HOW TO INVESTIGATE AN INCIDENT

To effectively prevent workplace loss, particularly worker injury, supervisors should investigate all incidents. All workers should be aware of the investigation process so they will be able to contribute information about any incident in their workplace.

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For the purposes of this Fast Fact, "incident" is defined as: an undesired event that did not result in harm to workers, damage to property or loss of process. The summary of the steps to investigate an incident is for employers and employees to understand and use, when an incident happens. It should be readily available for use at the workplace and can be used to help complete the workplace inspection forms.

STEP 1: TAKE IMMEDIATE ACTION

Immediate action may include:

- Taking immediate action to prevent injury or damage.
- Informing workers of the identified hazard and how it is being controlled.

- Securing the incident scene until the investigation at the scene is finished.
- Identifying potential information sources (people you can talk to, evidence you can look at or gather).

STEP 2: GATHER EVIDENCE

Gathering evidence helps you to gain a clear picture of what has happened so that actions can be taken to prevent similar incidents in the future. When gathering evidence:

- Identify the final event of the incident (the hazard).
- Gather data that ills in the complete picture of what happened from the beginning of the incident and what contributed to the final event. Question workers in a cooperative and non-judgmental manner. This must be a fact-finding exercise; do not assign blame.
- Ensure that the evidence is factual about actions that were seen, heard or done.

There are two ways to gather evidence:

1. Look for clues from the scene of the incident. For example:

- Take pictures.
- Make sketches.
- Take measurements.
- Take samples of substances/fluids.
- Note environmental conditions (e.g., housekeeping, lighting, noise, signs and/or workspace).
- Collect foreign objects or broken pieces of equipment.
- Check written work processes and procedures.

2. Collect information from people (e.g., the injured worker, witnesses and/or supervisor).

- Ask effective questions that stimulate more than “yes” or “no” answers.
- Be objective, do not ask questions that simply support pre-determined conclusions.
- Ensure that workers are asked if they have any ideas about how to control or eliminate the hazard.

STEP 3: PUT THE EVIDENCE IN ORDER

Put all the facts together in the order in which they occurred. This will help you develop a mental picture of what happened. Make sure that you have enough evidence (avoid information gaps) and that the evidence makes sense – each event interacts with at least one other incident event.

STEP 4: ANALYZE YOUR INFORMATION

Analyze your findings and identify why the incident occurred. The "whys" are the safety problems that must have existed for the incident to occur. Incidents generally occur because of a combination of "symptom" and "root" safety problems.

- Symptom safety problems are obvious. They include immediately recognizable problems such as not recapping a needle or wet and slippery floors. Symptom safety problems need to be analyzed to find out why they exist.
- Root safety problems are often management problems.

This can make it very difficult to be objective. Management responsibilities include: lack of/poor policy, procedures, training and supervision, no accountability, and lack of adequate resources.

STEP 5: RECOMMEND CORRECTIVE ACTION

Look ahead to see how the risk of similar incidents can be reduced. Use your knowledge and the knowledge and expertise of workers when identifying potential solutions.
Based on this information, recommend changes that are practical, will improve health and safety in the workplace, and upon which everyone can agree.

Your recommendations may be related to:

- policy/procedure revision or development
- training
- equipment repair, maintenance or replacement
- supervision

Make sure your recommendations are:

- Specific for the identified safety problems – fix what does not work.
- Effective and sound – ix an existing problem without creating any new safety problem.
- Practical – they will work and are not "pie in the sky."
- Affordable – are within available resources.
- Credible – can be trusted to work.
- Ranked according to priority. If not all recommendations can be carried out at once, identify which ones are most important.
- Based on consultation. Worker expertise can be very helpful in achieving these goals.

STEP 6: FOLLOW UP ON CORRECTIVE ACTION

Follow up your corrective actions to determine whether they have been implemented and, if so, whether they were effective. This information will help you when making corrective actions on subsequent incident investigations.
Without this follow up, the effort of investigating may be wasted.

STEP 7: WRITE AN INVESTIGATION REPORT

Write a report to explain what happened, why it happened and what can be done to prevent similar incidents. Your report should:

- Be objective.
- Be descriptive (clearly state the sequence of incident events – who, what, when, where and how, so a reader with no knowledge of the incident will be able to understand what happened).
- Identify the hazard – why the incident happened.
- Suggest corrective actions.
- Schedule follow up dates.
- Leave space for follow up comments.