

## **Chapter DRAFT - Incident Investigation and Reporting**

### **Policy**

WEM is committed to appropriately investigating all near misses, accidents, and incidents according to their severity to find the root cause and make changes that prevent it from happening again.

### **Responsibilities**

Accident investigation and reporting is a responsibility shared between the Company and its employees. The HSE Manager is responsible for establishing the Incident Investigation and Reporting policy before there is an incident.

- The members of the investigation team must be trained, qualified, and competent. Members of the investigation team must understand their roles and responsibilities for incident response and be familiar with the techniques used in incident investigations. The most qualified investigator available will be assigned investigations as incidents occur.
- Completing training for Incident Investigation
- Promptly investigating incidents
- Implementing identified risk control measures to prevent recurrence of incidents
- Consulting with staff in relation to the measures to be taken to prevent the recurrence of incidents
- Reviewing hazard / incident reports to ensure that all recommendations are implemented
- Ensuring, as far as is reasonably practicable, that adequate financial provision and other resources are made available to institute the recommended actions

### **Safety Committee Responsibilities**

Safety committee members are encouraged to participate in investigations of incidents and assist with the development of measures to prevent their recurrence.

- Personnel must be trained in their roles and responsibilities for incident response and incident investigation techniques
- Training requirements related to incident investigation and reporting (Awareness, First Responder, investigation, and training frequency) should be identified in this program

### **Employee Responsibilities**

- Not placing themselves or others at risk of injury
- Reporting incidents to their supervisor or manager, and health and safety representative (if applicable), as soon as possible after the event

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- Participating in the development of appropriate risk control measures to prevent the recurrence of similar incidents
- Using risk control measures as required and any other action taken, which is designed to protect health and safety

### **Training**

All personnel will receive, as part of their training in avoiding and preventing accidents and injuries, instruction concerning their roles and responsibilities in the event of an accident or incident. This training should include:

- What qualifies as reportable accidents or incidents (and near-misses)
- Who should be contacted in the event of a reportable incident
- An explanation of the accident / incident investigation plan
- Incident investigation techniques and employee responsibilities during and after an incident / accident

### **Procedures**

WEM requires that the company designate qualified personnel to conduct investigations of incidents once the company is notified of the event. All incidents must be investigated. Incident investigations must take place as soon as is practicable after an incident occurs. All incidents must be investigated, the extent of the investigation should reflect the seriousness of the incident.

WEM will investigate all lost-time injuries. Fatalities and catastrophes must be reported to OSHA within 8 hours. Serious accidents like work-related injuries or illnesses that result in hospitalizations, amputations, or loss of an eye must be reported to OSHA within twenty-four hours of the incident. WEM management will report incidents involving company employees to the Owner Client (host facility) as soon as possible but no later than twenty-four hours. OSHA requires reporting of work-related incidents resulting in the death of an employee or the hospitalization of one or more employees. Owner clients require all incidents to be reported including, but not limited to, injuries, spills, property damage, fires, explosions, and vehicle damage.

Accidents and near miss incidents that result in personal injury, property damage, chemical spill, or other emergencies will be immediately reported to the assigned supervisor at the time of the event and Emergency Medical Service, Fire Department, or Hazmat Services will be immediately summoned. Such events will be investigated and documented on the appropriate Company form.

All forms will be fully completed and submitted to the Field Superintendent for review and for discussion at the next scheduled Safety Committee meeting. These investigations demonstrate the company's commitment to providing a safe and healthful work environment. Disciplinary Policy will be enforced.

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To ensure accidents are reported, employees must be encouraged to participate in the fact-finding process. The point emphasized must be that hazardous conditions and unsafe practices are an indication of a much bigger problem with a breakdown in the safety and health policy. The purpose of the accident investigation then becomes one that will uncover these system problems and provide solutions that will result in long-term corrective action.

It is important to gather facts and interview witnesses as soon as possible after an accident to ensure the most accurate information is being recorded. The efficiency of the corrective measures is determined by the accuracy of the information gathered. The best place to conduct an interview is wherever the employee being interviewed feels most comfortable. The most important interviewing technique to ensure accuracy is to listen.

Note: Consider the event, a serious accident, if an employee is admitted to a hospital for treatment or observation because of injuries suffered from a workplace accident.

### **On site first response**

Employees who could be first responders should be trained and qualified in first aid techniques to control the degree of loss during the immediate post-incident phase.

### **Preventing further loss**

After an immediate rescue, WEM will take actions to prevent further loss. For example:

- Maintenance personnel should be summoned to assess the integrity of building and equipment, engineering personnel to evaluate the need for bracing of structures, and special equipment / response requirements such as safe rendering of hazardous materials or explosives employed.

### **Secure the Accident / Incident Scene**

For a serious accident, the first action the accident team needs to take is to secure the accident scene so material evidence is not moved or removed. Material evidence tends to walk off after an accident. If the accident is quite serious, OSHA may inspect and require that all material evidence be marked and remain at the scene of the accident.

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### **Reporting Requirements**

Local reporting sequence of events are as follows.

