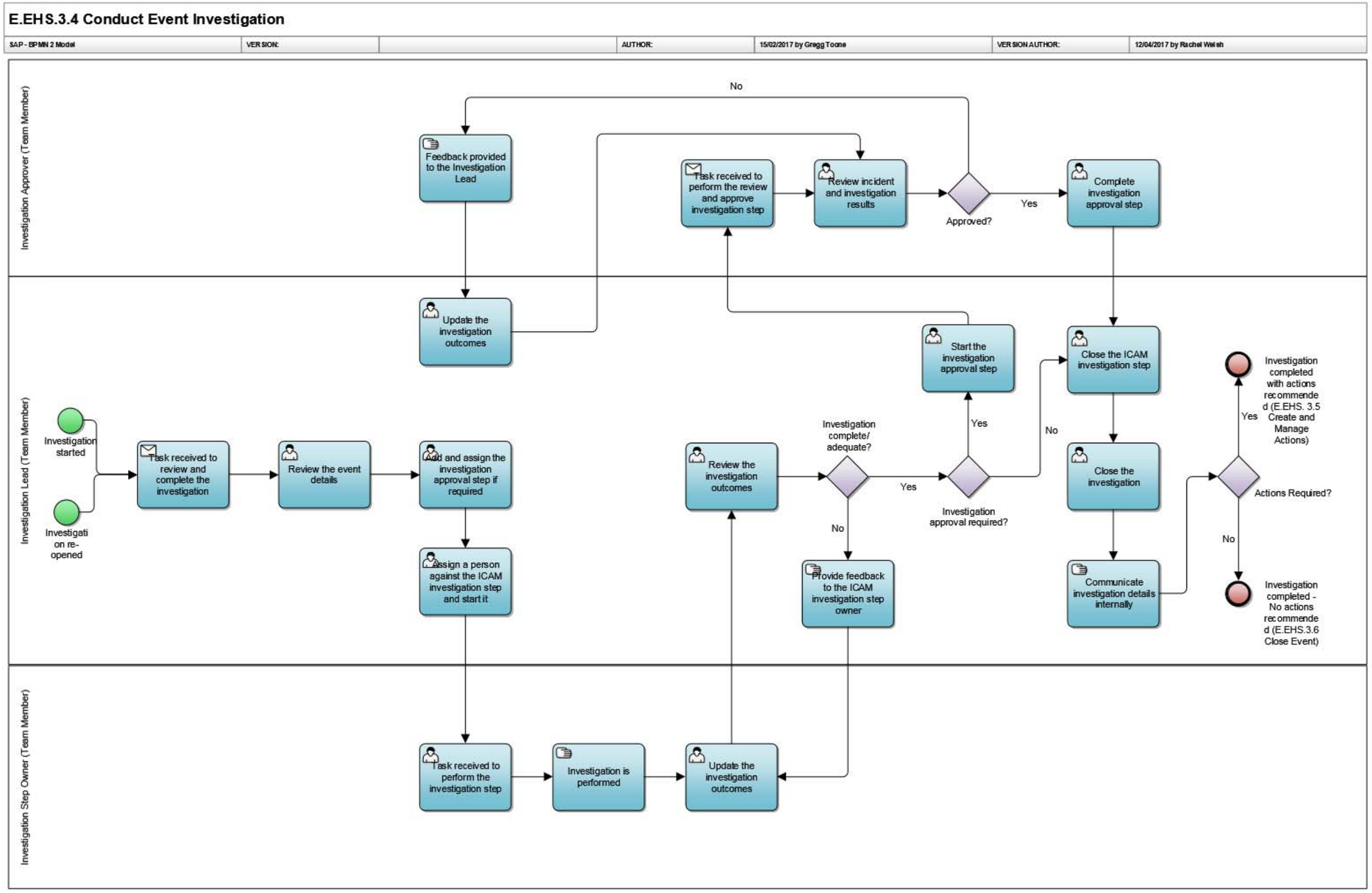


E.EHS.3.3 Record Event Detail

SAP - BPMN 2 Model	VERSION:		AUTHOR:	15/02/2017 by Gregg Toone	VERSION AUTHOR:	13/04/2017 by Rachel Welsh

