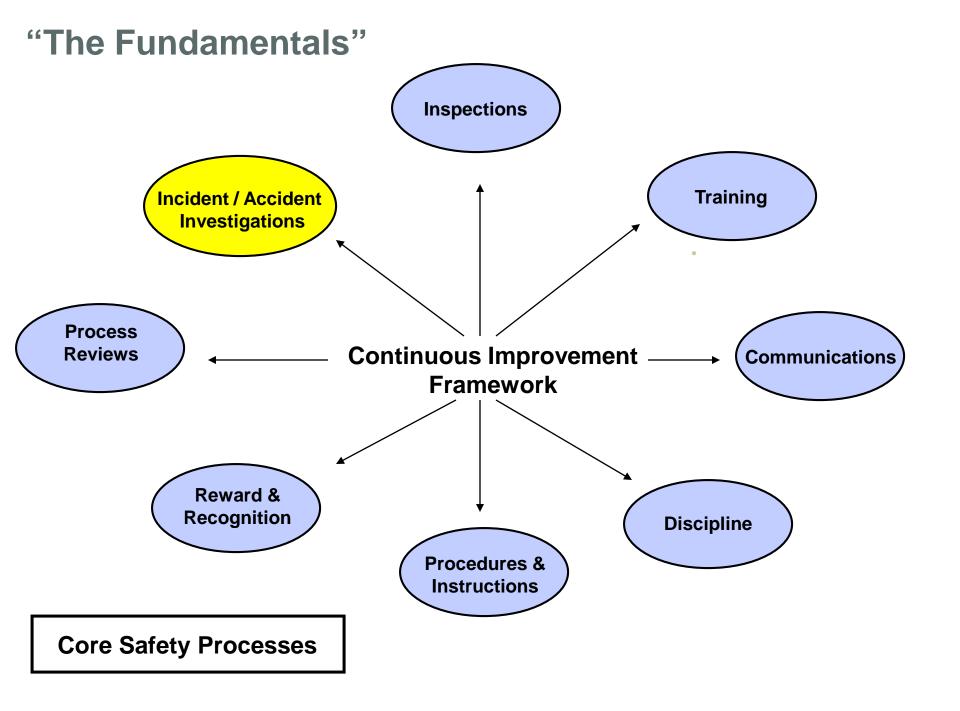
Effective Loss Control Through Accident/Incident Investigation, Reporting and Follow-up



Graphic provided by EMC Insurance

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What Is An "Incident"?

An **incident** is an unplanned and unwanted event which disrupts normal activities and has the potential of resulting in injury, harm, or damage to persons or property (e.g. fall on steps with no injury).

An incident disrupts the work process, does not result in injury or damage, but should be looked as a "wake up call". It can be thought of as the first of a series of events which could lead to a situation in which may become a loss.

What Is An "Accident"?

By dictionary definition: "an unforeseen event", ".chance..", "unexpected happening..", formerly "Act of God"

An **accident** is an unplanned and unwanted event definite as to time and place which disrupts normal activities and results in an injury, harm, or damage to persons or property (e.g. fall on steps resulting in a broken ankle).

What Is An "Accident"?

- An accident is NOT "just one of those things" or "just bad luck."
- From experience and analysis accidents are "caused occurrences."
- Accidents are predictable events they are the logical outcome of hazards.
- Accidents are preventable and avoidable hazards do not have to exist. They are often
 caused by things people do -- or fail to do.
- Accidents don't have to happen!



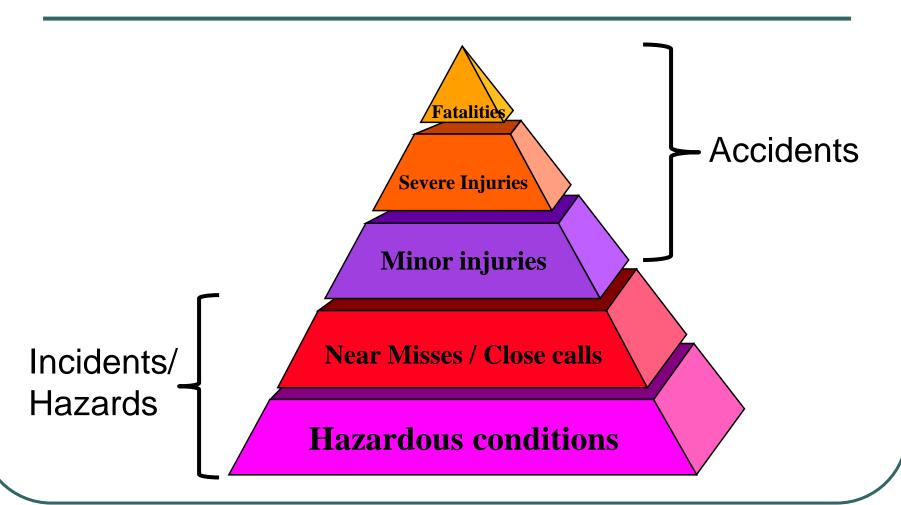
A Simplified Way to Look At "Incident" vs. "Accident"?

