



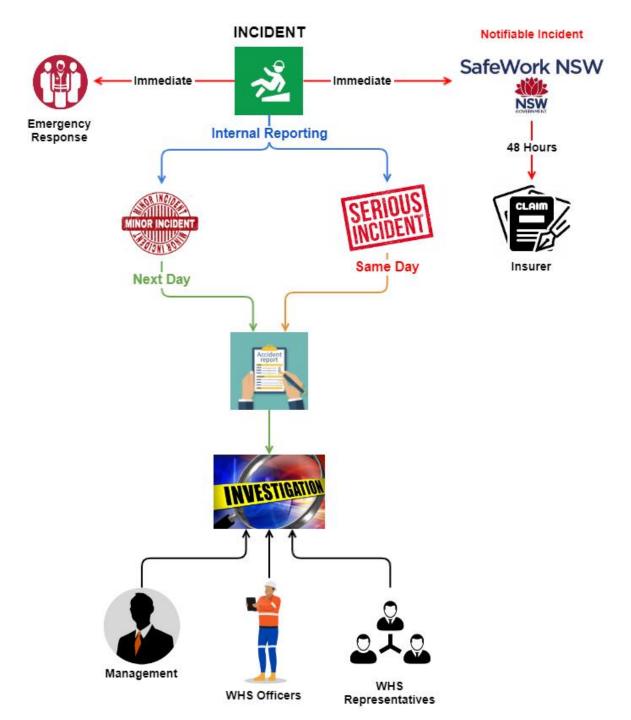
 ACCIDENT - An accident is an undesired event that results in personal injury or property damage.

INCIDENT - An incident is an unplanned, undesired event that adversely affects completion of a task.

NEAR MISS - Near misses describe incidents where no property was damaged and no personal injury sustained, but where, given a slight shift in time or position, damage and/or injury easily could have occurred.



Reporting Timeline



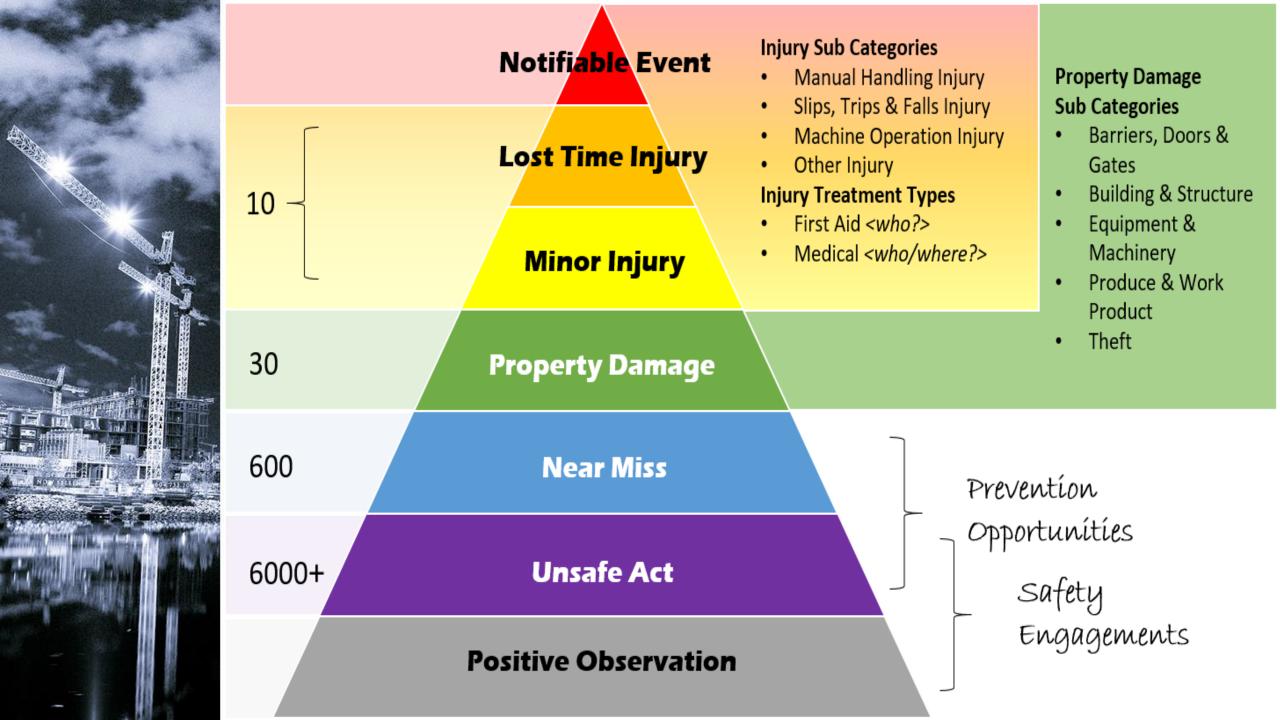
Notifiable Incidents

A notifiable incident is when:

- a person dies
- a person experiences a serious injury or illness
- a potentially dangerous incident occurs.