#### **Teir 1 - Injuries**

If an accident involving property damage, fatal or serious injury, illness, or hospitalization of one (1) or more employees occur (OSHA recordable or reportable), the Field Superintendent will immediately notify the following persons and agency:

- Corporate Manager
- General Council
- HSE Manager
- The area OSHA office (must be notified within 8 hours)
- Safety Committee

#### **Teir 1 - Environment (Outside Containment)**

If an environmental incident occurs that must be reported to local, state, and / or federal agencies, the following people should be notified:

- Corporate Manager
- General Council
- HSE Manager
- Appropriate local, state and / or federal agencies
- Safety Committee

#### **Tier 2 - Minor Incident and Environment (Inside Containment)**

Minor incidents are not OSHA recordable or reportable. And spills are contained by engineered containment. Incident forms are completed by HSE Manager.

- Field Superintendent
- Safety Committee

#### **Tier 3 - Near Miss / Good catch / Non-Reportable Release**

Incidents that are not Teir 1 or 2. These are discussed in safety meetings. Incident forms are filed for retention requirements.

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### **Time elements of when incident should be reported**

WEM is required to verbally report incidents to OSHA within 8 hours of discovery. Incidents must be reported to owner client as soon as possible (or within 24 hours).

### **Reportable Incidents**

- injury, illness, death, hospitalization of employees
- spills, property damage, fires, explosions, vehicle damage

### **Accident / Incident Causes**

Accidents occur when hazards escape detection during preventive measures, such as a job or process safety assessment, when hazards are not obvious, or as the result of combinations of circumstances that were difficult to foresee. A thorough accident investigation may identify

previously overlooked physical, environmental, or process hazards, the need for new or more extensive safety training, or unsafe work practices.

The primary focus of any accident investigation should be the determination of the facts surrounding the incident and the lessons that can be learned to prevent future similar occurrences. The focus of the investigation should NEVER be to blame. The process should be positive and thought of as an opportunity for improvement.

### **When Accident / Incident Investigations Are Required**

As a rule, investigations should be conducted for:

- All injuries (even minor ones)
- All accidents with potential for injury
- Fires, explosions, spills, property and / or product damage situations
- All near miss where there was potential for serious injury

Near-miss and incident reporting and investigation allow you to identify and control hazards before they cause a more serious incident. Accident / incident investigations are a tool for uncovering hazards that either were missed earlier or hazards where controls were defeated. However, it is important to remember that the investigation is only useful when its objective is to identify root causes. In other words, every contributing factor to the incident must be uncovered and recommendations made to prevent recurrence.

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### **Accident / Incident Investigation Plan**

When a serious accident occurs in the workplace, everyone will be too busy dealing with the emergency at hand to worry about putting together an investigation plan, so the best time to develop effective accident investigation procedures is before the accident occurs. Part of an effective Accident and Incident Investigation Plan is to assign responsibilities.

The plan should include procedures that determine:

- Who should be notified of the accident
- Who is authorized to notify outside agencies? (fire, police, etc.)
- Who is assigned to conduct investigations
- Training required for accident investigators
- Who receives and acts on investigation reports
- Timetables for conducting hazard correction

### **Gather Information**

The next step is to gather useful information about what directly and indirectly contributed to the accident.

The proper equipment will be available to assist in investigating, writing equipment such as paper, pens, pens, measuring equipment, cameras, small tools, audio recorder, Personal Protective Equipment (PPE), marking devices such as flags, equipment manuals, etc.

- The following tools should be used to gather as much information as possible:
- Locate witnesses, ensuring unbiased testimony, and obtain appropriate interviewing location
- To ensure detailed interviews, interviewers must be trained
- Interview eyewitnesses as soon as possible after the accident
- Interview witnesses separately, never as a group
- Statements must be collected
- Interview other interested persons such as supervisors, co-workers, etc.
- Follow-up interviews with all witnesses
- Review related records such as: training records, disciplinary records, medical records, maintenance records, OSHA 300 log, safety committee records

Document the scene with photographs, video, or sketches and appropriate measurements.

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### **Evidence**

Initial Identification of evidence immediately following the incident will include a listing of People, equipment, and materials involved and a recording of factors such as weather conditions, illumination temperature, noise, ventilation, Etc. and physical factors such as age and medical conditions. Witness statements and interviews are also considered as evidence and it is required that they be collected as part of each investigation.

WEM must keep a collection of evidence, and ensure that it is preserved and secure. Evidence such as people, positions of equipment, parts, and papers must be preserved, secured, and collected through, notes, photographs, witness statements, flagging, and impounding of documents and equipment.

### **Developing a Sequence of Events**

Use the information gathered to develop a detailed description of the accident. Make sure the accident is documented in enough detail to enable an individual unfamiliar with the situation to envision the sequence of events. Do not just describe the accident itself; include a description of events that led to the accident.

### **Analyze the Accident / Incident**

The next step is to determine the cause(s) of the accident. This is the most difficult step because first, the events must be analyzed to discover the surface cause(s) for the accident, and then, by asking “why” until the root causes are uncovered. Remember, surface causes are usually obvious and not too difficult to determine. However, it may take a great deal more time to accurately determine the weaknesses in the management system, or root causes, that contributed to the conditions and practices associated with the accident.

