Incident reporting and investigation procedures

Term	Definition
Accident	Any situation that occurred that resulted in injury or illness to individuals, damage or loss to assets, the environment, third parties or a loss of business opportunity.
Incident	Any situation that occurred and could have caused injury, illness to individuals and/ or damage/loss to assets, the environment or third parties but did not.
Near Miss	Any situation which had the potential to cause injury, illness, damage and/ or loss, but was avoided.
Occupational Disease	A disease or disorder that is caused by work or working conditions. The disease must have developed due to exposures in the workplace and the correlation between the exposures and the disease is well known in medical research.
First Aid Case (FAC)	The application of accepted principles of treatment on the occurrence of an injury or in the case of sudden illness using facilities and materials available at the time.
Medical Treatment Case (MTC)	Injury at work (other than LTI and RWC) requiring treatment from a doctor, that goes beyond first aid treatment, before the injured person resumes normal work. Medical treatment case does not result in lost time from work beyond the date of the injury.
Restricted Work Case (RWC)	Injury at work that results in limitations on work activity but does not lead to absence from the next scheduled work period, because of alternative job assignment.

What is the process of reporting an incident. What is the procedure for completing an incident report. What is incident reporting and investigation. What is the incident reporting procedure. What is included in an incident report. Incident reporting and investigation policy/procedures.

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QMS ISO 9001 EMS ISO 14001 OH&S ISO 45001 Incident Reporting & Investigation Procedure The purpose of this procedure is to outline your organization’s methodology to establishing the processes required for an effective incident and near miss response programme which methodically examines all undesired events that have or could have resulted in physical harm to interested parties or result in damage to property. The intent of any resulting investigation is to establish the facts and circumstances related to the event in order to determine the root-cause and develop remedial action to control the risk. 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The application of our templates is scalable and generic; regardless of the size and type of organization. Page 2 Incident reporting and investigation are reactions triggered by an event. In addition to reporting and investigating the incident, statistics should be recorded and analysed to identify trends and needs. Legal Obligation Employers have a legal obligation and a workers’ compensation insurance requirement to ensure incident reports and investigations are completed. Incident reporting and investigation contribute to the corporate memory. These memories demonstrate failures in existing systems and assist in learning from these failures so we can prevent similar or worse loss in future. Reporting The trending reports that are produced from investigating and reporting incidents can be used to identify deficiencies in the system so that corrections and improvements can be made. Review This clause states the requirements for the occurrence of an incident or nonconformity. The requirements also include action to prevent a similar incidents or nonconformities occurring. This must be achieved via review and analysis to determine what caused it, and any actions to prevent it re-occurring in the future. Analysis of incident reports suggests that many incidents are related to breakdowns in areas such as training, competence, planning and implementation of tasks, maintenance of equipment etc. The organisation needs to put in place systems which enable the capture and evaluation of non-harm events, so that appropriate corrective and preventive actions might be implemented, which either prevent occurrence or recurrence of the events. Processes and Procedures There needs to be robust systems in place to ensure that incidents are adequately investigated and appropriate lessons are learned. ISO 45001 requires your organization to put in place procedures to respond to health and safety related nonconformities. The definitions given in ISO 45001 are helpful in understanding the differences in terms, but put

simply, this clause addresses the need to manage things that either could have gone wrong or actually have gone wrong. The procedures need to ensure that proper control is exercised over the reporting and investigation of incidents, incidents and nonconformances, that any immediate actions are put in place, and that any longer-term corrective, or even preventive, actions are initiated and completed. The procedures need to define responsibilities for those involved at all stages of the process. The system needs to take account of injury or damage to employees, visitors, contractors and members of the public, as well as looking at property damage. There needs to be a thorough investigation of all incidents, so that the root-causes of the problem may be properly understood. Data needs to be gathered and records maintained of all stages in the