An **incident** is an accident without loss (injury or damage)

An **accident** is an incident with loss (injury or damage)



A Simplified Way to Look At "Incident" vs. "Accident"?

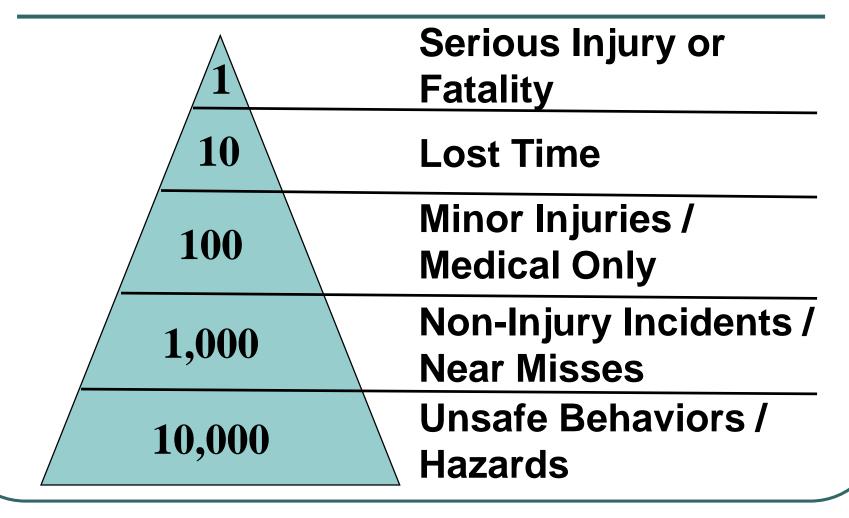


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What Is An "Occurrence"?

An **occurrence** is an accident with the limitation of time removed - an "accident" that is extended over a period of time rather than a single observable happening (e.g. bus mechanic experiencing hearing loss, mold problem from a prolonged roof leak).

Loss Control Hierarchy



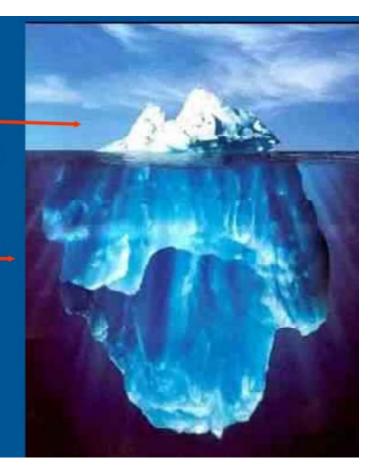
Look at it as the "Tip of the Iceberg"

Accidents

Accidents or injuries represent only a fraction of the errors that exist.

Incidents

Investigate incidents since they are potential "accidents in progress".



Accident cost iceberg Injury & illness costs \$1 Medical **Compensation costs (insured costs)** epsemsb politica 🕒 \$5 to \$50 epamab inemqiupe bus looT • Product and material damage Ledger costs of Production delays and interruptions property damage zeznegxe ligoel • Expenditure of emergency supplies (uninsured costs) Interim equipment rentals Investigation time \$1 to \$3 Wages paid for time lost Cost of hiring and/or training Uninsured replacements miscellaneous Overtime Extra supervisory time costs Clerical time Decreased output of injured worker upon return Loss of business and goodwill

