Incident investigation policy

Maintaining a safe and healthy environment is the primary North Side company's concern focused on amending occurrences that brough to an injury or could possible cause it. While establishing a safe workplace for all employees, contractors and clients or in the event an accident happens, it is crucial to report the circumstance so certain steps like effective investigation and systematic analysis can be performed to confirm that no further accident of any similar or more sever kind happen again as well as possible workplace risks are eliminated.

Procedure:

1.1. What is an incident?

'Incident' for the purposes of this procedure includes:

a) Any event that results in injury or disease no matter how minor;
b) Any dangerous occurrence - this term includes near misses - any event that endangers the health or safety of a person;
c) Any event that results in death.

1.2. Incident Systematic Management.

Incident investigation and analysis can be determined as a systematic pro-active approach to the continuous development and improvement of the Occupational Health and Safety (OHS) Management System. Constructive investigations yield essential information, which will assist in:

a) Determining injury rates;
b) Identifying trends and problem areas;
c) Permitting comparisons to be made, for example between injury rates for different areas of the workplace, across different time frames and involving different types of injury;
d) Complying with legal requirements, for example, providing data required for personal injury claims involving workers compensation payments.
e) Identifying the basic causes that contributed directly, or indirectly, to each incident.
f) Identifying deficiencies in the OHS Management System that permitted the incident to occur;
g) Suggesting specific corrective action alternatives for the management system.

1.3. Reporting Process.

a) Employee witnesses or is involved in an incident – the employee must complete Incident Reporting and Investigation Form and Injury Register (if injured) and report to management within 24 hours.
b) The responsible manager will report injury to insurer and enforcing authority (if applicable) within the statutory reporting timeframes.
c) Management in consultation with employees will ensure immediate interim action is taken as required to minimize risk within the workplace.
d) Manager will investigate incident and review concerns raised. The level of investigation will be determined at this stage.

e) The responsible manager will carry out necessary interviews and review documentation (within the investigation team – if full investigation is warranted).
f) The responsible manager will complete the final section of the Incident Reporting and Investigation Form.
g) The responsible manager will complete the necessary risk management documentation i.e. risk register and action plan.
h) Corrective actions will be implemented according to the risk action plan.
i) All documentation must be kept on file for easy access and retrieval, if required.
j) All incidents will be reviewed by management and health and safety representatives on a regular basis.

1.4. Determining the Root Cause

All incidents, including near misses, must be reported within 24 hours of the occurrence an investigation undertaken by management. The purpose is to determine the true and accurate circumstances, which led up to and contributed to the event and to prevent the event occurring again.

Accurate, clear and complete information is needed from the investigation process. Details which should be recorded and included in the incident investigation report are:

a) A description of the sequence of events leading to the incident
b) Correct identification of all causal factors
c) A description of all causal factors
d) The corrective actions already taken
e) Further recommendations for corrective actions; and
f) Review and sign-off by senior management

1.5. Investigation of Incidents

Accurate, clear and complete information is needed from the investigation process.

For the incident investigation to be successful in identifying all of the causes of the incident, it will be necessary to establish:

a) The events and circumstances leading up to the incident such as the types of events and circumstances leading up to the incident; the system of work currently in place; the instructions given for the work; variations from instructions or safe work systems; workplace conditions such as lighting, floor surfaces, stair treads and handrails, warning signs, and temperature and weather, if the incident occurred outside; the exact location of the incident; the materials in use or being handled; and the type of equipment in use.
b) Facts of the incident – facts relevant to the incident may include the state of the work system and the actions which occurred at the moment of the incident; the people directly involved, and those involved at a distance, if any; the tools, equipment, materials and fixtures directly involved; the time the incident occurred.
c) Facts of events immediately after the incident – relevant facts from events which occurred immediately after the incident may include the injuries or damage resulting directly from the incident; the events leading to consequential injury or damage; the people involved, including those rendering aid; and any problems in dealing with the injuries.

Investigation Team

Investigation team consists for minor incidents consist of the Managing Director, Technical Director, HSE Adviser.

In the event of an incident, which is reported to the enforcing authority regarding a major incident, the investigation team may involve specialist consultants and the enforcing authority representatives.