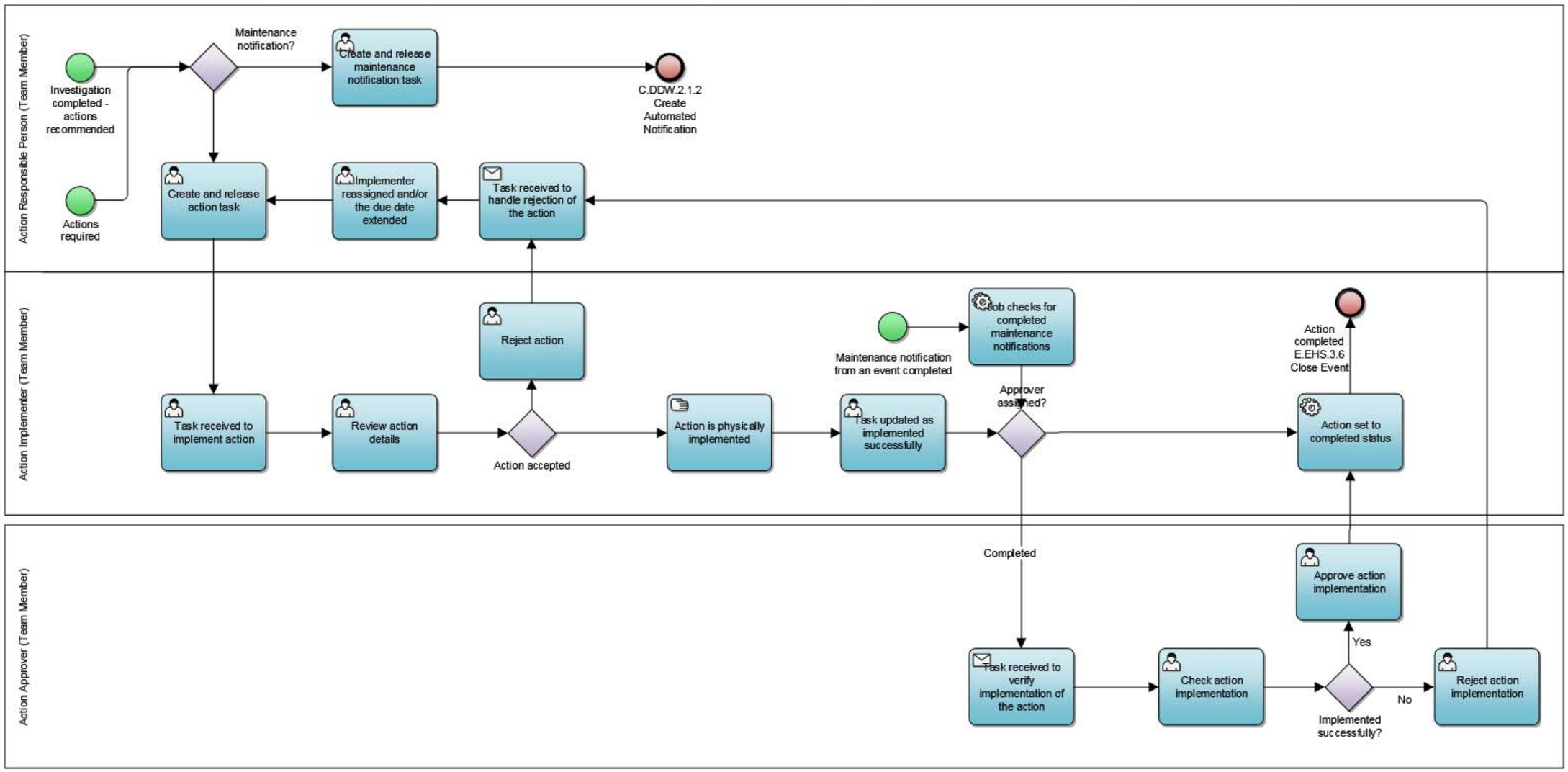


Appendix C – Event Investigation Process



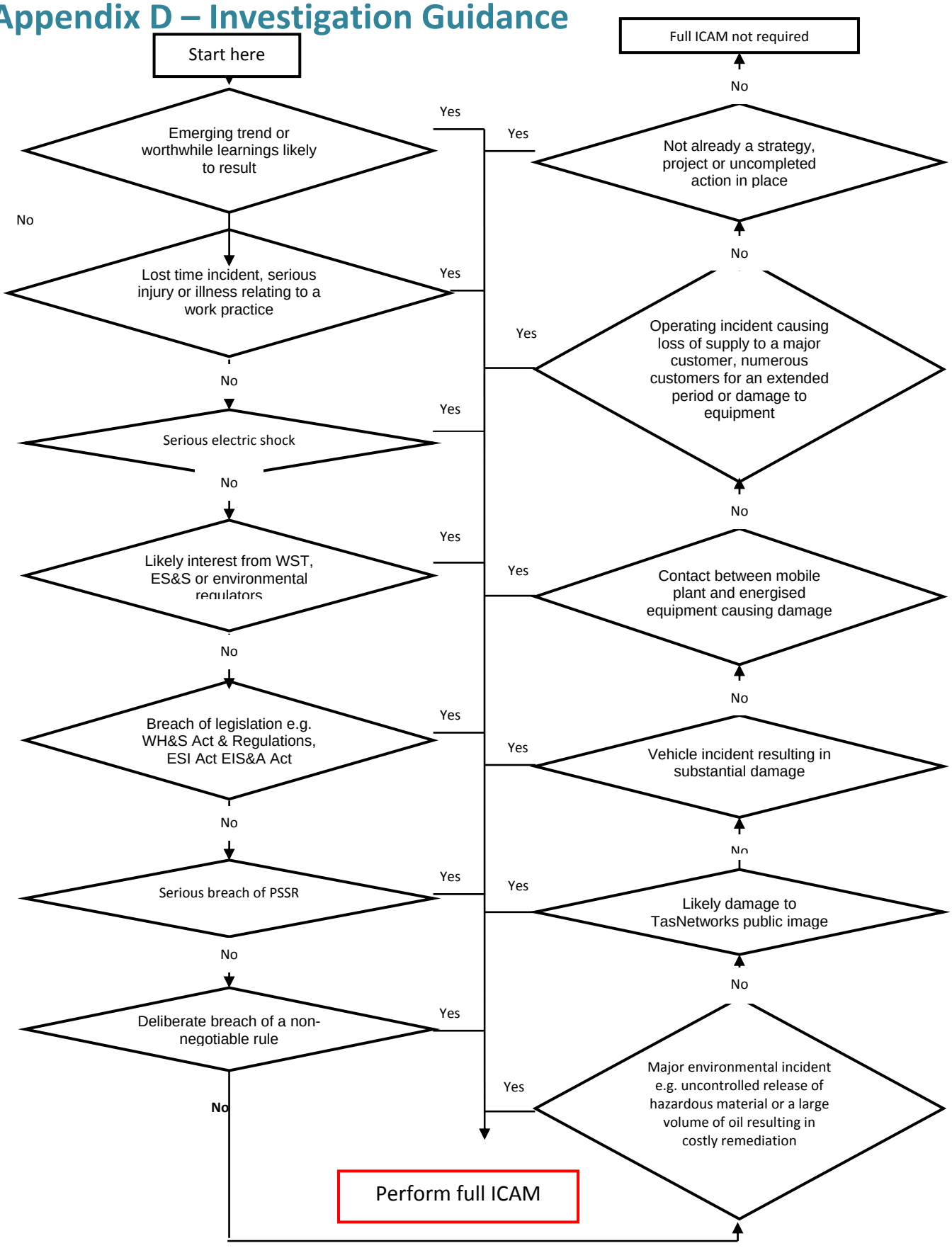
E.EHS.3.5 Create and Manage Actions

SAP - BPMN 2 Model	VERSION:		AUTHOR:	15/02/2017 by Gregg Toone	VERSION AUTHOR:	12/04/2017 by Rachel Welsh



Appendix D – Investigation Guidance

Predefined values to help determine when a formal root cause analysis is required



Appendix F – ICAM Organisational Factors (Root Cause Classifications)

Root Cause Classification	Root cause can be caused by:	Root cause can lead to:
Hardware *The quality, availability and position in life-cycle of tools, equipment and components. It is concerned with the materials selected rather than design or poor maintenance of the equipment*	• Poor stock or ordering system. • Poor quality due to the local availability. • Poor state of existing equipment. • Equipment not fit for purpose. • Lack of resources available to buy, maintain or improve equipment. • Theft.	• Inappropriate use of tools or equipment. • Absence or unavailability of tools or equipment. • Improvisation i.e. using tools unsuitable for the job.
Training *The provision of the correct knowledge and skills of Workers necessary for them to do their job safely. Failures may involve insufficient, ineffective or too much training, lack of resources or assessment and mismatch of abilities to tasks.*	Training not directed to all the job skill requirements. • Ineffective pre-employment selection process. • Poor training needs assessment. • No assessment of training effectiveness. • Differing standards of training. • Training the wrong people. • Making assumptions about a person's knowledge or skills.	• Workers unable to perform their jobs. • Excessive time spent in training. • Excessive supervision needed. • Increased numbers of people required for the job. • Jobs taking longer, of poor quality, wasting material.
Organisation *Deficiencies in the structure of responsibility and accountability are those which are not appropriate to current work. These may involve co-ordination, supervision and provision of communication and feedback.*	• Poorly defined departments or sections. • Unclear accountability, responsibility or delegation. • Lack of definition of objectives. • No structure to co-ordinate different activities. • Poor planning. • Excessive bureaucracy. • Frequent re-organisations.	• Multi-layer hierarchy, slow response to changes. • Wrong person, or nobody, takes responsibility. • Resources used for non-business needs. • Decisions delayed or deferred. • People are only held responsible, not accountable for their actions/decisions. • Poor control or management of events. • Rules and procedures not enforced.
Communication *Failures to communicate when the target is known but the message fails to get through or is late. Involves inadequate hardware and miscomprehension by those involved. Failure to validate reception.*	• Language problems and cultural barriers. • Lack of clear line of communication. • Poor feedback. • No standard communication format. • Missing or excessive information. • Inability to make contact with the correct person. • Unreceptive or hostile target.	• Misunderstanding or incorrect interpretation. • Doing the wrong thing, at the wrong time or place. • Missing information, people not informed, do not report. • Not knowing who to inform. • Not knowing where information is located.

