

CONFIDENTIAL

BOARD REPORT

Critical Review of the Safety Management System

Notifiable incident at the [REDACTED] facility

Post-incident review

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Executive Summary

At the CEO's direction, this report examines failures in [REDACTED] safety management system following a serious notifiable incident at the [REDACTED] facility during the current [REDACTED] transition. On 14 January 2026, a second-year cadet sustained a serious crush injury to his forearm when the drill line drill head re-cycled while he reached in to clear a jammed lintel and swarf at the drop end. The line had not been isolated, no leading hand was on the floor at the time, and injuries required surgical intervention. The incident is notifiable under section 35 of the Work Health and Safety Act 2011 (Qld), and a formal response to the regulator is pending.

An assessment of [REDACTED]'s safety management system against the national standard (AS/NZS ISO 45001:2018) identified multiple interconnected failures across planning, execution, monitoring and corrective action, with the primary failure being a lack of competence verification for unsupervised high-risk work during the split-site transition. Additional system failures were identified and require further Board attention, as detailed in Table 1.

In this report, the Board is asked to endorse:

- A four-stage competency verification framework for all high-risk work tasks (Section 2.2).
- Funding to configure [REDACTED] existing quality and documentation systems as an e-competency register (Section 2.3).
- Quarterly safety performance reporting as a standing Board agenda item (Section 2.4).
- Further investigation and reporting on the remaining system failures identified in Section 1, Table 1.

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1. Critical Analysis of Systematic Failures

This report was commissioned following the CEO's directive to identify failures in [REDACTED] safety management system after a serious incident at the [REDACTED] during the [REDACTED] transition. On 14 January 2026, a second-year cadet sustained a serious crush injury to his forearm (Figure 1) when the drill line drill head re-cycled while he reached in to clear a jammed lintel and swarf at the drop end of the line. The line had not been isolated, the regular leading hand was absent from the floor, and dispatch pressure to complete a committed residential order was a contributing factor. The incident is notifiable under section 35 of the Work Health and Safety Act 2011 (Qld), and section 32 (category 2 offence) applies where the failure exposes an individual to a risk of serious injury or death.



Figure 1. Drill line drop end where the cadet reached in to clear a jammed lintel and swarf without isolating the line. No leading hand was on the floor at the time, the revised isolation procedure had not been inducted, and competency sign-off for unsupervised operation had been deferred twice during the split-site transition. Source: CTV Footage still.

[REDACTED] safety management system is not entirely absent. Documented SWMS and isolation procedures for the drill line exist and are current in their revised form, training attendance records are held, and the emergency response on the day of the incident functioned as intended. However, these pockets of partial compliance mask five serious failures that span the full cycle of planning, execution, monitoring and corrective action.

Assessed against AS/NZS ISO 45001:2018 (Standards Australia & Standards New Zealand 2018) and its Plan-Do-Check-Act framework [REDACTED] et al. 2022), each failure reinforced the others, as mapped in Table 1 and illustrated in Figure 2.

Stage	What Went Wrong	ISO 45001 Clause	What Was Missing	Legal Exposure
Planning	No pre-transition risk assessment for split-site operations	Cl. 6.1.2; Cl. 8.1.3	No management-of-change process for [REDACTED]; no documented transition risk register	ss 19, 20; s 19(3)(c); Reg 36
Execution	Worker competency not verified for unsupervised high-risk work	Cl. 7.2; Cl. 8.1	Cadet's sign-off for unsupervised drill line operation deferred twice; induction to revised isolation procedure deferred to [REDACTED] no competency register gateway	s 19(3)(f); s 27(5)(e)(f)
Execution	Communication of updated procedures failed across sites	Cl. 7.4	Revised isolation procedure filed on [REDACTED] document system; [REDACTED] crew still operating from superseded paper manual	s 19(3)(f); Reg 39
Monitoring	Consultation with workers not conducted	Cl. 5.4; Cl. 9.3	No formal consultation on transition psychosocial and workload impacts since the merger with Steelbuilders was announced	s 47; s 27(5)(f)
Correction	Safety oversight degraded during transition	Cl. 10.2	Toolbox talks reduced from weekly to fortnightly; foreman attending [REDACTED] three days per week; no corrective action tracking	ss 27(5)(c), 27(5)(d)

Table 1. Safety system failures identified at [REDACTED] mapped against the ISO 45001 standard and relevant legal provisions. Source: Author created (Standards Australia & Standards New Zealand 2018; Safe Work Australia 2024; WHS Act 2011 (Qld); WHS Regulation 2011 (Qld)).

