Incident Investigations Quiz

QUESTION

Why is it important for managers (supervisors) and employees to work together to create effective investigation programs’

ANSWER

The most effective investigations are conducted by a team in which managers and employees work together each bringing in a different perspective, understanding and knowledge. Working together will also encourage all parties to ‘own’ the conclusions and recommendations and to jointly ensure corrective actions are executed in a timely manner.

WHY IS IT RIGHT

Investigating a worksite incident- a fatality, injury, illness, or close call- provides employers and workers the opportunity to identify hazards in their operations and shortcomings in their safety and health programs. Most importantly, it enables employers and workers to identify and implement the corrective actions necessary to prevent future incidents.

ACCIDENT VERSUS INCIDENT

The term “accident” was often used when referring to an unplanned, unwanted event. To many, “accident” suggests an event that was random, and could not have been prevented. Since nearly all worksite fatalities, injuries, and illnesses are preventable, OSHA suggests using the term “incident” investigation.

PREVENTION

There are obviously situations in which workers must disturb an injury or fatality scene, including these:

- You are trying to save a worker’s life or relieve someone’s suffering following an incident.
- You are trying to prevent serious damage or loss of property following an incident.
- You are attempting to maintain access to essential services such as water, gas or electricity.

Otherwise, you should not be entering the scene unless you have authority to do so or the investigator has concluded his or her examination of the area and given permission for workers to regain access. Tampering with an accident/incident scene to make it look as though conditions were compliant with safety regulations is extremely risky, not to mention foolish. Safety investigators can interview witnesses, including victims who survive their injuries and quickly determine that you aren't telling the truth. A lie can snowball and if you continue the deception you can be caught under a legal avalanche. Don't become part of any cover-up if a coworker asks you to lie for him or her. You've got nothing to gain and everything to lose, including your job and possibly, your freedom.

If you are first on the scene of a workplace accident, help the injured person and call for emergency medical help if required. As soon as possible, contact your supervisor and report the incident. If you witnessed what happened, write down the details of what you saw and heard. Your observations will help investigators determine what happened and how to prevent a similar incident in future.

One of the biggest challenges when you are investigating an incident is sorting out the irrelevant information from the relevant information. More specifically ' determine what is relevant to what happened, how it happened, and especially why it happened.

One way to do this is by using a systematic approach to investigate all incidents that focuses on finding the root causes. Doing so, means you can implement relevant and meaningful corrective actions.

You can use this 4-step approach to guide you. It can also be used as a training tool for members of your investigation team.

Step 1 ' Preserve and Document the Scene

- After you have verified the scene is safe and victims are being care for, the first step in the investigation is to secure the incident site to prevent evidence from being moved, altered, or tampered with.
- If evidence goes missing or is messed with ' you are going to miss out on important clues on what caused the event.
- Use cones, tape, or barriers to physically block off the scene.
- You can use photos or videos to preserve and document the scene.

Document the incident facts:

- Date and time of incident
- Investigator
- Name/s of the injured
- Injury description
- Date, time, and location of incident

Step 2 ' Collect Information

Collecting information of events leading up to the incident, the incident itself, and other important information is necessary to establish a timeline, identify victims and witnesses, and begin to uncover the initial and root causes of the incident.

One of the primary ways to gather information is to interview witnesses and the victim/s. The sooner a witness or victim is interviewed, the more accurate and candid his/her statement will be.

Set the interviewee at ease:

1. Clearly state the purpose of the investigation and interview ‘ to learn how to prevent future incidents and not to blame any one person.
2. Interview witnesses separately ‘ as least initially. A witness might say more if they aren’t in the same room as their supervisor, co-worker, or the victim. The same is true for when you interview the victim.
3. Let employee know they have a right to have employee representative (e.g., labor representative) present, if available/appropriate.
4. Conduct interviews in a quiet space, although in some cases, it might make sense to interview someone at the scene of the incident. It might help them explain something better, jog their memory, or help you both put questions and responses in context.

Ready to Begin the Interview.