Significant penalties apply if you don't notify us of a 'notifiable incident'.

You must notify your insurer within 48 hours.



When do you conduct an investigation?

- All incidents, whether a near miss or an actual injury-related event, should be investigated.
- Near miss reporting and investigation allow you to identify and control hazards before they cause a more serious incident.
- Accident/incident investigations are a tool for uncovering hazards that either were missed earlier or have managed to slip out of the controls planned for them. It is useful only when done with the aim of discovering every contributing factor to the accident/incident to "foolproof" the condition and/or activity and prevent future occurrences.

The objective is to identify root causes.

Who should investigate?

- Management The usual investigator for all incidents is the supervisor in charge of the involved area and/or activity.
- **Employees** Accident investigations represent a good way to involve employees in safety and health. Employee involvement will not only give you additional expertise and insight, but in the eyes of the workers, will lend credibility to the results. Employee involvement also benefits the involved employees by educating them on potential hazards, and the experience usually makes them believers in the importance of safety, thus strengthening the safety culture of the organisation.
- Safety Representative The safety department or the person in charge of safety and health should participate in the investigation or review the investigative findings and recommendations.
- Safety Committee Many organisations use a team or a subcommittee or the joint employee-management committee to investigate incidents involving serious injury or extensive property damage.



- 1. Determine what happened.
- 2. Determine why the incident occurred.
- 3. Describe the incident that took place—in other words, what prompted the investigation?
- 4. Establish the facts surrounding the occurrence. This is the heart of the investigation—the investigator must determine who, what, when, where and why.
- 5. Determine whether previous action had been taken to correct the problem. If so, what was it? Why did it fail this time?

The Interview

- 1. What was the employee doing at the time of the accident?
- 2. Was the employee qualified to perform this operation?
- 3. Were company procedures being followed?
- 4. Is there a documented Work Method in place?
- 5. Is the job or process new? Had the employee received training on this operation prior to the accident?
- 6. Were proper tools or equipment being used?
- 7. Was the proper supervision being provided?

The Interview

- 8. What was the location of the accident?
- 9. What was the physical condition of the area when the accident occurred? For example, was the temperature of the area hot or cold; if outside, was it wet or muddy; was there debris in the area, was the area clear, etc.?
- 10. What were witnesses doing at the time of the accident?
- 11. What immediate or temporary action could have prevented the accident or minimized its effect?
- 12. What long-term or permanent action could have prevented the accident or minimized its effect?
- 13. Did any unsafe act contribute to the cause of the accident? If so, is any disciplinary action being recommended?
- 14. Had any disciplinary action been taken with this individual for unsafe acts in the past?

Root Cause Analysis

Root Cause Analysis seeks to identify the origin of a problem. It uses a specific set of steps, with associated tools, to find the primary cause of the problem, so that you can:

- Determine what happened
- Determine why it happened
- Figure out what to do to ensure it will not happen again

Three Main Root Cause

- Physical causes (Work Factors) Tangible, material items failed in some way (for example, a car's brakes stopped working).
- **Human causes (Unsafe Acts)** People did something wrong. or did not doing something that was needed. Human causes typically lead to physical causes (for example, no one filled the brake fluid, which led to the brakes failing).
- Organisational causes (Unsafe Conditions) A system, process, or policy that people use to make decisions or do their work is faulty (for example, no one person was responsible for vehicle maintenance, and everyone assumed someone else checks the brake fluid level in the service trucks).





Above the surface you see the **Symptoms** of the problem

Dig deeper to find the Root Cause of the problem



STEPS TO CONDUCT

Root Cause Analysis

A SYSTEMATIC ANALYSIS TO UNCOVER THE FUNDAMENTAL OR DEEP-SEATED CAUSES OF AN INCIDENT, FAILURE, OR PROBLEM

STEP 1

STEP 2

STEP 3

STEP 4

STEP 5

STEP 6













Define the problem (or areas of improvement) Assemble as much data and inputs as possible.

Locate the 'root' causes Find
'Corrective'
and
'Preventive'
solutions

Create
actionable
strategies to
implement the
solution

Monitor the solution and confirm if it works