Root Cause Classification	Root cause can be caused by:	Root cause can lead to:
Incompatible Goals *The presence of conflicts between production, safety, planning, and economic goals as well as conflicts between group and peer pressures and personal goals. Incompatible goals become a problem when senior management give no guidelines on priorities*	• Conflict between safe work and production priorities. • Conflict between work and personal priorities. • Imbalance between safety requirements and budget constraints. • Taking procedural shortcuts for personal / production gain. • Conflict between appearance and functionality in a design.	• Suppressing information about hazards or injuries. • Shortcutting a procedure. • Overruling or relaxing procedures. • Putting people under pressure. • Operating closer than normal to operating limits.
Procedures *The presence of accurate, understandable procedures which are known and used. Relates to the way in which procedures are written, tested, documented and controlled.*	• Poor knowledge of the procedure writer. • Poor feedback on practicality. • Poor document control. • Gaps in the inventory of procedures needed. • Non-operational objectives (political/organisational). • Failure to have revision control system.	• Ambiguous, non-comprehensive, incorrect, outdated documents. • Difficult access for the users. • No procedures for some specific tasks. • Too many overlapping or conflicting procedures. • Failure to communicate existing or new procedures. • Documents in the wrong language. • Difficult procedures which encourage shortcuts. • Toleration of violations.
Maintenance Management *The appropriateness of the management of the maintenance system, involving planning, resourcing and type of maintenance rather than the execution of maintenance jobs. Poor practices, involving procedures, tools and training are covered elsewhere*	• Poor planning, controlling, execution and recording of maintenance. • State of equipment not communicated to relevant people. • Shortage of specialised, maintenance personnel. • Absent/inadequate manuals and documents. • Incorrect maintenance strategy.	• Defective or malfunctioning equipment. • Makeshift or unplanned maintenance. • Breakdown before life expectancy. • Unexpected rapid corrosion. • Equipment not operable in the way intended.

Root Cause Classification	Root cause can be caused by:	Root cause can lead to:
Design *The way in which equipment is constructed to make certain operations difficult or allow unexpected usage. Poor design may require extra effort and unusual maintenance. Inadequate design capacity may lead to extending the equipment beyond limits.* *Many design failures result from the physical and professional separation of the designer and end user.*	• No standardisation of equipment or usage. • No adapting to human needs and limitations. • Poor designer – user communication. • Time or financial constraints. • No indication of system status provided by design. (on/off, working or not, etc.). • Inadequate design premise data.	• Extra effort to do the job. • Unexpected performance of tools and equipment. • Inability to operate equipment properly. • Inability/difficulty in controlling processes. • Long or repeated training requirements. • Equipment is unused or improvised usage.
Risk Management *The systematic application of management policies, processes and procedures to the tasks of identifying, analysing, assessing reducing to ALARP (As Low as Reasonably Practical) and ongoing monitoring of risk in man-machine systems that contain a potential to have an adverse effect on people, the environment, equipment, property or the community.*	• Inadequate or poorly conducted risk management process. • Goals, objectives, scope and boundaries of risk management activity not clearly determined. • Level of risk analysis (JSA, QRA, Safety Case etc.) inappropriate for the degree of risk or phase of life-cycle. • Hazard identification process not being systematic or covering all operations and equipment. • Risk assessment conducted without the appropriate competencies/experience. • Inappropriate selection or poor implementation of risk control measure. • Inadequate monitoring of risk control effectiveness.	• Risk levels above ALARP. • Uncontrolled hazards and consequences. • Unexpected incident and accident rate. • Inappropriate Risk Ranking and allocation of risk control resources. • Incomplete, inadequate or out of date Risk Register. • Breach of local regulatory requirements.
Management of Change *The systematic assessment of change to operations, processes, equipment, services and personnel for potential risk and the application of appropriate action to ensure existing performance levels are not compromised.*	• Inadequate or poorly conducted management of change process. • Objectives and scope of change activity not clearly determined. • Inadequate risk vs benefit assessment of the impact of change. • Poor change implementation plan. • Poor communication of change. • Too fast or too slow implementation of change. • Inadequate tollgate mechanism to approve proposed change. • Inadequate monitoring of the effects of change to existing	• Adverse impact on production and safety performance. • Risk levels above ALARP. • Unexpected near misses, incidents and accidents. • Gaps in organisational structures and responsibilities. • Mismatch between equipment, operating procedures and training. • Insufficient manning levels, confusion and low morale. • Increase in equipment breakdown or damage. • Mismatch between policy, procedures and practice. • Breach of local regulatory requirements.