Of these five failures, one has the strongest direct connection to the crush injury: no one verified whether the cadet was competent to operate the drill line unsupervised, and no one ensured he had been inducted to the revised isolation procedure before the line was started that afternoon. His competency sign-off for unsupervised operation had been scheduled and then deferred twice during the transition, and his induction to the revised isolation procedure was recorded as "to be completed at [REDACTED]" Every other system failure identified above (Table 1) was enabled or amplified by this competence gap (ISO 45001, Cl. 7.2).

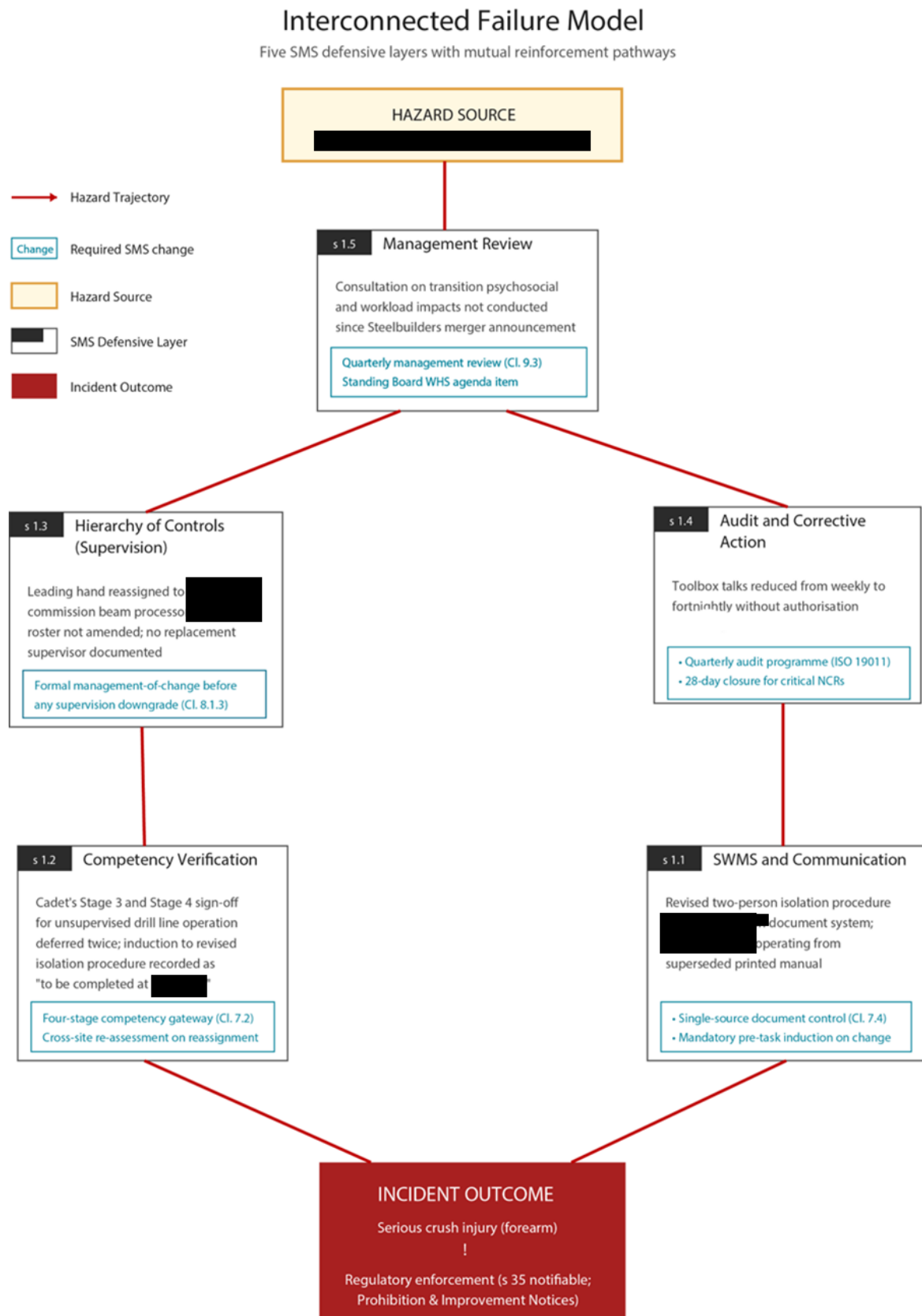


Figure 2. Interconnected Failure Model: five SMS defensive layers with mutual reinforcement pathways, showing how each identified failure enabled or compounded the others across all PDCA phases, culminating in the incident outcome. Required SMS changes (green) indicate the proposed controls detailed in Section 2. Source: Author created [REDACTED] et al. 2007; [REDACTED] & [REDACTED] 2025; [REDACTED] et al. 2022; Standards Australia & Standards New Zealand 2018).

1.1 The Core Failure: No One Verified Whether the Cadet Was Competent

The cadet was assigned to unsupervised operation of the [REDACTED] drill line on the afternoon of 14 January 2026. He held no verified competence for unsupervised line operation, he had not been inducted to the revised isolation procedure, and he was not under the direct supervision of a competent leading hand at the time of the incident. No one at any level of the organisation confirmed he was capable of safely performing this work before he was assigned to it.

Under section 19(3)(f) of the WHS Act, [REDACTED] is required to ensure workers receive the information, training, instruction and supervision necessary for their safety, and section 27 requires officers to exercise due diligence by ensuring appropriate resources and processes exist to verify competence.

AS/NZS ISO 45001:2018, Clause 7.2, sets out what a competent organisation must do: identify the competence each role requires, confirm workers hold that competence through education, training or experience, take action to close any gaps, and keep documented evidence (Standards Australia & Standards New Zealand 2018). None of those steps occurred in respect of this cadet before he was placed on the drill line without supervision.

