Effective Workplace Incident Investigations

SERGE SIROIS, INVESTIGATION OFFICER

WORKSAFE NB
AGENDA

• Introduction
• Why Investigate?
• What to Investigate?
• Who should investigate?
• Preparation for an Effective Investigation
• Incident Reporting
• Phases of an Investigation
• Summary
• WorkSafeNB’s Investigations Process
INTRODUCTION

• What is an Incident / Accident?
  • An unwanted, unplanned event which disrupts the orderly flow of the work process; it may or may not involve injury to people, or damage to equipment
  • Potential loss situation
  • Incidents also include near misses
WHY INVESTIGATE?

• Prevention
  – Knowing what really happened
  – Determining the real cause
  – Identifying the risks
  – Develop controls
  – Define trends
  – Demonstrate concerns

• Fact finding not fault-finding
WHY INVESTIGATE?

• Benefits
  • Shows concerns
  • Increases productivity
  • Reduces operating costs
  • Shows that front line leaders have control
Why Investigate?

Costs associated to Incidents

Direct costs tend to be the ones that we think of first.

Indirect costs may be those that are less obvious BUT, as you can see from the diagram, they account for more of the overall cost of an accident than the direct costs.

Direct costs

- Injury, ill-health and damage

Indirect costs

- Lost time
- Extra wages/overtime
- Sick pay
- Production delays
- Fines
- Loss of contracts
- Legal costs
- Damage to product, plant, buildings, tools and equipment
- Clearing the site
- Investigation time
- Excess on insurance claims
- Loss of business reputation
WHAT TO INVESTIGATE?

• All incidents should be investigated
• High potential incidents are investigated in depth to allow adequate control of the problem
  • Ex: Incident resulting in first aid or minor property damage are not investigated as thoroughly as one that resulted in death or significant property damage.....unless the potential outcome of the “minor” incident had significant potential.
What to Investigate?

Accident Pyramid

- For every: 1 - Major Accident
- There were 3 Lost Time Accidents
- 30 First Aid Accidents
- 300 Near Misses
- And 3,000 “At Risk” Behaviors

Careful Attention
WHO SHOULD DO THE INVESTIGATION?

• Designating the investigator or the investigating team is a critical first step
• Possible choices
  • Immediate supervisors
  • JHSC
  • Health & safety professionals / advisors
  • Special committee
  • Middle / senior management
WHO SHOULD DO THE INVESTIGATION?

• **Occupational Health and Safety Act, Section 15 A**

  • *j*) participate in all inspections, inquiries and **investigations** concerning the health and safety of employees, and in particular the investigation of any matter referred to in section 43;
PREPARATION FOR AN EFFECTIVE INVESTIGATION

A good investigation system starts with a clear Investigation Policy / Procedure
PREPARATION FOR AN EFFECTIVE INVESTIGATION

• **Investigation Procedure / Policy**
  
  – *Occupational Health and Safety Act, Section 8.1(1)* Every employer with 20 or more employees regularly employed in the Province shall establish a written health and safety program, in consultation with the committee or the health and safety representative, that includes provisions with respect to….

  • *(e) a system for the prompt investigation of hazardous occurrences to determine their causes and the actions needed to prevent recurrences;*
  
  • *(f) a record management system that includes reports of employee training, accident statistics, work procedures and health and safety inspections, maintenance, follow-up and investigations;*
THE FIRST STEP!

- If you don’t know about it you can’t investigate it
- Develop an Incident Reporting Procedure
FIRST STEP

• Why incidents do not get reported
  – Fear of punishment
  – Concern about records
  – Concern about reputation
  – Fear of medical treatment
  – Desire to avoid work interruption
  – Poor understanding of importance
  – Avoidance of red tape

• How to get incidents reported
  – React in a positive way
  – Give more attention to loss control
  – Recognize individual performance
  – Develop awareness of the value of incidents information
  – Show personal belief by action
  – Make mountains out of molehills
What is the first thing that you should do when there is an incident at your workplace?
PHASES OF AN INVESTIGATION
INITIAL ACTIONS

• **Respond promptly and positively**
  - Take charge and give specific instructions to specific people / Secure scene
    - Section 43(3) of the OHS Act
      - 43(3) Except as otherwise ordered by an officer, no person shall disturb the scene of an accident that results in serious injury or death except as is necessary
        (a) to attend to persons injured or killed;
        (b) to prevent further injuries; or
        (c) to protect property that is endangered as a result of the accident.
PHASES OF AN INVESTIGATION
INITIAL ACTIONS (CONT.)

