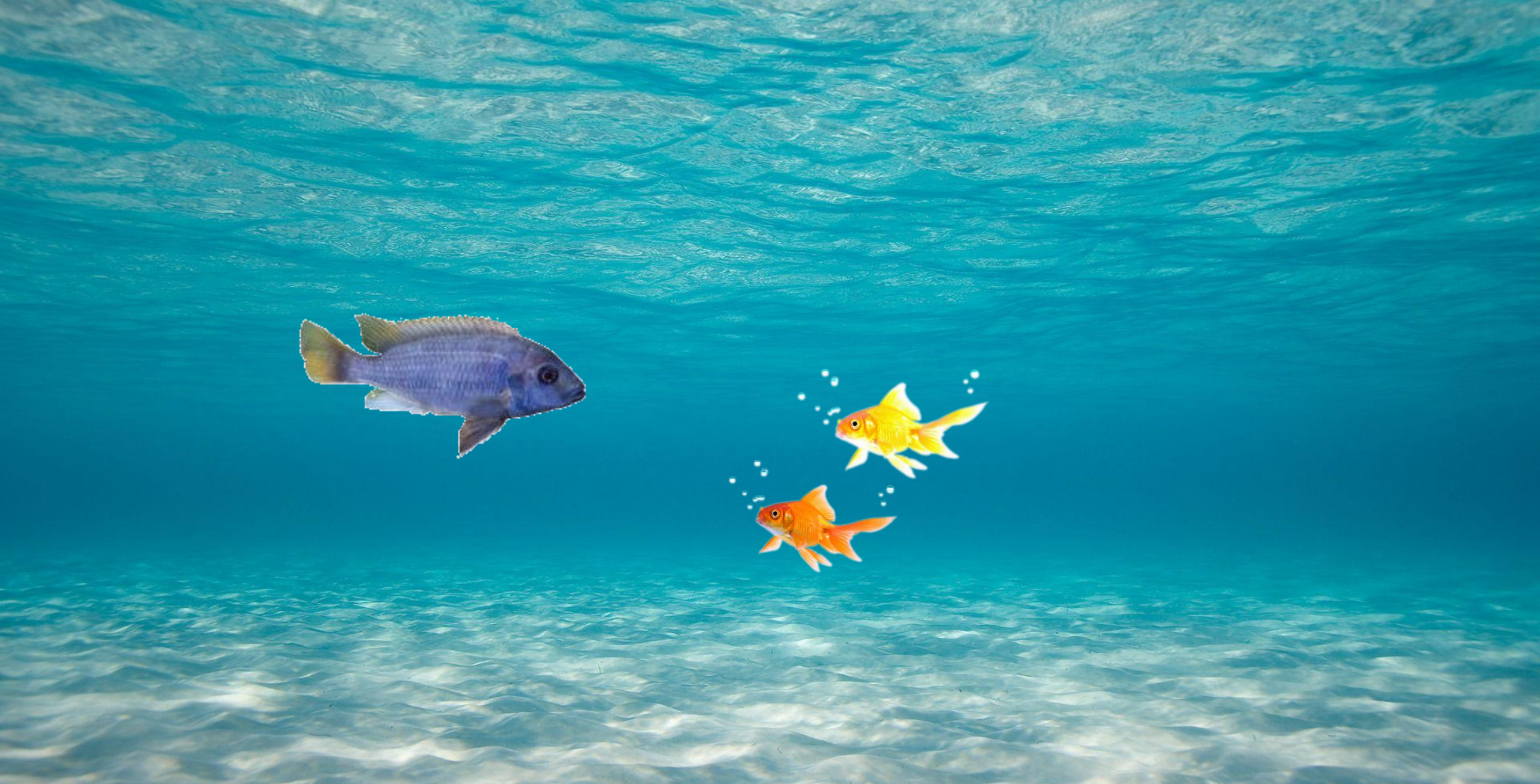





# Incident Investigation & Injury Reporting

MASTERING THE BASICS OF INVESTIGATING & REPORTING AN INJURY



\*This is Water speech by David Foster Wallace




In the context of  
Safety...