What the Standard Requires (ISO 45001, Cl. 7.2)	What [REDACTED] Actually Had in Place
Define what competence each role requires (Cl. 7.2(a))	Competency requirements for unsupervised drill line operation were not documented as a gateway control; no updated competency matrix covered the split-site transition period, and roles on each site were not re-baselined when personnel were reassigned between [REDACTED] and [REDACTED]
Confirm workers actually hold that competence (Cl. 7.2(b))	The cadet held no verified competence for unsupervised drill line operation; his Stage 3 and Stage 4 sign-off was deferred twice during the move, and his induction to the revised isolation procedure was recorded as "to be completed at [REDACTED]"
Fill competence gaps through training, mentoring or hiring (Cl. 7.2(c); WHS Act s 19(3)(f))	The regular leading hand, who had previously mentored the cadet, was reassigned to commission the [REDACTED] beam processor; no replacement mentor was allocated to the [REDACTED] cadet, and supervised practice effectively ceased
Keep documented proof of competence on file (Cl. 7.2(d))	No centralised electronic competency register; [REDACTED] continued to operate from a superseded paper manual while the updated version was held only on the [REDACTED] document system

Table 2. Clause 7.2 Competence: ISO 45001 requirement versus [REDACTED] practice on 14 January 2026. Source: Author created (Standards Australia & Standards New Zealand 2018; WHS Act 2011 (Qld); WHS Regulation 2011 (Qld)).

The reassignment of the regular leading hand to commission the [REDACTED] beam processor illustrates the systemic nature of this failure. The leading hand was competent through years of experience, and in practice, he had become the system of work on the [REDACTED] drill line. When he was moved, that competence left with him because it was never documented, transferred, or systematically verified [REDACTED] 2018). The cadet then inherited a high-risk task without the

competence and supervision that had previously kept it safe. This is precisely the kind of single point of failure that the competence requirements in ISO 45001 (Cl. 7.2) are designed to prevent (Standards Australia & Standards New Zealand 2018; [REDACTED] et al. 2022).

