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Accident/Incident Investigation Plan

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Definitions

Accident: An undesired event that results in personal injury or property damage.

Incident: An unplanned, undesired event that adversely affects completion of a task.

Near Miss: Incidents where no property was damaged and no personal injury was sustained, but where given a slight shift in time or position, damage and/or injury easily could have occurred.

When to Conduct an Investigation

1. All accidents/incidents should be investigated upon notification, even a near miss.
2. Investigations and discovering contributing factors to accidents/incidents/near misses are a tool for uncovering hazardous activities and thereby preventing future incidents.
3. The objective in any investigation should be to identify root causes and not setting blame.

Who Should Investigate

Typically the supervisor responsible for the area or activity will investigate. They may seek assistance in conducting the investigation from the Security & Safety Director and this person will be responsible to review any results. They may involve members of the safety committee for their insight as this will assist them in better understanding hazards throughout the college. This may also lend more credibility to the outcome.

Steps in an Investigation Process

The investigation process should begin after arranging for first aid or medical treatment for the injured person(s). In getting started, remind everyone involved—especially workers— the investigation is to learn and prevent, not find fault. Steps of the investigation process include:

1. Call or gather the necessary person(s) to conduct the investigation and obtain the investigation kit.
2. Secure the area where the injury occurred and preserve the work area as it is.
3. Identify and gather witnesses to the injury event.
4. Interview the involved worker as soon as practical.
5. Interview all witnesses.
6. Document the scene of the injury through photos or videos.
7. Complete the investigation report (contained in this plan).

8. Use results to improve and prevent future injuries and illnesses before they result in incidents.

9. Ensure follow-up on completion of corrective actions.

The Documented Investigation Process

As with many processes, preparation and documentation are crucial. The investigation should answer the questions, who, what, when, where, why, and how. The investigation must focus on facts not opinions. Thoroughly review all facts, fault may not be with the injured worker, but may be faulty processes or equipment or supervisory or administrative issues. The investigation procedure should detail:

- Who conducted and participated in the investigation
- Type of incident(s) investigated
- Information collected
- Identification of causal factors (often referred to as root causes)
- Determination of corrective actions
- Tracking completion of corrective actions

Who is involved - Normally, the investigation is conducted by the injured worker's immediate supervisor. However, assistance can also be provided by the Security & Safety Director, or Safety Committee Members. In cases involving a fatality, South Central College Administration and or Minnesota State System personnel may also be involved. Those participating in the investigation would include the injured worker, witnesses to the incident or events preceding it, and the injured worker's immediate supervisor if some other person is conducting the investigation. The injured employee may also request the presence of an employee representative during the interview if contractual agreements are in place.

What gets investigated - Any incident resulting in a fatality or serious injury should be thoroughly investigated. To obtain the best possible data to aid in predicting and preventing future incidents, it is also recommended that all recordable, first aid and near miss/close call incidents be investigated.

Information to collect - The type of information that should be collected during the investigation process includes:

- Worker characteristics (age, gender, department, job title, experience level, tenure in company and job, training records, and whether they are full-time, part-time, seasonal, temporary or contract)
- Injury characteristics (describe the injury or illness, part(s) of body affected and degree of severity)
- Narrative or bulleted format to describe and articulate the sequencing of events (location of incident; complete sequence of events leading up to the injury or near miss; objects or substances involved in event; conditions such as temperature, light, noise, weather; how

injury occurred; whether preventive measure had been in place; what happened after injury or near miss occurred)

• Characteristics of equipment associated with incident (type, brand, size, distinguishing features, condition, specific part involved)

• Characteristics of the task being performed when incident occurred (general task, specific activity, posture and location of injured worker, working alone or with others)

• Time factors (time of day, hour in injured worker's shift, type of shift, phase of worker's day such as performing work, break time, mealtime, overtime, or entering/leaving facility)

• Supervision information (at time of incident whether injured worker was being supervised directly, indirectly, or not at all and whether supervision was feasible)

• Causal factors (specific events and conditions contributing to the incident)

• Corrective actions (immediate measures taken, interim or long-term actions necessary)

What to have on hand - To be prepared to complete an investigation promptly following an incident. The Security & Safety Director will have an investigative kit available as needed. The kit will include:

• Investigation forms
• Interview forms
• Barricade markers/tape
• Warning tags or padlocks
• Camera or video recorder
• Voice recorder
• Measuring tape
• Flashlight
• Sample containers

Interviewing people - Interviewing injured workers and witnesses necessitates reducing their possible fear and anxiety, and developing a good rapport. Interviews should follow these steps:

1. State the purpose of the investigation and interview is to do fact-finding, not fault-finding.

2. Ask the individual to recount their version of what happened without interrupting. Take notes or record their response.

3. Ask clarifying questions to fill in missing information.

4. Reflect back to the interviewee the factual information obtained. Correct any inconsistencies.

5. Ask the individual what they think could have prevented the incident, focusing on the conditions and events preceding the injury.