Root Cause Classification	Root cause can be caused by:	Root cause can lead to:
Contractor Management The evaluation, selection and retention of contracted services, equipment, personnel and material to ensure risks to people, the environment, equipment or property are reduced to a level which is ALARP.	• Inadequate or poorly conducted contract management process. • Lack of consideration of risk associated with the contract. • Poorly defined selection criteria i.e. cost over performance. • Lack of formal contractor evaluation procedure. • Lack of a clearly defined work scope. • Contract not clearly defining HSE obligations, performance and reporting requirements. • Unclear reporting relationships, lines of communication, roles and responsibilities. • The failure to identify/plan bridging requirements between the contractor and company standards. • Inadequate or poorly conducted HSE compliance and performance monitoring and review.	• Risk levels above ALARP. • Deterioration in production and safety performance. • Requirement for additional supervision. • Substandard competency and manning levels. • Differing, conflicting or poor interface of procedures and systems of work. • Poor worker/contractor relations, industrial relation issues, high personnel turnover. • Imbalance between contract compliance, production and HSE goals. • Lack of reporting of hazards, near-misses and incidents.
Organisational Culture Culture includes: the set of beliefs; values (what is important); norms and fundamental assumptions (the way we do things) which define the organisation. In effect, the shared values and beliefs interact with an organisation's structures and control systems to produce a set of "unwritten rules" that govern behavioural norms.	• Competing company policy. • Ineffective management decisions about policy. • Diverse and conflicting values and beliefs of the people within an organisation. • Poor (or filtered) organisational level reporting and relationships. • Factions and politics. • Unaddressed worker fears and anxieties. • Low levels of trust and stress. • Getting away with un-necessary risk taking. • Inappropriate social interaction. • Poor leadership. • Inconsistency between organisation’s values and actions. • Lack of compliance, performance monitoring and review.	• Poor communications between divisions. • Failure to complete tasks. • Non-adherence to rules. • Poor commitment to safety, environment and community issues. • Reluctance for voluntary resolution of identified hazards. • Low occurrence reporting. • Lack of clear management structures / processes. • Low staff morale and motivation. • Miscalculation of the level of acceptable risk. • Ambiguous expectations of behaviour requirements. • Slow acceptance of change, restricting continual improvement process. • Unsafe work conditions not addressed.

Root Cause Classification	Root cause can be caused by:	Root cause can lead to:
Regulatory Influence *The regulatory body has an influence on safety culture by defining and controlling the safety framework in which the organisation must operate. The framework includes: legislative requirements, documentation and safety practices required of organisations and regulatory oversight.*	• Ambiguous regulations. • Duplicated safety practices. • Multiple requirements for documentary evidence. • Conflicting regulatory requirements. • Lack of knowledge regarding Regulatory requirements.	• Delays in meeting regulatory requirements. • Additional resources to meet regulatory requirements. • Prescriptive regulatory requirements. • Restrictive work practices. • Difficulties in interpreting regulations. • Non-reporting of hazards due to fear of enforcement action/ penalty. • Inability to demonstrate compliance or satisfy other legal requirements. • Potential revocation of operating licence or other regulatory sanctions.
Organisational Learning *The strategies that organisations have in place for ensuring lessons are learnt from occurrence investigations, corrective action implementation, audit findings, risk management processes and reviews.*	• Not investigating occurrences systemically. • Failure to communicate lessons to the workforce. • Poor evaluation of effectiveness of corrective actions. • Failure to appreciate the risk exposure or vulnerability within an organisation. • Failure to investigate and rectify non-compliance findings from audits. • Lack of leadership / commitment to learning. • Ineffective sharing of lessons. • Inadequate incident reporting. • Lack of resources (financial and human). • Inadequate safety records / data systems. • Lack of effective data / trend analysis.	• Poor safety culture. • Poor safety record. • Loss of public and worker confidence. • Repeat occurrences. • Lost time injuries, serious injuries and fatalities. • Safety deficiencies. • Ineffective risk management controls. • Deficient procedures and processes. • Lack of operating excellence and continuous improvement for organisations. • Non-compliance with regulations. • Statutory fines / penalties.

