

Chapter 5 INCIDENT INVESTIGATION

All incidents, regardless of size or impact need to be investigated. The process helps Sign Designs look beyond what happened to discover why it happened. This allows us to identify and correct shortcomings in our safety and health management programs. Most importantly, it enables us to identify and implement the corrective actions necessary to prevent future incidents. Incident investigations are focused on identifying and correcting root causes, not on finding fault or blame. All incidents will be investigated. The extent of the investigation will be determined by the seriousness of the incident.

Responsibility and Training

The Production Manager is responsible for conducting incident investigations for all manufacturing incidents. The Installation Manager is responsible for conducting incident investigations for all installation related incidents. These managers will then report to senior management, and all department heads, the results of the investigation. Continually asking “Why” will eventually get to the root cause of the incident.

Since field operations are performed by small crews of employees, the designated crew leader will be trained, and responsible for the initial steps in incident investigations in the field. The crew leader needs to understand all safety policies and processes, prepared to act to stabilize the situation with care of the injured employee as priority, and be completely familiar with the investigation procedure.

Required Incident Reporting

OSHA Incident Reporting – All recordable incidents need to be reported to OSHA, and to the jobsite client as follows:

- Work related fatalities are reported within 8 hours
- Inpatient hospitalizations, amputations, losses of an eye are reported within 24 hours

All other recordable incidents are reported on the OSHA 300A

Investigation Procedures

Sign Designs, Inc. uses a 4 step approach to investigate an incident. These steps are:

1. Preserve and Document the Scene
2. Collect Information
3. Determine the Root Causes
4. Implement Corrective Actions

Preserve and Document the Scene – Preserve the scene to prevent material evidence from being moved or altered. The investigator can use necessary equipment to preserve and document. Due to the nature of our business we usually have the necessary equipment with us. Following is a list of potentially useful equipment:

- ☒ Camera
- ☒ Video / Audio recorder
- ☒ Measuring devices in various sizes
- ☒ Clipboard and writing pad
- ☒ Pens, pencils, markers
- ☒ Graph paper
- ☒ Straight-edge ruler
- ☒ Incident investigation forms
- ☒ Flashlight
- ☒ Strings, stakes, warning tape
- ☒ Photo marking cones
- ☒ Personal Protective Equipment
- ☒ High visibility plastic tapes to mark off area
- ☒ First aid kit
- ☒ Latex gloves
- ☒ Identification tags
- ☒ Variety of tape: Scotch, masking, duct
- ☒ Hammer
- ☒ Chalk

Document the incident facts such as the date of the investigation and who is investigating. Essential to document the scene is capturing the injured employee's name, injury description, whether they are temporary or permanent, and the date and location of the incident. Investigators can also document the scene by video recording, photographing and sketching. In addition, the documentation should include a listing of people, equipment, and materials involved and a recording of environmental factors such as weather, illumination, temperature, noise, ventilation, and physical factors such as fatigue, age, and medical conditions.

Evidence such as people, positions of equipment, parts, and papers must be preserved, secured, and collected through notes, photographs, witness statements, flagging, and impoundment of documents and equipment.

Collect Information - Witness interviews and statements must be collected. Locating witnesses, ensuring unbiased testimony, obtaining appropriate interview locations, and use of trained interviewers should be detailed. The need for follow-up interviews should also be addressed.

Incident information is collected through interviews, document reviews and other means. In addition to interviews, investigators may find other sources of useful information. These include Equipment Manuals, Industry Guidance Documents, Company policies and records, Maintenance schedules, Records and logs, Training records, Audit and follow-up reports, Enforcement policies and records, Previous corrective action recommendations.

Interviews can often yield detailed, useful information about an incident. Since memories fade, interviews must be conducted as promptly as possible. The sooner a witness is interviewed, the more accurate and candid the statement will be. Many times, a witness will need to be re-interviewed.

Written incident reports should be prepared and include an incident report form and a detailed narrative statement concerning the events. The format of the narrative report may include an introduction, methodology, summary of the incident, investigations names, narrative of the event, findings and recommendations. Photographs, witness statements, drawings, etc. should be included.

Determine the Root Causes – Determining the root cause is finding the underlying reasons why the incident occurred. The actual incident may have been caused by a symptom of the real problem. *For example, a slip and fall on oil on the floor may not be an issue of why the oil was not cleaned, or the fact that the oil is there to begin with. It may be indicative of a poor vehicle maintenance program.* Correcting the root cause will prevent the incident from recurring.

To determine the root cause the investigator needs to continue to ask “why?” Eventually the root cause will surface. Once the root cause is determined, corrective action can be taken.

Implement Corrective Actions – An incident investigation is not complete until corrective action is taken. Implementation should entail program level improvements and will be supported by management. Changes in safety policies and process will be immediately to prevent a reoccurrence of the incident. Specific corrective actions address root causes directly. Other corrective actions can be general across the board improvements. Corrective action should result in revising safety policies and providing retraining of all employees. Changes in safety policies and process will be immediately to prevent a reoccurrence of the incident.