2.1. Reporting to Statutory Authorities.

The company will comply with all the statutory reporting requirements. These arrangements oblige North Side to report the details of certain incidents to the relevant enforcing authority. The types of incidents, which must be reported, are usually:

a) Incidents resulting in loss of life which must be reported immediately.
b) Incidents resulting in a worker taking a number of days off work due to injury.
c) Incidents involving damage or potential damage to dangerous items.

3. Review of Corrective Actions.

The responsible Managing Director will review the information gained from the incident investigation and carry out a risk management process.

After the investigation has been conducted, the Incident Investigation and Reporting form will be completed detailing the action needed to be carried out to eliminate or minimize the hazard using the risk management processes.

4. Risk Identification, Assessment and Control.

4.1. Identifying and assessing all hazards that have caused incidents using the following risk management methods:

a) Defining the scope of the activity that is to be assessed.
b) Identifying the risks.
c) Assessing the risks.
d) Controlling the risks.
e) Monitoring and reviewing the process.

4.2. Implementing all controls using the following hierarchy of hazard control:

a) Eliminating the hazard.
b) Substituting the hazard.
c) Modifying the process.
d) Isolating the hazard.
e) Implementing engineering controls.
f) Using a combination of controls.
g) Using back up controls, such as personal protective equipment.

4.3. In addition, «Company» the organization shall:

a) See that all corrective actions identified in an investigation are authorized with signed documentation.

b) Allocate responsibility against each corrective action, to ensure everyone is aware of what is required of them. Any lack of response shall be tracked to the responsible person.
c) Ensure any corrective actions have a time frame allocated to them for completion.
d) Ensure all employees concerned have received sufficient training, or arrange for retraining, as deemed necessary by the findings of the investigation.
e) Where a specific task or process has caused the incident, a job safety and environmental analysis will be undertaken in order to re-assess the risks associated within the area.
f) After implementing corrective actions, ensure they are evaluated at a future time. This is to ensure that the controls have not caused any further hazards, and that they are in fact appropriate to reducing the likelihood of a recurrence of the same event.

5. Use of Incident Statistics

The company will use the information gained from incident statistics to measure trends over a period of time so that the company has an indication of whether it is improving, stable or deteriorating with regards to Health and Safety performance.

5.1. Negative Performance Indicators

The company will measure "Average Lost Time Rate" and the average time lost per occurrence of injury or disease. This rate is an indication of the severity of occurrences being experience by employees over a period of time.

5.2. Positive Performance Indicators

Positive Performance Indicators are pro-active and show the effectiveness of training, management commitment and support, and resources given to safety, which are all part of the larger picture.

Statistics will also provide the company status with an indication of the effectiveness of the corrective or preventative actions taken to minimize or eliminate the hazard which caused the accident.

6. Privacy Considerations

The Privacy Act provides the legislative basis for protection of individuals' rights in regard to disclosure of personal information. Personal information may only be divulged in circumstances which correspond with the stated use.

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Each facility shall have a written procedure for reporting and investigating all incidents as required by the Corporate HSE standards.

Site management will investigate incidents and near misses that had (or might have had), significant consequences for employees, the local community, the environment or facilities. All investigations will be conducted promptly and will gather sufficient information to identify the direct and indirect (root causes) of each incident. The site will implement corrective action to prevent recurrence of the event as quickly as possible and will document such corrective action.

Annually an analysis of all incident investigations will be conducted to determine corrective action to address deficiencies relating to the HSEMS, environmental, unsafe conditions and at-risk behaviors.

Incident Investigation Procedure and Reporting Requirement

Scope

Monthly HSE Report		
Reporting Division:		
Location:		
	Month	Year-to-date
1. Exposure hours		
2. Number of recordable injuries/illnesses		
3. Total recordable incident rate		
4. Number of lost workday cases*		
5. Lost workday incident rate		
6. Number of lost workdays		
7. Incident rate of lost workdays		
8. Fatal injuries		
9. Number of restricted activity cases		
10. Number of days of restricted activity		
11. Total recordable injuries		
12. Total recordable illnesses		
13. Number of near miss incidents		
14. Number of environmental incidents		
15. Number of automobile incidents		

16. Date of last lost workday injury/illness			
17. Cumulative hours since last lost workday injury/illness			
18. Did your facility have a Regulatory agency inspection this month? Yes/No This year? Yes/No			
19. Did your facility experience a single incident involving over $1000 property damage this month (fire, explosion, collision, etc)? Yes/No			
Prepared by:		Date:	

This report is due by the 5th working day of the month following the reporting period.