Appendix G – Reportable Environmental Incidents

The following environmental incidents are reportable to external regulators, as required by legislation:

INCIDENT TYPE		AUTHORITY	APPLICABLE LEGISLATION
Conservation Area	▪ Development – Unauthorised ▪ Maintenance – Unauthorised	DPIPWE Parks & Wildlife	*Nature Conservation Act 2002 [TAS]*
Controlled Waste	▪ Interstate Consignment – Unauthorised ▪ Treatment / Disposal – Unauthorised ▪ Treatment / Disposal – Incorrect Method ▪ Clearance by unlicensed waste contractor	DPIPWE EPA Division	*Environmental Management & Pollution Control Act 1994 [TAS]* *Movement of Controlled Waste NEPM 2010 [CTH]*
Covenant Land	▪ Access – Unauthorised ▪ Development – Any Development ▪ Maintenance – Unauthorised	DPIPWE Parks & Wildlife	*Nature Conservation Act 2002 [TAS]*
Crown Land	▪ Development – Unauthorised ▪ Maintenance – Unauthorised	DPIPWE Parks & Wildlife	*Crown Lands Act 1976 [TAS]*
Emissions – Air	▪ Dust – Public Complaint ▪ Odour – Public Complaint ▪ Gases – Public Complaint ▪ Stack Emissions – Public Complaint ▪ Exceedance of Licence or Permit Threshold	DPIPWE EPA Division	*Environmental Management & Pollution Control Act 1994 [TAS]* *Environment Protection Policy (Air Quality) 2004 [TAS]*
Emissions – Noise	▪ Noise – Public Complaint ▪ Noise – Excess of Licence or Permit Threshold	DPIPWE EPA Division	*Environmental Management & Pollution Control Act 1994 [TAS]* *Environment Protection Policy (Noise) 2009 [TAS]*