# An Awareness Exercise



What Does Safety  
Mean to You?

# Investigation vs. Reporting

- ▶ What is the difference?
- ▶ What should be investigated?
- ▶ What should be reported?

# How To Write a Report

- ▶ Statements v. Reports
- ▶ ***“Just the facts please”***
- ▶ Key components
  - ▶ Who
  - ▶ What
  - ▶ When
  - ▶ Where
  - ▶ Why
  - ▶ How





# Key Report Components

- ▶ Arrange facts in chronological order
- ▶ Absolute accuracy- don't rely on memory
- ▶ Obtain pertinent information on the spot.
  - ▶ Names, Addresses, Phone #'s
  - ▶ Photographs of the scene
  - ▶ Witness Statements



# Who

- ▶ Who was involved in the incident.
- ▶ It could be multiple persons.
- ▶ Victims, witnesses, suspects customers, employees, etc.
- ▶ Statements of those involved



# What

- ▶ What occurred?
- ▶ A description of the incident.
  - ▶ In your words – factual
  - ▶ In the words of the associate(s) involved
  - ▶ From the witness perspective

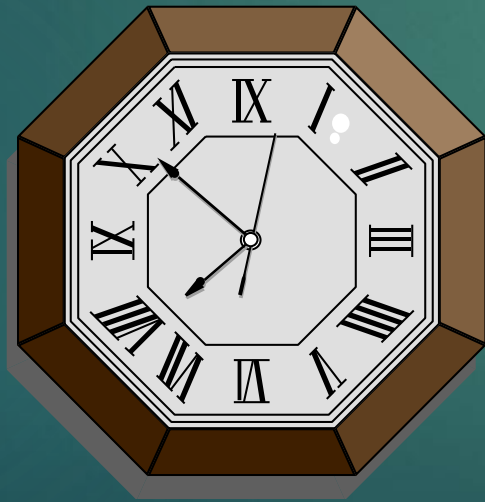
# Where

- ▶ The exact location where the event/ incident took place.
- ▶ Be specific.
  - ▶ Common hallway by main entrance
  - ▶ Near windows in Classroom 5
- ▶ A picture is worth a....
- ▶ Any CCTV coverage?



# When Did the Incident Occur

- ▶ The time and date that the incident occurred.
- ▶ If not exact or unknown try to establish a range.





# Why Did the Incident Occur?

- ▶ Be careful!!
- ▶ The reason the event/incident took place
- ▶ Do not speculate
- ▶ Investigate
- ▶ Statements & accounts will tell the story
- ▶ Determine root cause
  - ▶ Physical conditions
  - ▶ Equipment or tools involved
  - ▶ Approximate weight/description of product
  - ▶ Employee's knowledge of policy
  - ▶ New Employee?

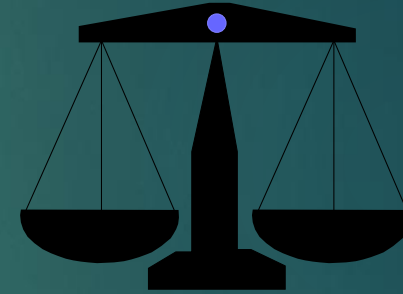


# How

- ▶ How did the incident come to your attention?
- ▶ How did it occur?
- ▶ Establish sequence of events?


# Report Writing Audience

- ▶ Upper management
- ▶ Police Departments
- ▶ Attorneys
- ▶ Insurance Companies
- ▶ Regulatory Agencies
- ▶ “Remember all reports are legal documents!”