investigation process. It is vital that relevant corrective action be put in place to address problem that have arisen. This action should be reviewed through the risk assessment process prior to implementation; after all, the intention is not to make an unsafe situation worse! Immediate Action It is vital that unsafe situations are made safe as soon as practicable, which means that corrective action may take place in a number of phases with immediate action to prevent further harm, and medium or longer-term action, dependent on the programme needed, to prevent recurrence of the issue. A formal system to implement preventive actions is also needed, using data gathered during audit and safety tours, or associated with changes of materials, processes or equipment etc. Again, proper records need to be taken of any preventive actions put into place, and they should of course have been subject to risk assessment. Analysis All nonconformances need to be classified and analysed on a regular basis, so that the organisation may understand how effective the health and safety management system is proving to be. The analysis should include such things as incidents, injuries, lost time, ill-health absence, absenteeism, types of damage etc. The results of the analysis need to be communicated to all relevant interested parties. This is particularly the case where the organisation is active at a number of sites or in a number of countries, where the spreading of ‘learning opportunities’ may be more difficult. Corrective actions are not closed-out, or there is no objective evidence of close-out Inconsistency of actions throughout the organisation Lack of communication about issues The mechanism for collecting information on near-misses is weak or non-existent Lack of awareness Inadequate investigation of incidents Poor close-out of identified actions No review or evidence of review of risk assessments Corrective actions not subjected to risk assessment Implementing a systems approach will help ensure all incident investigations are successful. Step 1: Preserve and Document the Scene Preserve the scene to prevent material evidence from being removed or altered; investigators can use cones, tape, and/or guards. Document the scene by documenting the incident facts such as the date of the investigation and who is investigating. Essential to documenting the scene is capturing the injured employee’s name, injury description, whether they are temporary or permanent, and the date and location of the incident. Investigators can also document the scene by video recording, photographing and sketching. Incident information is collected through interviews, document reviews and other means. In addition to interviews, investigators may find other sources of useful information. These include: Equipment manuals Industry guidance documents Company policies and records Maintenance schedules, records and logs Training records (including communication to employees) Audit and follow-up reports Enforcement policies and records Previous corrective action recommendations Interviews Interviews can often yield detailed, useful information about an incident. Since memories fade, interviews must be conducted as promptly as possible: preferably as soon as things have settled down a bit and the site is both secure and safe. The sooner a witness is interviewed, the more accurate and candid his/her statement will be. An incident investigation always involves interviewing and possibly re-interviewing some of the same or new witnesses as more information becomes available, up to and including the highest levels of management. Carefully question witnesses to solicit as much information as possible related to the incident. Since some questions will need to be designed around the interviewee, each interview will be a unique experience. When interviewing injured workers and witnesses it is crucial to reduce their possible fear and anxiety, and to develop a good rapport. Tips for Interviewers When conducting interviews, investigators should: Conduct the interview in the language of the employee/interviewee; use a translator if needed Clearly state that the purpose of the investigation and interview is fact-finding, not fault-finding Emphasize that the goal is to learn how to prevent future incidents by discovering the root-causes of what occurred Establish a climate of cooperation, and avoid anything that may be perceived as intimidating or in search of someone to blame for the incident Let the employee know that they can have an employee representative (e.g.;, labor representative), if available/appropriate Ask the individuals to recount their version of what happened Do not interrupt the interviewee Take notes and/or record the responses; interviewee must give permission prior to being recorded Have blank paper and or sketch available for interviewee to use for reference Ask clarifying questions to fill in missing information Reflect back to the interviewees the factual information obtained; correct any inconsistencies Ask the individuals what they think could have prevented the incident, focusing on the conditions and events preceding the injury Step 3: Determine the Root-causes The root-causes of an incident are exactly what the term implies: The underlying reasons why the incident occurred in a workplace. Root-causes generally reflect management, design, planning, organizational and/or operational failings (e.g.; employees were not trained adequately; a damaged guard had not been repaired). Finding the root-causes goes beyond the obvious proximate or immediate factors; it is a deeper evaluation of the incident. This requires persistent “digging”, typically by asking “Why” repeatedly. Conclusions such as “worker was careless” or “employee did not follow safety procedures” don’t get at the root-causes of the incident. To avoid these incomplete and misleading conclusions in the investigative process, investigators need to continue to ask “why?” as in, “Why did the employee not follow safety procedures?”