• **Ensure First Aid and call Emergency services**
  • People’s well being and lives come first (First Aid training) ask for someone to get help if needed, call emergency services
  • Control potential secondary incidents
    • Secondary incidents are usually more serious.......explosions that follows the puncture, the collapse that follows the impact
PHASES OF AN INVESTIGATION
INITIAL ACTIONS (CONT.)

• Identify sources of evidence at the scene
  • *Important to* identify the essential information before it can be disturbed or destroyed
  • Four (4) categories of evidence
    • 1) *People* / Witness
    • 2) *Positions* of People, equipment or items including environmental conditions
    • 3) *Parts* or items, tools (physical items)
    • 4) *Paper*, any documentation which has a bearing on the incident (policies, procedures, records)
PHASES OF AN INVESTIGATION
INITIAL ACTIONS (CONT.)

• **Preserve evidence from alteration or removal**
  • If the loss potential is high, then a good investigation is more important than getting back to work
  • Better to keep things from being moved
  • Keep people away from the incident scene so nothing is disturbed
PHASES OF AN INVESTIGATION
INITIAL ACTIONS (CONT.)

• Determine the loss potential
  • Seeing how badly people are hurt and property is damaged is easy
  • It’s also important to determine how bad it could have been and how likely it is to occur again
  • This will determine how the investigation should proceed
PHASES OF AN INVESTIGATION
INITIAL ACTIONS (CONT.)

• Notify appropriate personnel
  • Managers may need to be on scene right away
  • Might only be a courtesy call
  • Notification procedure provides guidelines for these decisions
PHASES OF AN INVESTIGATION
GATHERING INFORMATION

• Get the BIG Picture first
  • Large amount of information available on an incident scene, look around, visualize what might have happened

• Document the scene
  • Take notes, pictures, sketches
PHASES OF AN INVESTIGATION GATHERING INFORMATION (CONT.)

- Identify Witnesses
  - Anyone who knows something related to what happened
    - Direct witnesses: eyewitness
    - Indirect witnesses: supervisor, co-worker
  - Best to start with eyewitness and people involved
  - Witnesses are most likely to forget the details if not questioned promptly
  - The first details gives the investigator the starting point to identify the causes
PHASES OF AN INVESTIGATION
GATHERING INFORMATION (CONT.)

• Interview Witnesses
  • Memory and willingness to talk can be affected by the way people are questioned
    • Interview separately
    • Interview in an appropriate place
    • Put the person at ease
    • Get the individual’s version
    • Ask necessary questions at the right time
    • Record key points by taking notes
    • Have the witness make a sketch
    • End in a positive note
    • Keep the line open
PHASES OF AN INVESTIGATION
GATHERING INFORMATION (CONT.)

• Equipment Examination (Parts)
  • Have a look at the tools, equipment and materials that were used
  • Look for proper guards, safety features, hazard warnings labels
  • Technical assistance might be required for material failure analysis
• Records Check
  • Training, maintenance, work schedule, work instructions, practices, procedures
PHASES OF AN INVESTIGATION

ANALYZING CAUSES

• As information is gathered, investigators will pick a few most obvious causes
• Investigators might need to go back for more information to get to the real problem
• Determine the root cause
  • Who ?, what ?, where ?, when ?, how ? and why ?
• Use an accident causation model
Phases of an Investigation
Analyzing causes

HOW LOSSES OCCUR

LACK OF CONTROL
Inadequate:
• System
• Standards
• Compliance

BASIC CAUSES
Personal Factors
and
Job/System Factors

IMMEDIATE CAUSES
Substandard Acts, Practices, and Substandard Conditions

INCIDENT Event

LOSS
Unintended Harm
and/or
Damage

WHY LOSSES OCCUR

Careful
Attention

WORK SAFE
TRAVAIL SÉCURITaire
NB
PHASES OF AN INVESTIGATION
TAKING REMEDIAL ACTIONS

• Temporary Actions
  • What can I do right now to keep this from happening again?
    • Worn-out tool that needs to be replaced
    • Hole that needs to be covered
    • Guard needs to be replaced
    • Change in PPE
    • Procedure
PHASES OF AN INVESTIGATION
TAKING REMEDIAL ACTIONS (CONT.)