# Taking Statements

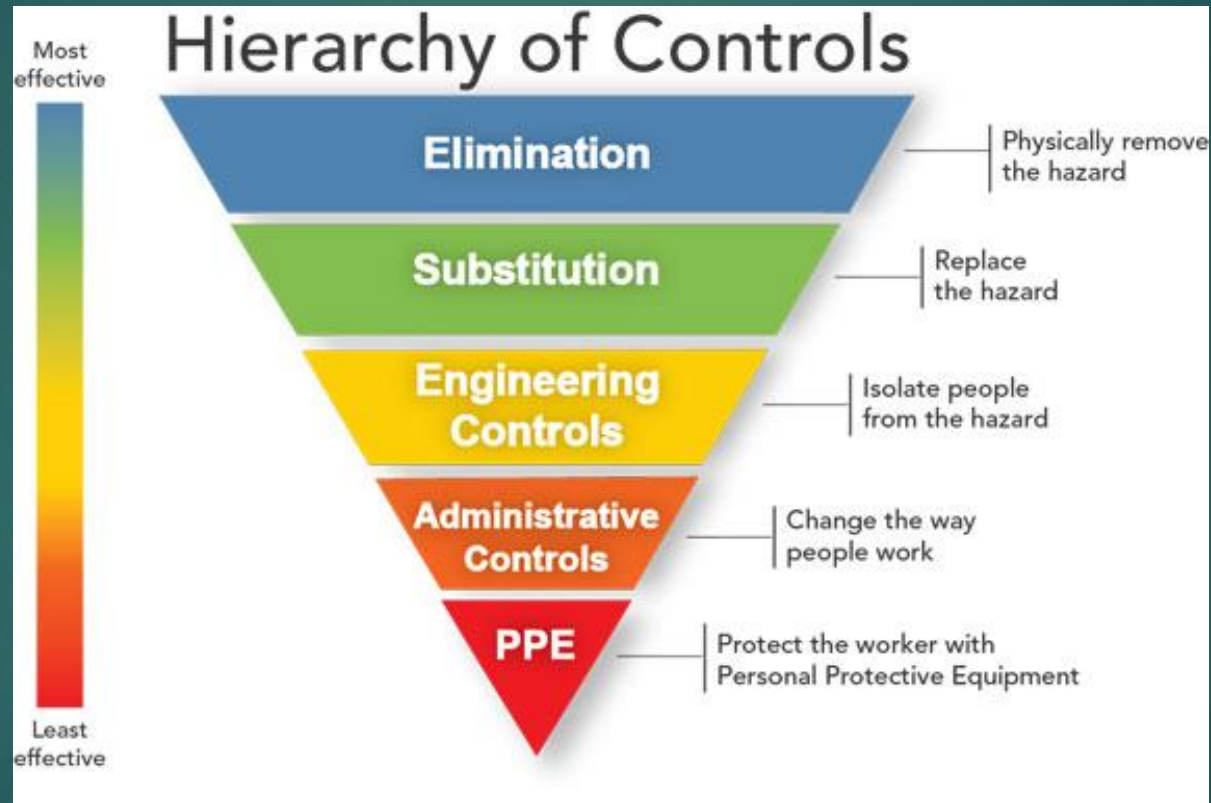
- ▶ Always interview a witness first
- ▶ Take notes
- ▶ Refresh the witnesses memory
- ▶ If possible have the witness write out the statement themselves
- ▶ Review the statement before the witness leaves and have them sign it
- ▶ If witness refuses to sign, state it on your report



*When In Doubt Write it  
Out!*



# Approach to Injury Prevention



# Slip and Fall Incident

CASHIER FALL

# Report writing activity

- ▶ Based on the video you just saw, practice the basics of report writing –
  - ▶ The 5 Ws
  - ▶ Any supplemental information



How did it go?

# Potential Barriers to Investigation



- ▶ Management may be reluctant to support your role in Root Cause Analysis.
- ▶ Management may resist due to time and resource commitments.
- ▶ Investigation may be difficult and subjective
- ▶ Management may feel that the outcome will cast an undesirable light on the organization



# Environmental Factors


- ▶ Most root causes can be traced back to decisions, actions, or inactions by one or more employees.
- ▶ Some of these could be:
  - ▶ Competence of personnel
  - ▶ Hiring qualified personnel
  - ▶ Lack of or insufficient training
  - ▶ Adequacy of technology or tools
  - ▶ Appropriateness of organization or departmental culture
  - ▶ Health of the organization or departmental morale
  - ▶ Level or number of resources (budget/personnel)

# Environmental Factors Continued

- ▶ Process circumstances and other influencing items that led the person or persons to make the decisions
- ▶ Decision-making authority of the person or persons involved.