Determining causal factors – The purpose of all this fact-finding is to determine all the contributing factors to why the incident occurred. Statements such as "worker was careless" or "employee did not follow safety procedures" don't get at the root cause of the incident. To avoid these incomplete and misleading conclusions in your investigative process, continue to ask "Why?" as in "Why did the employee not follow safety procedures?" Contributing factors may involve equipment, environment, people and management. Questions that help reveal these may include:

1. Was there a hazardous condition a contributing factor? (defects in equipment/tools/materials, condition recognized, equipment inspections, correct equipment used or available, substitute equipment used, design or quality of equipment)
2. Was the location of equipment/materials/worker(s) a contributing factor? (employee supposed to be there, sufficient workspace, environmental conditions)
3. Was the job procedure a contributing factor? (written or known procedures, ability to perform the job, difficult tasks within the job, anything encouraging deviation from job procedures such as incentives or speed of completion)
4. Was lack of personal protective equipment or emergency equipment a contributing factor? (PPE specified for job/task, adequacy of PPE, whether PPE used at all or correctly, emergency equipment specified, available, properly used, function as intended)
5. Was a management system defect a contributing factor? (failure of supervisor to detect or report hazardous condition or deviation from job procedure, supervisor accountability understood, supervisor or worker adequately trained, failure to initiate corrective action)

Completing report and documenting corrective actions - Once you have gathered information and interviewed the involved worker and any witnesses, you can prepare the investigation report itself and formulate corrective actions. The report should go to the Security & Safety Director, Vice President of Finance and Operations, and Human Resources for South Central College. The report should be completed within as reasonable time frame dependent upon situational circumstances. Information will be communicated from the report with the Administrative Cabinet, Safety Committee and other employees as appropriate only from a perspective of initiating future corrective actions. Each corrective action listed should have a person assigned ultimate responsibility for the action, a completion date set and a target date for completion of the item. When considering corrective actions, monetary or time concerns should not enter into the validity of a corrective action.

Incident Investigation Process Diagram

Determine:
- Who conducts and participates in investigation
- What incidents to investigate
- What information to collect
- Prepare investigation kit
- Create investigation and interview forms
- Document investigation procedures
- Select and train investigators

- Arrange for first aid or medical treatment of injured person(s)
- Secure the scene
- Identify and gather witnesses
- Retrieve investigation kit
- Interview injured worker and witnesses
- Document scene with photos or videos
- Collect information

- Review documentation
- Identify causal factors (root causes) using the “Why” method
- Determine corrective actions
- Prepare report
- Communicate report

- Implement corrective actions
- Track completion of corrective actions
- Share information with others
- Critique process for continuous improvement

South Central COLLEGE

Incident Report Form

1. Employee Information

Employee Name	*Department*	*Job Title*	*Supervisor*

2. Related Specific Information

Type (Check box)		*Date*	*Time*	*Location / Work Area*	*Shift*
	Near Miss				
	First Aid				
	Medical Treatment				
	Fatality				
	Other				

3. Visible Surface Cause – *What caused the incident / accident to occur?*

4. Root Cause Analysis (check all that apply)

Unsafe Acts		*Unsafe Conditions*		*System Deficiency(ies)*	
	Improper work technique		Poor workstation design or layout		Lack of written procedures
	Safety policy violation		Congested work area		Safety policies not enforced
	Improper PPE / PPE not used		Hazardous substances		Hazards not identified
	Operating without permit		Fire or explosion hazard		PPE unavailable
	Failure to warn or secure		Inadequate ventilation		Insufficient worker training
	Operating at improper speeds		Improper material storage		Insufficient supervisor training
	By-passing safety devices		Improper tool or equipment		Improper maintenance
	Guards not used		Insufficient knowledge of job		Inadequate supervision

	Improper loading or placement		Slippery conditions		Inadequate job planning
	Improper lifting		Poor housekeeping		Inadequate hiring practices
	Servicing machinery in motion		Excessive noise		Inadequate workplace inspection
4. Root Cause Analysis (check all that apply, continued)					
	Horseplay		Inadequate guarding of hazards		Inadequate equipment
	Drug or alcohol use		Defective tools/equipment		Unsafe design or construction
	Unnecessary haste		Insufficient lighting		Unrealistic scheduling
	Unsafe act of others		Inadequate fall protection		Poor process design
	Other (specify):		Other (specify):		Other (specify):

5. Analysis – *Why did this occur?* (Answer the question of why five times)
Why -
Why -
Why -
Why -
Why -

6. Required Corrective / Preventative Actions		
Action Item Detail	*Responsible Party*	*Target Date*

7. Required Concurrences			
Title	*Print Name*	*Signature*	*Date*
Investigator / Supervisor			
Safety Committee Member			
Security & Safety Director			