. If the answer is “the employee was in a hurry to complete the task and the safety procedures slowed down the work”, then ask “Why was the employee in a hurry?” The more and deeper “why?” questions asked, the more contributing factors are discovered and the closer the investigator gets to the root-causes. If a procedure or safety rule was not followed, why was the procedure or rule not followed? Did production pressures play a role, and, if so, why were production pressures permitted to jeopardize safety? Was the procedure out-of-date or safety training inadequate? If so, why had the problem not been previously identified, or, if it had been identified, why had it not been addressed? It cannot be stressed enough that a successful incident investigation must always focus on discovering the root-causes. Investigations are not effective if they are focused on finding fault or blame. If an investigation is focused on finding fault, it will always stop short of discovering the root-causes, because it will stop at the initial incident without discovering their underlying causes. The main goal must always be to understand how and why the existing barriers against the hazards failed or proved insufficient, not to find someone to blame. The questions listed below are examples of inquiries that an investigator may pursue to identify contributing factors that, in turn, can lead to root-causes: If a procedure or safety rule was not followed, why was the procedure or rule not followed? Was the procedure out of date or safety training inadequate? Was there anything encouraging deviation from job procedures such as incentives or speed of completion? If so, why had the problem not been identified or addressed before? Was the machinery or equipment damaged or fail to operate properly? If so, why? Was a hazardous condition a contributing factor? If so, why was it present? (e.g.; defects in equipment/tools/materials, unsafe condition previously identified but not corrected, inadequate equipment inspections, incorrect equipment used or provided, improper substitute equipment used, poor design or quality of work environment or equipment) Was the location of equipment/materials/worker(s) a contributing factor? If so, why? (e.g.; employee not supposed to be there, insufficient workspace, “error-prone” procedures or workspace design) Was lack of personal protective equipment (PPE) or emergency equipment a contributing factor? If so, why? (e.g.; PPE incorrectly specified for job/task, inadequate PPE, PPE not used at all or used incorrectly, emergency equipment not specified, available, properly used, or did not function as intended) Was a management programme defect a contributing factor? If so, why? (e.g.; a culture of improvisation to sustain production goals, failure of supervisor to detect or report hazardous condition or deviation from job procedure, supervisor accountability not understood, supervisor or worker inadequately trained, failures to initiate corrective actions recommended earlier) Accidents/incidents are seldom caused by a single human error or technical failure. They are mostly a result of series of failures in different parts of multiple systems. Therefore, you may need to conduct an internal incident investigation (including visiting the scene, conducting interviews, taking phones, and checking records, etc.) to improve understanding of the events leading up to the incident. Step 4: Implement Corrective Actions The investigation is not complete until corrective actions are implemented that address the root-causes of the incident. Implementation should entail programme level improvements and should be supported by senior management. Note that corrective actions may be of limited preventive value if they do not address the root-causes of the incident. Throughout the workplace, the findings and how they are presented will shape perceptions and subsequent corrective actions. Superficial conclusions such as "He/she should have used common sense," and weak corrective actions such as “Employees must remember to wear PPE”, are unlikely to improve the safety culture or to prevent future incidents. In planning corrective actions and how best to implement them, employers may find that some root-causes will take time and perseverance to fix. Persisting in implementing substantive corrective actions, however, will not only reduce the risk of future incidents but also improve the company’s safety, morale and its bottom line. Specific corrective actions address root-causes directly; however, some corrective actions can