### **Surface Causes**

The causes of accidents are those hazardous conditions and individual unsafe employee / manager behaviors that have directly caused or contributed in some way to the accident.

Hazardous conditions may exist in any of the following categories:

- Materials
- Machinery
- Equipment
- Tools
- Chemicals
- Environment

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- Workstations
- Facilities
- People
- Workload

It is important to know that the most hazardous conditions in the workplace are the result of unsafe behaviors that produced them. Individual unsafe behaviors may occur at any level of the organization.

Some example of unsafe employee / manager behaviors include:

- Failing to comply with rules
- Using unsafe methods
- Taking shortcuts
- Horseplay
- Failing to report injuries
- Failing to report hazards
- Allowing unsafe behaviors
- Failing to train
- Failing to supervise
- Failing to correct
- Scheduling too much work
- Ignoring worker stress

### **Root Causes**

The root causes for accidents are the underlying system weaknesses that have somehow contributed to the existence of hazardous conditions and unsafe behaviors that represent surface causes of accidents. Root causes always pre-exist surface causes. Inadequately designed system components have the potential to feed and nurture hazardous conditions and unsafe behaviors. If root causes are left unchecked, surface causes will flourish! Root causes may be separated into two categories:

#### **1) System design weaknesses**

Missing or inadequately designed policies, programs, plans, processes, and procedures will affect conditions and practices generally throughout the workplace. Defects in system design represent hazardous system conditions.

#### **2) System implementation weaknesses**

Failures to initiate, carry out, or accomplish safety policies, programs, plans, processes, and procedures. Defects in implementation represent ineffective management behavior.



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System design weaknesses: missing or inadequate safety policies / rules; training program not in place; poorly written plans; inadequate process; no procedures in place; develop preventive actions.

System implementation weaknesses: safety policies / rules are not being enforced; safety training is not being conducted; adequate supervision is not conducted; incident / accident analysis is inconsistent; lockout / tagout procedures are not reviewed annually.

### **Corrective Actions**

All the work done to this point culminates with recommendations to prevent similar accidents from happening in the future. Recommendations should relate directly to the surface and root causes of the accident. These recommendations should include recommended actions such as:

- Assigned responsibilities relative to the corrective actions
- Actions should be tracked to closure
- Engineering controls (for example, local exhaust ventilation or use of a lift assisting device)
- Work practice controls (for example, pre-plan work, and remove jewelry and loose-fitting clothing before operating machinery)
- Administrative controls (e.g., standard operating procedures or worker rotation)
- Personal protective equipment (for example, safety glasses or respirators)

It is crucial that, after making recommendations to eliminate or reduce the surface causes, that the same procedure is used to recommend actions to correct the root causes. If root causes are not corrected, it is only a matter of time before a similar accident occurs.

### **Written Incident Report**

Written incident reports should be prepared and include an incident report form and a detailed narrative statement concerning the event. The format of the narrative may include an introduction, methodology, summary of the incident, investigation board members names, narrative of the event, findings, and recommendations. Photographs, witness statements, drawings, etc. should be included. WEM will complete a written investigation report that includes immediate corrective actions to be taken as well as long-term actions that are required to prevent the recurrence of the incident.

### **Documentation and Communications of Lessons Learned**

Lessons learned should be reviewed and communicated. Changes to processes must be placed into effect to prevent recurrences or similar events. WEM will document all incident investigations in a written report that includes at a minimum, the description of the incident, evidence collected, an explanation as to the cause of the incident, and corresponding corrective actions.

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### **Summary**

A successful accident investigation determines not only what happened, but determines how and why the accident occurred. Investigations are crucial as an effort to prevent a similar or perhaps more disastrous sequence of events.

Research has shown that a typical accident is the result of many related and unrelated factors that somehow all come together at the same time. Usually, ten or more factors contribute to a serious accident. Although, this combination of factors normally makes an investigation very time consuming and resource intensive, the good news is that accidents can normally be prevented by removing only a few of the contributing factors.

All lessons learned must be reviewed and communicated to all company employees to prevent recurrence of the incident or those similar.

**WEM HSE**

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**Employee Incident Report**

Name	
Date	
Work Site	
Manager / Supervisor	

Incident	
Action Taken	

Employee Signature	
Date	

Supervisor Signature	
Date	

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### **Investigation Report**

The Investigation Report will include the following elements (See safety files for examples):

- Summary
  - Employee Name(s)
  - Date of Incident
  - Time of Incident
  - Type of Incident
  - Date of Investigation
  - Investigator
  - Authority
- Conclusion
- Recommendation / Investigative Note
- Incident
- Witness Statements
- Appendix
  - Attachments
- Certification
  - Investigator's Signature
  - Printed Name
  - Date
  - Approving Official's Signature
  - Printed Name
  - Date

**WEM HSE**

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**Training Record**

Trainer	
Signature	
Date	

Content of Training

Attendees (please print)
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