The remaining four failures in Table 1 are significant and require separate attention. However, each was made worse by the competence gap. A current isolation procedure is ineffective if the worker has not been inducted to it, a revised SWMS is ineffective if it has been filed on a site the worker does not access, and a reduced toolbox talk cadence cannot carry information the cadet was never trained to receive. Of all five failures, the absence of competence verification is the most directly connected to the crush injury, the most straightforward to prove, and the most readily fixed. It also carries serious legal consequences for the organisation. [REDACTED] faces potential prosecution under sections 19, 20 and 32 of the WHS Act, and Board members may face personal liability under the officer due diligence obligations in section 27 (Work Health and Safety Act 2011 (Qld)).

2. Proposal: Overhaul of Competence Verification (Clause 7.2)

2.1 The Competence Gap at [REDACTED]

As established in Section 1.1, [REDACTED]'s current training system records attendance at classroom and induction sessions. That satisfies Stage 1 of the four-stage framework proposed below to verify competence (Standards Australia & Standards New Zealand 2018; [REDACTED] et al. 2006; [REDACTED] et al. 2016). Stages 2 to 4, workplace instruction, supervised practice, and formal assessment, are not consistently applied, and during the current split-site transition the gateway between course attendance and unsupervised operation has effectively collapsed. The result is that a cadet with no verified competence in the revised isolation procedure, and with supervised practice interrupted by his mentor's reassignment, was permitted to operate the drill line unsupervised. The proposal below redesigns how [REDACTED] verifies worker competence before assigning high-risk work, bringing the organisation into compliance with AS/NZS ISO 45001:2018 (Cl. 7.2) and section 19(3)(f) of the WHS Act.

2.2 Four-Stage Competency Verification Framework

The proposed framework requires every worker assigned to a high-risk task to complete four mandatory stages before commencing work (Figure 3). Attending a course or reading a revised procedure does not mean a worker can do the job safely. The current national standard (AS/NZS ISO 45001:2018) makes this distinction clear: training alone, which was all the previous standard (AS/NZS 4801) required, is necessary but not sufficient (Standards Australia & Standards New Zealand 2018). Competence requires training plus instruction plus supervised practice plus assessment. [REDACTED] et al. (2006) found that more engaging, hands-on training methods produce stronger safety outcomes than passive instruction alone, [REDACTED] et al. (2012) confirmed that training effectiveness depends on methods beyond classroom delivery, and [REDACTED] et al. (2018) found that active training methods produced substantially stronger awareness outcomes than passive methods alone.

Stage 1: (Training): Classroom or online instruction covering the theoretical knowledge required for the task, including the current isolation procedure, the current SWMS, and the applicable WHS obligations. This is what [REDACTED] currently records.

Stage 2: (Workplace Instruction): Hands-on instruction at the workstation, specific to the task and the equipment actually in use on the worker's assigned site. Each session is logged with date, instructor, equipment and content covered, and is re-run whenever the worker is reassigned between [REDACTED] and [REDACTED].

Stage 3: (Supervised Practice): The worker performs the task under direct observation by a competent supervisor. The supervisor signs off when the worker demonstrates safe and effective performance. A worker who has attended a course but cannot perform the task safely does not proceed. Critically, if the nominated supervisor is reassigned, Stage 3 pauses until a replacement is confirmed.

Stage 4: (Formal Assessment): Assessment under both normal and emergency conditions, including isolation, jam clearance and guard removal scenarios, documented and recorded in the electronic competency register (Standards Australia & Standards New Zealand 2018). Annual renewal applies to all high-risk task competencies, and interim re-assessment is triggered by any change of site, equipment, or procedure.