1. Ask the individual to recount their version of what happened and don’t interrupt them.
2. Take notes and/or record the responses; interviewee must give permission prior to being recorded.
3. Have paper and pen/pencil available for interviewee.
4. Ask clarifying questions to fill in missing information; repeat back to the interviewees the information obtained; and correct any inconsistencies.
5. Ask the individual what they think could have prevented the incident.

In addition to interviews, other sources of helpful information include:

- Equipment manuals
- Industry guidance documents
- Company policies and records
- Maintenance schedules, records and logs
- Training records (including communication to employees)
- Audit and follow’up reports
- Enforcement policies and records
- Previous corrective action recommendations

Step 3 ‘ Determine the Root Causes

The root causes are the underlying reasons why the incident occurred. Root causes generally reflect management, design, planning, organizational and/or operational failings (e.g., employees were not trained adequately; a damaged guard had not been repaired).

If you truly want to prevent a repeat of an incident, you must go beyond the easy surface causes **”worker was careless’ or ’employee didn’t follow the SOP.’** Focusing on the easy causes is a lazy way out and it won’t get you the answers you need to put meaningful corrective actions in place.

Remember: Investigations are not effective if they are focused on finding who to blame because they will stop at the initial incident and stop short of discovering the root causes.

Step 4 ‘ Implement Corrective Actions

Your investigation isn’t done until all the underlying causes of the incident have been identified and corrective actions are in place.

Some of the corrective actions will be quick and easy fixes; others may take more time and planning. Some may be specific and address a root cause directly and others may be sweeping improvements to the safety program in general.

Regardless, it is important that you communicate the corrective actions throughout the workplace. Employees pay attention to what management pays attention to and what management ignores. If you ignore incidents or don’t follow through on corrective actions your employees will get the message loud and clear. Employee safety isn’t valued.

WHY IS EVERYTHING ELSE WRONG

RECOMMENDATIONS

The most important final step in incident investigation is to come up with a set of well-considered **Recommendations** designed to prevent recurrences of similar incidents. **Recommendations** should:

- be specific
- be constructive
- identify root causes
- identify contributing factors

Resist the temptation to make **Only General Recommendation**s to save time and effort. For example, you have determined that a blind corner contributed to an incident. Rather than just **Recommending** “eliminate blind corners” it would be better to suggest:

- install mirrors at the northwest corner of building X (specific to this incident)
- install mirrors at blind corners where required throughout the worksite (general)

Never make **Recommendations** about disciplining a person or persons who may have been at fault. This action would not only be counter to the real purpose of the investigation, but it would jeopardize the chances for a free flow of information in future investigations.

In the unlikely event that you have not been able to determine the causes of an incident with complete certainty, you probably still have uncovered weaknesses within the process, or management system. It is appropriate that **Recommendations** be made to correct these deficiencies.

The Written Report

The prepared draft of the sequence of events can now be used to describe what happened. Remember that readers of your report do not have the intimate knowledge of the incident that you have so include all relevant details, including photographs and diagrams. Identify clearly where evidence is based on certain facts, witness accounts, or on the team’s assumptions.

If doubt exists about any particular part of the event, say so. The reasons for your conclusions should be stated and followed by your recommendations. Do not include extra material that is not required for a full understanding of the incident and its causes such as photographs that are not relevant and parts of the investigation that led you nowhere. The measure of a good report is quality, not quantity.

Always communicate your **findings and recommendations** with workers, supervisors and management. Present your information ‘in context’ so everyone understands how the incident occurred and the actions needed to put in place to prevent it from happening again.

Some organizations may use pre-determined forms or checklists. However, use these documents with caution as they may be limiting in some cases. Always provide all of the information needed to help others understand the causes of the event, and why the recommendations are important.

Recommendations Should Not:

- Propose any punitive actions.
- Propose briefing unit personnel on the accident. Such briefings are basic management responsibility and a normal function of safety managers and supervisors at all organizational levels.
- Recommend that a new policy, regulation, or standard operating procedure is needed when established guidelines exist but are not followed.