• Permanent Actions
  • Usually controlled by higher management
  • Investigator to make recommendations
    • Process improvement
    • Engineering modifications
    • Equipment change
    • Policies, Procedures
PHASES OF AN INVESTIGATION
WRITING THE INVESTIGATION REPORT

• Standard Form
  • A standard form can be used by organization
  • Do not leave spaces blank (if using a standard form)
  • Be as specific as possible
  • Must include
    • Incident description; pre-contact, contact and post-contact phase of the event
    • Basic cause
    • Corrective actions & Recommendations
• Recommendations
  • Critical actions in investigation must come from higher management
  • Should be practical, workable and implemented
  • Prioritize your recommendation
  • Higher management must provide response to recommendation
PHASES OF AN INVESTIGATION

COMMUNICATION

• One of the most valuable actions is sharing the incident information

• A tool for information release is an Incident Announcement form

• Other ways of sharing
  • Posting the form
  • Safety talks
  • Information sessions
PHASES OF AN INVESTIGATION
COMMUNICATION (CONT.)

• Sharing the incident information will promote a strong safety culture and sustainability of the investigation process

• Information shared should be kept to a minimum. Do note share personal information about employees ex: DOB, wages, telephone numbers, health information
PHASES OF AN INVESTIGATION

FOLLOW UP

• Verify if the recommendations have been completed
• Make sure the recommendations don’t have unexpected, undesired effects
• A good follow up is needed for the investigation to be effective
SUMMARY

• Workplace Incidents:
  • Are caused by unsafe acts and conditions
  • Are Preventable
  • Must be reported (serious and near misses)
  • Must be investigated immediately to establish root cause(s)

• A positive safety culture is required
WORKSAFENB’S INVESTIGATIONS PROCESS

OHS ACT

• **43(1)** The employer shall notify the Commission immediately if an employee suffers an injury resulting in
  • (a) a loss of consciousness,
  • (b) an amputation,
  • (c) a fracture other than a fracture to fingers or toes,
  • (d) a burn that requires medical attention,
  • (e) a loss of vision in one or both eyes,
  • (f) a deep laceration,
  • (g) admission to a hospital facility as an in-patient, or
  • (h) death.
43(2) Where an injury is reported under subsection (1), the employer shall immediately give notification to the committee or to the health and safety representative.
WORKSAFE NB’S MODEL
OHS ACT

• **43(3)** Except as otherwise ordered by an officer, no person shall disturb the scene of an accident that results in serious injury or death except as is necessary
  • (a) to attend to persons injured or killed;
  • (b) to prevent further injuries; or
  • (c) to protect property that is endangered as a result of the accident.
43(4) The employer shall notify the Commission immediately if
• (a) an accidental explosion or an accidental exposure to a biological, chemical or physical agent occurs at a place of employment, whether or not a person is injured, or
• (b) a catastrophic event or a catastrophic equipment failure occurs at a place of employment that results, or could have resulted, in an injury.
WORKSAFE NB’S MODEL

• Incident reported go to WorkSafeNB’s Regional Offices where the incident occurred

• Details of the incident determines the type of Investigation WorkSafeNB will conduct
WORKSAFE NB’S MODEL

• Centralized Investigation Officers
  • Fatalities
  • Zero Tolerance
    • fall protection, lockout and trenching
  • Life Altering Injury
    • paraplegia
    • quadriplegia
    • amputation of limb
    • third degree burn to at least 50% of body
    • loss of vision in at least one eye
WORKSAFE NB’S MODEL

• Multiple Injured Workers
• Unexpected Explosions
  • an event causing great damage and distress which exceeds the capacity for the workplace to function normally
• Unexpected and potentially harmful exposures to a biological, chemical or physical agent that requires immediate medical treatment beyond the capacity of the workplace’s designated first aid providers
WORKSAFE NB’S MODEL

• Catastrophic failure
  • Any unexpected and sudden event or loss of equipment causing great damage and distress which exceeds the capacity of the workplace to function normally

• All other types of incidents are investigated by the Regional Health & Safety Officers
WORKSAFE NB’S MODEL ADVANTAGES

• Consistency
• Standardization of
  • Evidence collection
  • Witness statements
  • Photography evidence
  • Scene documentation
Incident Investigation Continuum - WorkSafeNB

- Report of incident received
- Preliminary investigation by first officer on scene
- Evidence gathering complete. Preparation of investigation report
- Accident Review Committee (ARC) - File review and determination of recommendation (prosecution or not)
- WorkSafeNB determines investigation mode (causal or meets criteria for serious incident investigation)
- Crown reviews file – determines whether to proceed with charges
- Coroners Inquest*

Statute of Limitations
Maximum one year from date of incident information must be laid before the Court