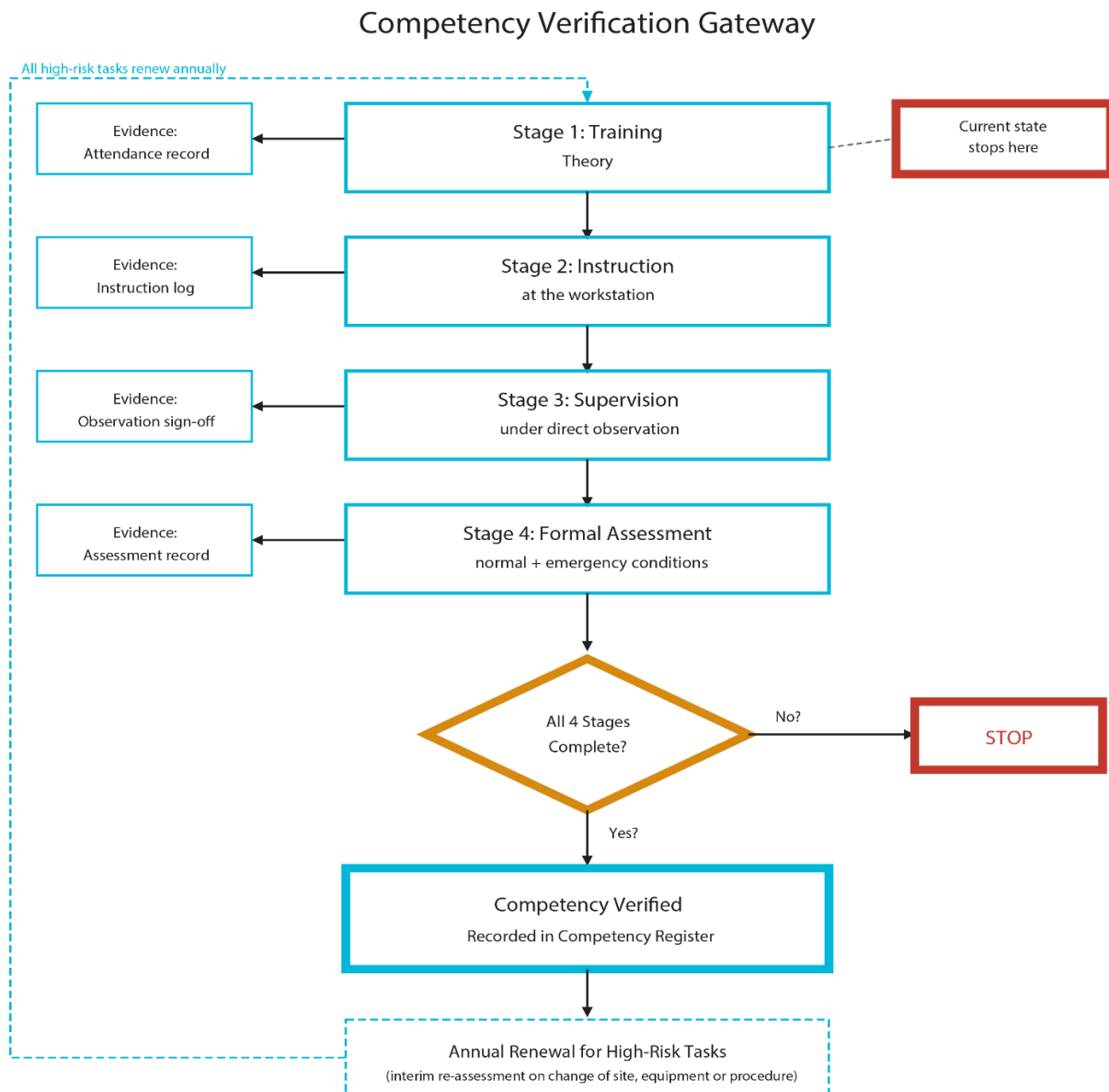


Figure 3. How competence will be verified before a worker is assigned to high-risk work. Workers must complete all four stages before they can be assigned to a task. [REDACTED] currently stops at Stage 1 (course and induction attendance only). The annual renewal cycle, with interim re-assessment on any change of site, equipment or procedure, ensures competence does not lapse over time or across the [REDACTED] transition.

2.3 Implementation at [REDACTED]

The framework will be hosted on [REDACTED]'s existing quality and documentation systems, which already hold training attendance records, SWMS, ITPs, welder qualifications and the supporting Form 16, WPS, PQR, MDR and NDT documentation. The specific platform currently used for document control and training records is to be confirmed with the HR and IT functions as part of the implementation plan, and the competency register will be configured within that same environment rather than procured separately. This is a practical advantage: the Board can demonstrate progress without a lengthy tender process, and the existing attendance and qualification data provides an immediate baseline for Stage 1 records.