# Techniques for Root Cause Analysis

- ▶ Five Whys
- ▶ Failure mode and effects analysis
- ▶ SIPOC (Suppliers, inputs, processes, outputs, customers diagram.
- ▶ Flowcharting of the process flow, system flow, and data flow.
- ▶ Fishbone diagrams
- ▶ Critical to quality metrics
- ▶ Pareto chart
- ▶ Statistical Correlation



Why?

1:43

# 5 Why's

1. Write down the specific problem - The worker fell. Why?
2. Write down answer; Oil on the floor. Ask 2<sup>nd</sup> Why?
3. Continue until what you consider is the true root cause is defined.
4. Don't allow an early believable answer keep you from continuing to ask why. Broken part. Why?
5. The parts keep failing. Why?
6. Changes in procurement practices. Why?

(VIDEO)





# RCA – Failure, Modes, and Effect Analysis

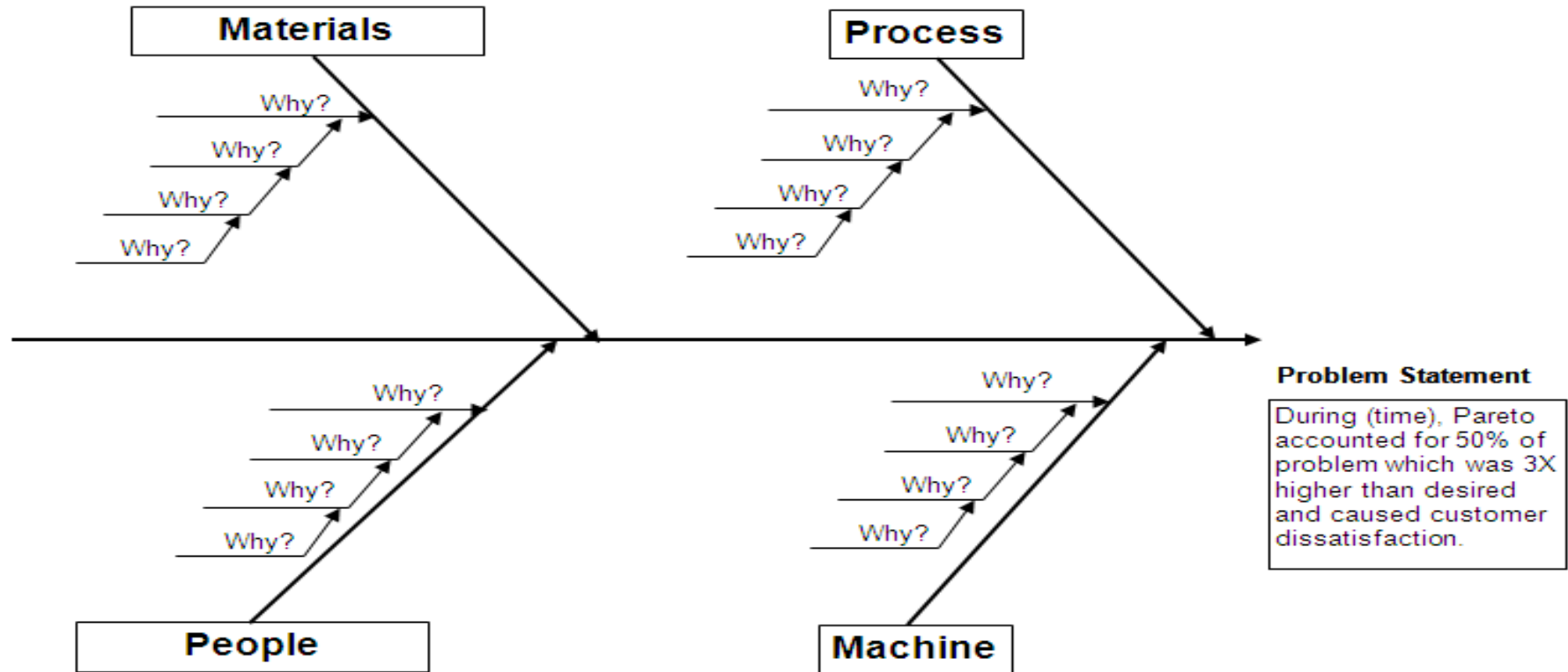
- ▶ This is a step-by-step approach identifying all possible failures in a design, a manufacturing or assembly process, or a product or service.
  - ▶ What is process step?
  - ▶ What is key process input?
  - ▶ In what ways can the key inputs go wrong?
  - ▶ What is the impact on the outputs?
  - ▶ How severe is the effect to the customer?
  - ▶ What causes the potential failure?
  - ▶ How often does the failure occur?
  - ▶ What existing controls can prevent the failure?

