

Executive Safety Incident Report

Review of 6 incident(s)

Prepared for: Executive Safety Board · Prepared by: Safety & Risk Office · Reporting period: Year-to-Date

Executive summary

This review covers 6 workplace incident(s): 0 fatality-class event(s) and 3 serious injuries or serious-injury risks, plus 3 other event(s). Every event involved preventable factors. The pattern points to enterprise-level weaknesses rather than isolated operator error, with the highest exposures in mobile plant, machinery interaction, vehicle movement, work at height, stored materials and chemical transfer.

Key metrics

6 high-severity incidents: 0 fatalities and 3 serious injuries or serious-injury risks. 3 involved high-risk machinery or mobile plant. 3 included a procedural failure; 1 required engineering redesign. 1 involved communication failures during plant or vehicle movement.

Systemic findings

- Critical controls were absent, ineffective or not verified, particularly guarding, isolation and exclusion zones.
- Competency and authorisation controls were insufficient for several high-risk tasks.
- Pre-start inspections, ground assessments and equipment-condition checks were inconsistently applied.
- Emergency equipment and physical safeguards were not always positioned for the foreseeable risk.

Control response

Immediate containment and corrective actions have been completed for the reviewed incidents, including machinery isolation, guarding and lockout improvements, exclusion-zone controls, revised loading and movement protocols, upgraded PPE and eyewash coverage, ground-stability checks, attachment inspections and targeted refresher training. Effectiveness reviews report sustained compliance and no repeat events within the reviewed period.

Incident severity

Category	Count	%
Fatalities	0	0%
Serious injuries	3	50%
Other injuries / near miss	3	50%

Risk profile

Indicator	Count
High-risk machinery involved	3
Chemical exposure	1
Incidents with procedural failure	3
Incidents requiring engineering redesign	1
Incidents involving communication failure	1

Systemic weakness indicators

Systemic weakness
Lockout/Tagout failures
Guarding deficiencies
PPE selection errors
Lack of exclusion zones
Inadequate operator competency verification

Incident review

Incident 1 — Entrapment in Harvester Attachment (Serious Injury)

Description	A worker's leg became trapped in rotating harvester components while clearing debris with the machine still live.
Root cause	Inadequate guarding and no lockout/tagout before accessing moving equipment.
Immediate containment	Machine isolated, area secured, and the injured worker transported to hospital.
Corrective action	Install fixed guards, implement lockout/tagout, and retrain operators before the next harvest cycle.
Preventive action	Guarding pre-start checks, warning signage, and quarterly isolation audits.
Effectiveness review	Controls verified on three consecutive shifts; no repeat access to live components.
Closure notes	Closed after effectiveness review and operator competency sign-off.

Action	Status	Priority	Due date
Verify CAPA close-out — Entrapment in Harvester Attachment	Active	high	2026-09-05

Incident 2 — Unattended contractor in restricted plant room (Near Miss)

Description	A contractor was found in the plant room without an escort or logged access request.
Root cause	Escort sign-in was not enforced at the loading-dock entrance.
Immediate containment	Contractor escorted out; access logs reviewed for other unauthorised entries.
Corrective action	Badge reader installed and contractor access policy reissued.
Preventive action	Quarterly access-log audit added to the security checklist.
Effectiveness review	No repeat unescorted entries in 30 days.
Closure notes	Closed after badge-reader verification.

Action	Status	Priority	Due date
Verify CAPA close-out — Unattended contractor in restricted plant room	Active	high	2026-08-28

Incident 3 — Near-miss: forklift and pedestrian in loading bay (Near Miss)

Description	A forklift operator braked hard to avoid a pedestrian who crossed an unmarked walkway.
Root cause	Walkway markings had worn away and no exclusion zone was enforced during loading.
Immediate containment	Loading paused and pedestrians redirected pending temporary barriers.
Corrective action	Repaint pedestrian routes and install physical barriers at the bay entrance.
Preventive action	Weekly walkway inspection added to the supervisor checklist.

Action	Status	Priority	Due date
Repaint pedestrian routes and install physical barriers at the bay entrance	In progress	high	2026-09-20

Action	Status	Priority	Due date
Weekly walkway inspection added to the supervisor checklist.	open	medium	2026-09-29

Incident 4 — Chemical splash during transfer (Serious Injury Risk)

Description	Two operators received chemical splash to gloves and apron during a corrosive transfer.
Root cause	Transfer procedure did not require a closed coupling or face shield for this product.
Immediate containment	Eyewash used, product isolated, and the store locked pending investigation.
Corrective action	Specify closed couplings and mandatory face shield for corrosive transfers.
Preventive action	Add the product to the high-hazard transfer register with a competency gate.

Action	Status	Priority	Due date
Specify closed couplings and mandatory face shield for corrosive transfers.	open	high	2026-09-24
Add the product to the high-hazard transfer register with a competency gate.	open	medium	2026-09-29

Incident 5 — Overnight false fire alarm — evacuation held (Near Miss)

Description	A smoke detector triggered a full evacuation; the brigade found dust ingress, not fire.
Root cause	Detector head overdue for cleaning in a high-dust aisle.
Immediate containment	Brigade confirmed no fire; detector isolated pending service.
Corrective action	Clean and recertify all detector heads in DC2.
Preventive action	Bring detector servicing onto a 90-day cycle.

Action	Status	Priority	Due date
Confirm preventive control — Overnight false fire alarm — evacuation held	done	medium	2026-09-12

Incident 6 — Telehandler operated without exclusion zone (Serious Injury Risk)

Description	A telehandler worked adjacent to an open pedestrian route with outriggers not fully deployed.
Immediate containment	Plant stopped and a temporary exclusion zone established.
Corrective action	Mandatory outrigger check and physical barriers before lift.
Preventive action	Competency refresh for all telehandler operators this month.

Action	Status	Priority	Due date
Mandatory outrigger check and physical barriers before lift.	open	critical	2026-09-22
Competency refresh for all telehandler operators this month.	open	medium	2026-09-29

Executive recommendations

Priority 1 — Critical controls reset: enterprise-wide lockout/tagout enforcement, mandatory guarding verification, and exclusion-zone redesign across all sites.

Priority 2 — Competency and authorisation: re-certify all high-risk plant operators and formalise competency-based authorisation for chemical handling and work at height.

Priority 3 — Engineering controls: review machinery guarding and interlock adequacy; ground-stability engineering assessments for mobile plant zones; close access and equipment-integrity gaps.

Priority 4 — Leadership accountability: weekly critical-control checks by line leaders and monthly executive safety walk-throughs, with exceptions escalated until closed.

Executive direction required: endorse the four enterprise priorities, assign accountable owners and target dates, and review critical-control verification monthly until sustained compliance is demonstrated.

Review and approval

Prepared by: _____ Date: _____

Reviewed by: _____ Date: _____

Approved by: _____ Date: _____