To implement an incident investigation program that focuses on serious (environmental, product, automobile, recordable injuries and illnesses), near miss and minor incidents.

Purpose

The purpose of incident investigations is to determine the "root cause(s)" of an incident, so that corrective action can be taken to eliminate or control specific hazards. Through the investigation of incidents, we are able to analyze and learn about causes, which in turn will give us a better control of incidents.

General

Incident defined: All incidents should be reported. Those with serious potential should be selected for further investigation. A serious or serious potential incident is one that either results or could reasonably result in:

- An injury or illness involving lost or restricted work activity, including contract employees and visitors
- A significant spill or release of chemical or product
- Significant damage to buildings or equipment/tools
- Off-facility impact

First aid cases are also investigated and reported; though not as rigorously as above type incidents.

The Incident Investigation Process

The incident investigation process contains 5 steps:

1. Gather Information
2. Determine Causes (direct and indirect)
3. Corrective Action(s)
4. Communication
5. Follow-Up

Step 1 - Gather Information

Before beginning this process, it is very important to have the correct people involve to perform an investigation, they should include: 1) supervisor, 2) injured or involved employee(s), 3) witnesses, 4) union safety representative, if appropriate and 5) other resources, if necessary. The initial investigation should take place at the scene. The investigating team will be able to examine the scene and visually see what took place. It is critical to document what was said and observed.

Step 2 - Determining Causes (Direct and Indirect)

As the investigation team gathers information for an incident, it is important to investigate the behaviors involved in an incident. Remember, between 90 and 96% of all injuries that occur in industry are related to employee behavior. Behaviors fall into two categories direct or indirect. Direct causes are usually easily identified, and in most cases the incident investigation stops here. However, indirect causes require more effort in surfacing and is usually an indication breakdown in a management system (i.e. procedures not being up-to-date, taking shortcuts to get a job task completed, etc.). To better illustrate direct and indirect here is an example: An employee was running to the lunch room and slipped on an oil spot that was on the floor and injured himself. Most investigations would identify the employee running and the oil as the direct cause to the incident and in most cases, the investigation would stop here. However, you have not identified the "root cause" of the incident.

Step 3 - Corrective Actions

Once the investigation team completes the investigation and generates a report that identifies how the incident occurred, direct and indirect causes, the next step is to identify corrective actions that will address the incident. Corrective actions that require little time to execute should be done immediately. However, situations where the corrective action is more involved (i.e. ordering material, AFE, etc.), the recommendation should involve a short- and long-range plan. These recommendations should be tracked to ensure closure.

Step 4 - Communication

Once the incident investigation report has been completed and corrective actions identified. It is important to communicate the incident report with the entire facility and in some cases, within the division, group or corporation when a serious injury (i.e. more that $1,000.00) occurred. The purpose of communicating and sharing incident investigations is that another department, group or division my have the potential for the same incident to occur. Also, the name of the injured employee should be removed when communicating incident reports. Remember, the purpose of an incident investigation is not to place blame, but to identify recommendations that will eliminate the incident from occurring again.

Step 5 - Follow-Up

The final step (follow-up) is where a lot of incident investigation program fail. Once an investigation has been completed and corrective actions identified most investigations stop here. The reason for this is that we fail to monitor corrective actions and they fall through the cracks. It is vital to the incident investigation process to develop a tracking system that will give you the capability to see what corrective items have not been completed. By having a monitoring system that tracks closure will ensure a successful investigation program. Each facility location should analyze their incident history for trends and guidance in determining future corrective actions.

Reporting Requirements

Any time an NS location encounters a Lost Workday Injury or a serious environmental incident, they are to send a copy of the investigation report to the Corporate EHS Director located in Russia. The Corporate EHS Director in many cases will send a corporate wide communication concerning the incident, and ask facility locations to audit their facility for the same potential hazards identified in the investigation report.