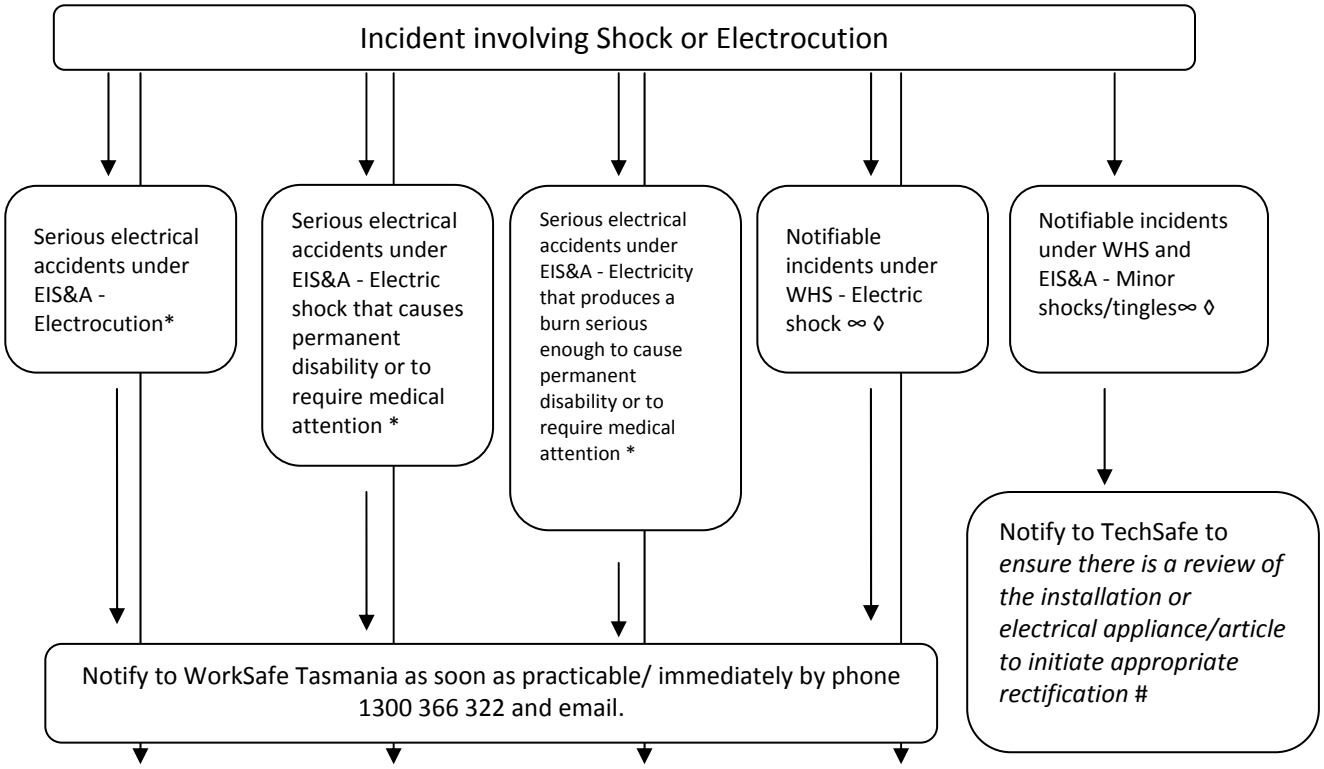
INCIDENT TYPE		AUTHORITY	APPLICABLE LEGISLATION
Emissions – Wastewater	▪ Exceedance of Licence or Permit Threshold ▪ Discharges to sewer – Unauthorised ▪ Discharges to drains – Unauthorised ▪ Clearance by unlicensed waste contractor	DPIPWE EPA Division Regional Water Authorities	*Environmental Management & Pollution Control Act 1994 [TAS]* *State Policy on Water Quality Management 1997 [TAS]* *Sewers & Drains Act 1954* *Water & Sewerage Industry Act 2008* *Water & Sewerage Industry (General) Regulations 2009*
Forests	▪ Clearance, >100 tonnes – Not Reported ▪ Clearance, threatened vegetation – Not Reported ▪ Development (Non-ESI) – No *Forest Practices Plan (FPP)* ▪ Works (Non-ESI) – Contrary to *Forest Practices Plan (FPP)*	Forest Practices Authority	*Forest Practices Act 1985[TAS]* *Forest Practices Code 2000 [TAS]*
	▪ Construction, State Forest – Unauthorised	Forestry Tasmania	
Heritage – Aboriginal	▪ Damage – Site / artefact , Unauthorised ▪ Destruction – Site / artefact, Unauthorised	DPIPWE Aboriginal Heritage	*Aboriginal Relics Act 1975 [TAS]*
Heritage – European	▪ Damage – Building, Unauthorised ▪ Damage – Place / Site, Unauthorised ▪ Damage – Trees / Gardens, Unauthorised ▪ Destruction – Any, Unauthorised	Tasmanian Heritage Council	*Historic Cultural Heritage Act 1995 [TAS]*
National Parks	▪ Development – Unauthorised ▪ Maintenance – Unauthorised	DPIPWE Parks & Wildlife	*National Parks and Reserves Management Act 2002 [TAS]* *World Heritage Management Plan (EPBC)*

INCIDENT TYPE		AUTHORITY	APPLICABLE LEGISLATION
Private Reserves	▪ Development – Unauthorised ▪ Maintenance – Unauthorised	DPIPWE Parks & Wildlife	*Nature Conservation Act 2002 [TAS]*
Private Sanctuary	▪ Development – Unauthorised ▪ Maintenance – Unauthorised	DPIPWE Parks & Wildlife	*Nature Conservation Act 2002 [TAS]*
RAMSAR Wetlands / CTH Land / Migratory Species	▪ Discharges / Pollution ▪ Damage, harm or destruction ▪ Development – Unauthorised ▪ Maintenance – Unauthorised	DPIPWE Parks & Wildlife	*Environment Protection & Biodiversity Conservation Act 1999 [CTH]*
Reserves	▪ Development – Unauthorised ▪ Maintenance – Unauthorised	DPIPWE Parks & Wildlife	*National Parks and Reserves Management Act 2002 [TAS]*
Spills / Pollution / Loss of Containment	▪ On Land – Chemical, > 1L or 1Kg ▪ On Land – Oil, > 20L ▪ On Water – Any type, any volume ▪ To Atmosphere – SF6 (any volume) ▪ Sediment, >10 tonnes	DPIPWE EPA Division	*Environmental Management & Pollution Control Act 1994 [TAS]*
Telecommunications	▪ Construction – No Planning Approval ▪ Construction – Impact on Sensitive areas, Unauthorised ▪ Construction of Overhead Infrastructure, Unauthorised ▪ Construction – Assets exceed size/dimension limits	Local Councils DPIPWE	*Land Use Planning & Approvals Act (LUPAA) 1993 [TAS]* *Environmental Management & Pollution Control Act 1994 [TAS]* *Telecommunications Act 1997 [CTH]* *Telecommunications (Low-impact Facilities) Determination 1997*