Competency verification becomes a mandatory gateway: no worker is assigned to high-risk work unless the register confirms completion of all four stages for the relevant task category on the site where the work is performed (Standards Australia & Standards New Zealand 2018). Given the current split-site operation, where approximately 60 per cent of plant and personnel have already relocated to [REDACTED] and the balance remain at [REDACTED] to complete committed residential orders, this gateway protects the organisation every time a worker is reassigned between sites, inducted to a new machine, or asked to operate under a revised procedure. The system that collapsed when the regular [REDACTED] leading hand was reassigned to commission the [REDACTED] beam processor cannot collapse again, because competence is no longer stored in one person's head; it is documented, verified and transferable ([REDACTED] et al. 2022).

Workers will be consulted in developing competency requirements for each high-risk task category, consistent with the consultation obligations under section 47 of the WHS Act ([REDACTED] 2008). This consultation will also formally address the transition-related psychosocial and workload concerns that, per Section 1, had not been consulted on since the merger with Steelbuilders was announced. Competency requirements will be reviewed annually and updated whenever tasks, equipment, sites or regulatory requirements change, including at each major milestone of the [REDACTED] relocation (Standards Australia & Standards New Zealand 2018).

2.4 KPIs and Assurance

The following measures are designed to give the Board early warning that competence controls are working, before something goes wrong ([REDACTED] & [REDACTED] 2015; [REDACTED] & [REDACTED] 2022).

KPI	Target	Frequency	Responsible	Reporting
% of high-risk workers with all 4 stages verified for their current site	100%	Ongoing	Site Managers [REDACTED] and [REDACTED]	Monthly to Safety Manager
Average time from Stage 1 to Stage 4 completion	≤90 days	Monthly	Safety Manager	Quarterly to Board
% of competency renewals and cross-site re-assessments completed on schedule	100%	Monthly	Safety Manager	Quarterly to Board
Quarterly audit of the competency register (ISO 19011)	100% of audits completed	Quarterly	Safety Manager	Quarterly to Board

KPI	Target	Frequency	Responsible	Reporting
Board competency status report tabled	100% scheduled reports tabled	Quarterly	Executive General Manager	Standing Board agenda item

Table 3. Competence-focused KPIs. Source: Author created (Standards Australia & Standards New Zealand 2019; Safe Work Australia 2023; Comcare 2022; Comcare 2023; [REDACTED] & [REDACTED] 2015; [REDACTED] & [REDACTED] 2022).

The Board is asked to approve funding to configure [REDACTED]'s existing quality and documentation systems to host the competency register, audit findings, and renewal tracking, and to prioritise the cross-site re-assessment function so that no worker moves between [REDACTED] and [REDACTED] without a verified, site-specific competency record. A serious notifiable incident has already occurred. If these failures remain unaddressed, the organisation faces potential prosecution under sections 19 and 32 of the WHS Act, and individual officers, including Board members, may face personal liability under the due diligence obligations in section 27. Endorsing this framework now gives the Board a credible basis to engage the regulator on a formal resolution, such as an enforceable undertaking under Part 11 of the WHS Act, should that option be appropriate (Work Health and Safety Act 2011 (Qld)).

3. Conclusion

The cadet's crush injury on 14 January 2026 was not a single moment of poor judgment under dispatch pressure. It was the foreseeable result of assigning a second-year cadet to unsupervised operation of a high-risk drill line during a split-site transition, without verifying his competence, without inducting him to the revised isolation procedure, and without maintaining his supervised practice after his mentor was reassigned to commission the [REDACTED] plant (Work Health and Safety Act 2011 (Qld), s 19). Five interconnected system failures allowed it to happen [REDACTED] et al. 2022), with the absence of competence verification carrying the strongest causal connection to the crush injury and the most serious legal consequences for the organisation and its officers (Standards Australia & Standards New Zealand 2018). Additional system failures were identified and require further Board attention, as detailed in Table 1.

The proposed four-stage framework addresses this gap using [REDACTED]'s existing quality and documentation systems, supports compliance with section 19 and the officer due diligence obligations in section 27 (Work Health and Safety Act 2011 (Qld)), and ensures that what happened when the [REDACTED] leading hand was reassigned cannot happen again. The Board is asked to endorse the framework, approve the configuration of existing systems to host the competency register, and direct that safety performance reporting become a standing quarterly agenda item. A serious notifiable incident has already occurred. Early and decisive action on this framework is the strongest demonstration of the Board's commitment to meeting its safety obligations during the balance of the [REDACTED] transition. This is the most robust of protection systems against further incidents of the same kind.