Other Requirements

Injuries

If a fatal injury, illness or hospitalization of three or more employees, the facility manager will immediately notify the following persons and agency:

- Corporate EHS Director
- Manager
- Managing Director

Environmental

If an environmental incident occurs that is required to be reported to local, state and/or federal agencies please notify the following persons:

- Corporate EHS Director
- Managing Director
- Group Manager
- Appropriate local, state and/or federal agency

INCIDENT INVESTIGATION FORM

1.Location of Incident

Site Address:

Supervisor:

2. Details of the incident being investigated

Incident Report Number:

Name of Injured Person (If Applicable):	Date of Incident:
Name of person who reported Incident:	Date of Report:

3. Details of the Incident Investigation

Name of person completing this form:	Date Completed:
Telephone Number:	Email address:

Is this form being completed as part of an 'onsite' investigation? Yes/No	Names of Investigations Team:
Have any witnesses been interviewed as part of the incident investigation? Yes/NO	Names of witnesses interviewed:

4. Description of Events

Describe the sequence of events that lead to the incident:

Describe the Sequence of events following the incident:

Describe the task being performed at the time of the incident:

5. Risk Rating of Incident & Likelihood of Reoccurrence

Using the Two Variable Risk Matrix (Right):

-Rate the consequences (Severity) of the incident

-Rate the likelihood of the incident occuring or reoccuring

-Circle the resultant risk rating on the Risk Matrix

Likelihood Label	Consequences (Severity) Label				
	Neglible(I)	Significant(II)	Moderate (III)	Major (IV)	Catastophe (V)
Almost Certain (A)	medium	High	High	Very High	Very High
Likely (B)	medium	medium	High	High	Very High
Possible (C)	Low	medium	High	High	High
Unlikely (D)	Low	Low	medium	medium	High
Rare (E)	Low	Low	medium	medium	High

INCIDENT INVESTIGATION FORM - PAGE 2 of 2

5.1.Identify the behavioural causes of the Incident

Did any of the following behaviours contribute to the cause of the incident? (choose and tick)

Performing task without authority		Distracting, teasing or abusing a person	
Performing task at unsafe speed		Using unsafe or tagged out equipment	
Performing task while affected by drugs/alcohol		Using equipment in an unsafe manner	
Perfoming task with improper work technique		Unsafe placement of equipment or objects	
Performing task without PPE		Unsafe manual handling technique	
Performing task without correct PPE		Unsafe Position or Posture	
Failure to warn of hazard		Unsafe acts of others	
Failure to secure hazardous item		Other **(specify):**	
Making safety device inoperable		Not applicable	

What are the management systems (procedural) deficiencies that led to the unsafe behaviours? (Choose and tic

Inadequate Standard Operating Procedure/Policies		Inadequate workplace inspection	
Inadequate Supervision		Inadequate equipment provided	
Inadequate Hazard Identification		Inadequate design or construction of workplace	
Inadequate assessment of risk		Inadequate task or process design	
Inadequate provision of PPE		Unrealistic sheduling	
Inadequate Operator training		Other **(Specify):**	
Inadequate supervisor training		Not applicable	

5.2.Identify the Physical causes of the incident

Did any of the following conditions contribute to the cause of the incident? (Choose and tick)

Inadequate or absent gaurding		Inadequate fire or explosion risk control	
Poor workstation design or layout		Inadequate noise control	
Poor condition of equipment or objects		Inadequate ventilation	
Equipment or objects with unsafe design		Inadequate temperature control	
Unsafe storage or equipment or objects (housekeeping)		Inadeqaute fall protection	
Unsafe walking surfaces		Inadequate signage or warning systems	
Unsafe lighting or glare		Inadeqautley controlled use of chemicals/substances	
Unsafe clothing or shoes		Other **(specify):**	
Unsafe task or process		Not applicable	

What are the management systems (procedural) deficiencies that led to the unsafe conditions (Choose and tick)

Inadequate Standard Operating Procedure/Policies		Inadequate workplace inspection	
Inadequate Supervision		Inadequate equipment provided	
Inadequate Hazard Identification		Inadequate design or construction of workplace	
Inadequate assessment of risk		Inadequate task or process design	
Inadequate provision of PPE		Unrealistic sheduling	
Inadequate Operator training		Other **(Specify):**	
Inadequate supervisor training		Not applicable	

INCIDENT INVESTIGATION FORM - PAGE 3 of 3

6. Planned actions to prevent or reduce risk of re-occurrence

Planned actions to be taken to prevent or reduce risk of re-occurrence.
Planned actions should address the identified causes of the incident.

[1] Elimination Control ☐ [2] Substitution Control ☐ [3] Engineering Control ☐ [4] Administrative Control ☐ [5] PPE ☐

Detail the actions