INCIDENT TYPE		AUTHORITY	APPLICABLE LEGISLATION
Threatened Fauna	▪ Damage contrary to Conservation Covenant ▪ Damage contrary to Land Agreement ▪ Damage to Habitat ▪ Destruction / harm to individuals ▪ Interaction with Infrastructure	DPIPWE Threatened Species Unit	*Threatened Species Protection Act 1995 [TAS]* *Environment Protection & Biodiversity Conservation Act 1999 [CTH]*
Threatened Flora	▪ Damage contrary to Conservation Covenant ▪ Damage contrary to Land Agreement ▪ Destruction / harm to individuals, Unauthorised ▪ Damage to Vegetation Community	DPIPWE Threatened Species Unit	*Threatened Species Protection Act 1995 [TAS]*
World Heritage Areas	▪ Unauthorised Development ▪ Unauthorised Maintenance	DPIPWE Parks & Wildlife	*Environment Protection & Biodiversity Conservation Act 1999 [CTH]* *World Heritage Management Plan (EPBC)*

v

Appendix H – Flowchart to determine notification requirements for shock or electrocution incidents



Other requirements:

- Notification should be attention to the Secretary.
- Fully reported in writing to the Secretary, within 21 days of the accident, containing details of the accident, the reasons for the accident and any remedial actions needed, and
- The site of a serious electrical accident must not be interfered with, unless it is necessary to provide medical or other assistance, to protect life or property, or authorised officer permits. For example, this includes isolating and where required, earthing.

Other requirements:

- Written notification using their Incident Notification Form within 48 hours of calling WorkSafe Tasmania.
- The incident site is not to be disturbed until an inspector arrives at the site, or any earlier time that an inspector directs. Exemptions include making the site safe.

*Considered a *serious electrical accident* by the EISA Act 1997 and WorkSafe Tasmania. Notification and reporting to WorkSafe is deemed to meet the requirements under the Act.

∞ Considered a dangerous incident under the WHS Act and Regulations 2012. Fatalities, serious injuries and serious illnesses are also required to be notified under the Act.

◊ Instances where workers or other people have reported minor electric shocks (i.e. “tingles”) or do not require “medical attention” after receiving a minor shock are to be reported to TechSafe and do not need to be notified to WorkSafe Tasmania.

Described by Electricity Standards and Safety *as outside the intent of the mandatory notify electric shock and serious electrical accidents.*

“Medical attention” is defined by Building Standards and Occupational Licensing for TasNetworks as Treatment by a trained medical professional due to physiological or psychological effects sustained as a result of a discharge of electricity or contact with live electrical parts, in association with:

- *An admission to hospital (but not including an initial assessment within the emergency department of a hospital)*
- *Administering or prescribing of medication in association with an injury*
- *Monitoring of an injury or physiological effect (e.g. irregular heart beat)*
- *The bandaging or dressing of an injury (e.g. burn dressing)*

It does not include a precautionary check-up by a trained medical professional, including an assessment of any physiological or psychological effects that do (or did) not require any further attention or treatment e.g. an ECG test or skin condition or muscle assessment.

It is the intent of the above clarification to provide common examples; other scenarios may exits that may or may not be included in term “medical attention”.

Information used in this flowchart:

- *http://www.justice.tas.gov.au/building/electrical_standards/electrical_incidents_and_accidents*
- *http://worksafe.tas.gov.au/industry_and_safety/topics/subject/incident_notification*
- *http://www.safeworkaustralia.gov.au/sites/swa/about/publications/pages/incident-notification-fact-sheet*
- *http://recordpoint.tnad.tasnetworks.com.au/_layouts/15/RecordPoint/RecordProcessor.aspx?Operation=OpenPermaLink&Key=R0000135125|Record*

http://teamzone.tnad.tasnetworks.com.au/health-safety-and-environment/Shared%20Documents/Incident%20Investigation%20Templates%20and%20Notification%20Form%20-%20Safety/Notifiable%20incident%20-%20correspondence%20with%20WST%20and%20WorkSafe.msg