# Fishbone Diagram

## Cause and Effect Diagram

Project Name:   
Project Leader:

Original Date:   
Update Date:



# Pareto Chart

- ▶ A bar graph that categorizes the frequency of a certain type of event.
- ▶ Could be used for customer or Hotline complaint types.

## Types of Hotline Complaints



# Five Cs

- ▶ Criteria
- ▶ Condition
- ▶ Consequence/Effect
- ▶ Cause
- ▶ Corrective Action/Recommendation

# Five Cs

## ▶ Criteria

- ▶ The law, regulation, contractual obligation, policy, procedure, or best practice that is expected to be followed

## ▶ Condition

- ▶ The factual analysis of the process as it exists

## ▶ Consequence/Effect

- ▶ Why the issue is important and noteworthy from a compliance, financial, or operational standpoint.

# Five Cs

## ▶ Cause

- ▶ The root cause which allowed the condition to not emulate the criteria.

## ▶ Corrective Action/Recommendation

- ▶ Change that will address the root cause, allow the current condition to mirror best practice or other criteria and does not cost more in relation to its effect.



# Investigating an Incident

- ▶ Review each incident in detail
- ▶ Go beyond the obvious-Keep asking “Why”
- ▶ Practice the 5 Whys
- ▶ Get to the Root Cause!

	Why?	Because...
1	Why is Tom injured?	...he had a fall
2	Why did he fall?	...the floor was wet
3	Why was the floor wet?	...there was a leaking valve
4	Why was the valve leaking?	...there was a seal failure
5	Why did the seal fail?	...it was not maintained



**A continuum of causes**

# 5 Whys Continued

- By the fifth why, you should have identified or be close to identifying the root cause.
- More complex issues may require a greater investment of resources and more rigorous analysis.
- Consider the objective of the investigation before investing more time and effort

# Group Activity



- ▶ You have been provided with a description of an actual incident/injury
- ▶ Given the information provided, discuss & write down –
  - ▶ Three things that went wrong in the incident
  - ▶ Three things you would do following the incident
  - ▶ Three things you would do to prevent the incident

# Incident

John has just joined his new position 3 weeks ago and was assigned as a dishwasher. His job involves both manual dishwashing and operating the dishwashing machine.

At 3:45p on Friday afternoon, John picks up a bottle of chemical and pours it into the wash bin for manually washing dishes. He approximates the amount of detergent needed and proceeds to put the bottle away when some of the chemical splashes on his skin.

He notices a little burning and rinses lightly and returns to his job. Later, he notices that the burning has increased and his skin is now discolored.

He notifies the manager and goes home. The next day, John has to go to the doctor for severe chemical burns to his skin.

# Review

- ▶ Don't stop at the first Why
- ▶ Remember the 5 Ws
  - ▶ Who
  - ▶ What
  - ▶ When
  - ▶ Where
  - ▶ Why

**QUESTION, YOU HAVE?**



**ANSWER, I SHALL.**

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