Information Collection Checklist

WHO?	WHERE?
<input type="checkbox"/> Who was injured? <input type="checkbox"/> Who saw the incident? <input type="checkbox"/> Who was working with the employee? <input type="checkbox"/> Who had instructed/assigned the employee? <input type="checkbox"/> Who else was involved? <input type="checkbox"/> Who else can help prevent recurrence?	<input type="checkbox"/> Where did the incident occur? <input type="checkbox"/> Where was the employee at the time? <input type="checkbox"/> Where was the supervisor at the time? <input type="checkbox"/> Where were fellow workers at the time? <input type="checkbox"/> Where were other people who were involved at the time? <input type="checkbox"/> Where were witnesses when incident occurred?
WHAT?	WHY?

<ul style="list-style-type: none"> <input type="checkbox"/> What was the incident? <input type="checkbox"/> What was the injury? <input type="checkbox"/> What was the employee doing? <input type="checkbox"/> What had the employee been told to do? <input type="checkbox"/> What tools was the employee using? <input type="checkbox"/> What machine was involved? <input type="checkbox"/> What operation was the employee performing? <input type="checkbox"/> What instructions had the employee been given? <input type="checkbox"/> What specific precautions were necessary? <input type="checkbox"/> What specific precautions was the employee given? <input type="checkbox"/> What protective equipment should have been used? <input type="checkbox"/> What protective equipment was the employee using? <input type="checkbox"/> What had other persons done that contributed to the incident? <input type="checkbox"/> What problem or questions did the employee encounter? <input type="checkbox"/> What did the employee or witnesses do when the incident occurred? <input type="checkbox"/> What extenuating circumstances were involved? <input type="checkbox"/> What did the employee or witnesses see? <input type="checkbox"/> What will be done to prevent recurrence? <input type="checkbox"/> What safety rules were violated? <input type="checkbox"/> What new rules are needed? 	<ul style="list-style-type: none"> <input type="checkbox"/> Why was the employee injured? <input type="checkbox"/> Why and what did the employee do? <input type="checkbox"/> Why and what did the other person do? <input type="checkbox"/> Why wasn't protective equipment used? <input type="checkbox"/> Why weren't specific instructions given to the employee? <input type="checkbox"/> Why was the employee in the position? <input type="checkbox"/> Why was the employee using the tools or machine? <input type="checkbox"/> Why didn't the employee check with the supervisor when the employee noted things weren't as they should be? <input type="checkbox"/> Why did the employee continue working under the circumstances? <input type="checkbox"/> Why wasn't the supervisor there at the time?
WHEN?	HOW?
<ul style="list-style-type: none"> <input type="checkbox"/> When did the incident occur? <input type="checkbox"/> When did the employee start on that job? <input type="checkbox"/> When was the employee assigned on the job? <input type="checkbox"/> When were the hazards pointed out to the employee? <input type="checkbox"/> When was the employee's supervisor last check on job progress? <input type="checkbox"/> When did the employee first sense something was wrong? 	<ul style="list-style-type: none"> <input type="checkbox"/> How did the employee get injured? <input type="checkbox"/> How could the employee have avoided it? <input type="checkbox"/> How could fellow workers have avoided it? <input type="checkbox"/> How could supervisor have prevented it - could it be prevented?

Incident Investigation Form

Section A: Information Step 1

Company Name: _____ Date: _____

Investigator (or) Team Name (s) and Titles:

Name Title

Section B: Incident Description/Injury Information Step 1 and Step 2

1) Name and Age of Injured Employee: _____

Use additional pages if needed

Section C: Identify the Root Causes: What Caused or Allowed the Incident to Happen? *Step 3*

The Root Causes are the underlying reasons the incident occurred, and are the factors that need to be addressed to prevent future incidents. If safety procedures were not being followed, **why were they not being followed?** If a machine was faulty or a safety device failed, **why did it fail?** It is common to find factors that contributed to the incident in several of these areas: equipment/machinery, tools, procedures, training or lack of training, and work environment. If these factors are identified, you must determine why these factors were not addressed before the incident.

Use additional pages if needed

Section D: Recommended Corrective Actions to Prevent Future Incidents *Step 4*

Use additional pages if needed

Section E: Corrective Actions Taken/ Root Causes Addressed *Step 4*

Use additional pages if needed

- A. "Near misses" and minor first aid incidents.
 - I. Any employee and witness is to report the incident to their immediate supervisor.
 - II. The immediate supervisor will determine with the employees the cause of the incident, the employee or employees responsible and discuss how the incident can be prevented in the future. (Second and future incidents involving the same employees require a written report to the employee's personnel file.)

- B. Injuries / Illnesses requiring more than first aid.
 - I. A loss requiring more than first aid is defined as any loss causing more than four hours off work and / or costing more than \$500.
 - II. More than first losses require a written report to the employee's personnel file.
 - III. Losses involving lost time, more than \$500 in cost, are to be posted and discussed with all employees with emphasis on cause and prevention.

- C. Procedures to follow after every incident:
 - I. The employee and immediate supervisor are required to provide a written report to the Safety Director within 24 hours.
 - II. The report shall identify the following:
 - A. Who was responsible and / or contributed to the loss?
 - II. What actually happened? (In detail.)
 - III. What caused the loss? (Be very specific.)
 - IV. Where did the loss occur? Location, address.
 - V. Why did the incident / loss occur?
 - VI. When did it occur?
 - VII. How will this incident / loss be prevented from happening in the future?