be general, across-the-board improvements to the workplace safety environment. Sample global corrective actions to consider are: Strengthening/developing a written comprehensive safety and health management programme Revising safety policies to clearly establish responsibility and accountability Revising purchasing and/or contracting policies to include safety considerations Changing safety inspection process to include line employees along with management representatives Step 5: Feedback to Person(s) Reporting the Incident Upon completion of the investigation, a closing meeting should be scheduled between the investigation team and the parties responsible for implementing recommendations. All parties should commit themselves to respect the results of the investigation and to develop a corrective action plan in response to the findings. Corrective action plans should be documented in a way that allows for accountability and future follow-up. To build up and maintain employees’ confidence in reporting incidents, ways should be established for employees to follow up to find out what actions are taken as a result of their reports. Feedback to employees is even more important when no action is taken, because in the absence of any visible action and follow-up, employees will come to see less meaning in reporting incidents and eventually will stop reporting them. For anonymous reports, this feedback may be circulated in the form of a notice board, a message on the company intranet or an e-mail to all employees containing a brief statement of the reported issue and action(s) taken based on the report, or the reason(s) why no action needs to be taken. Review of Hazard and Incident Reports by the OH&S Committee. Monitor the adequacy of investigations undertaken and the appropriateness and effectiveness of the corrective/preventive actions recommended Provide advice on corrective/preventive action recommended and/or make further recommendations as necessary Review the implementation and effectiveness of recommended corrective/preventive action of previous incidents Disseminate relevant information arising from hazard and incident investigations to appropriate sections of the business Analyse trends in hazard and incident reports received so as to be able to recommend and monitor prevention programmes Related Information You Might Find Useful Next ISO 45001 Clause 10.3 Continuous Improvement Each ISO 45001 Clause Explained Learn More About ISO 45001

23/02/2022 · Under clause 10.2 of ISO 45001, companies need to establish, implement and maintain a process for the investigation and reporting of incidents. Taking corrective action, the company can be better equipped to react to future incidents and manage them effectively. The Incident Reporting and Investigation Procedure for ISO 45001 consists of six ... Part B - Procedures (8) Incident reporting and investigation are essential to achieve a healthy and safe work, learning and research environment for all staff, students, contractors and visitors at Victoria University. Comprehensive incident recording, investigation and reporting are fundamental to ensuring that adequate preventive action is taken following an incident. 23/02/2022 · Under clause 10.2 of ISO 45001, companies need to establish, implement and maintain a process for the investigation and reporting of incidents. Taking corrective action, the company can be better equipped to react to future incidents and manage them effectively. The Incident Reporting and Investigation Procedure for ISO 45001 consists of six ... An incident reporting procedure flow chart or 'workflow'. Once this initial incident report is completed, your flow chart or workflow events will 'begin' - and these workflows should become as standardised as possible. You'll see an example of a simple workflow and actioned safety incident flow chart below. To define the procedure for event and incident reporting and investigation. 2.0 Scope This guideline is applicable to all events and incidents (except equipment or machine breakdown related), which can affect the safety, identity, strength, purity and/ or quality of the product which can be, ... Unplanned deviations from approved procedures e.g ... An incident reporting procedure flow chart or 'workflow'. Once this initial incident report is completed, your flow chart or workflow events will 'begin' - and these workflows should become as standardised as possible. You'll see an example of a simple workflow and actioned safety incident flow chart below. To define the procedure for event and incident reporting and investigation. 2.0 Scope This guideline is applicable to all events and incidents (except equipment or machine breakdown related), which can affect the safety, identity, strength, purity and/ or quality of the product which can be, ... Unplanned deviations from approved procedures e.g ... Part B - Procedures (8) Incident reporting and investigation are essential to achieve a healthy and safe work, learning and research environment for all staff, students, contractors and visitors at Victoria University. Comprehensive incident recording, investigation and reporting are fundamental to ensuring that adequate preventive action is taken following an incident.

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