Benefits of Incident/Accident Investigation

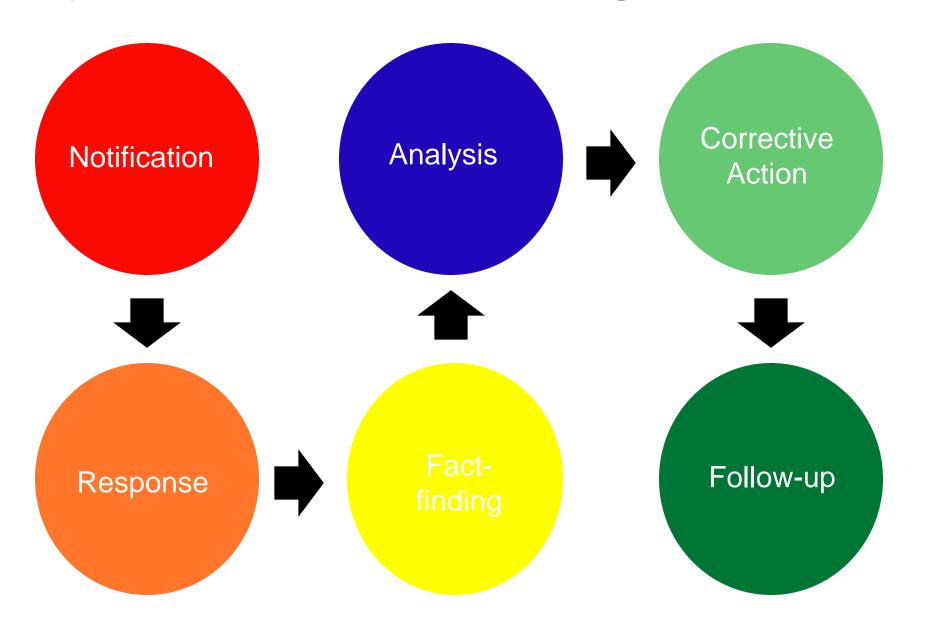
- Prevent future accidents/incidents by identifying and eliminating hazards
- Expose deficiencies in process and/or equipment
- Maintain worker morale
- Greater safety awareness provides the cornerstone for a effective workplace safety / injury prevention program
- Facts gathered in the even of litigation
- Reduce injury and worker compensation costs



Accident Investigation

- The goals of accident investigation are:
 - Determine/find the root cause(s)
 - Take the appropriate corrective action(s)
 - Prevent a similar accident/incident from happening again
- No accident investigation has ever changed what has already happened
- Accident investigation should NOT assign blame - it should identify breakdowns in the safety process

Steps in the Accident Investigation Process



Notification

Your plan, policy, procedure or process should, at a minimum, address:

- What types of incidents/accidents required to be reported and investigated
 - All injuries or accidents with the potential for injury
 - All incidents/accidents resulting in property damage
 - All "near misses" where there was potential for serious injury
- Who, internally and externally, should be notified when an incident/accident occurs
- How the incident/accident should be reported

Notification

- Is there an established safety-oriented culture within the school district?
- Is there a positive relationship between the school district and its employees?
- Are effective processes in place to encourage and facilitate timely reporting of incidents/ accidents to the appropriate district staff?
- Have barriers to report incidents/accidents been identified and removed?
 - Employee/supervisor accident reporting training
 - Electronic or on-line accident reporting functionality

Response

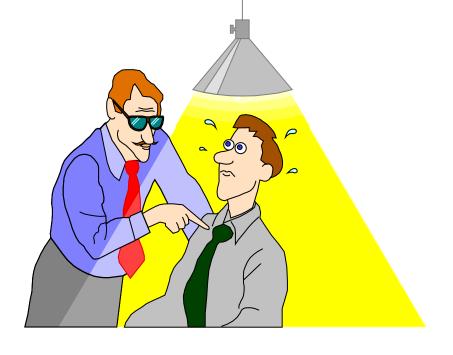
- Obtain/ensure medical treatment
- Eliminate dangerous/obvious hazard
 - Don't wait for investigation process
- Secure the accident scene
 - Control unsafe conditions
 - Preserve material (critical) evidence
 - Prepare for possible third party involvement
- Provide appropriate notifications regarding the accident/injury
- Identify who should be involved in the accident investigation process

Fact-finding

- Collect / gather accident-related information
- Examine / document the accident scene
 - Note location of person(s) at the time of the accident
 - Note location of objects
 - Note conditions (including weather if applicable)
 - Take photographs or video (as warranted)
- Develop a sequence of events
 - Detailed step by step description of the accident
 - Do not just describe the accident itself, include a description of the events that led up to the accident

Fact-finding

- Interview the injured employee(s) <u>as soon as possible</u>
- Identify and interview accident witnesses
- Utilize practical, simple approaches
 - Who, What, Where, When, How, WHY
- Keep probing for more information
- Don't jump to conclusions and recommendations too quickly
- Remember that accidents rarely result from a single cause - they usually result from network of multiple causes



Interviewing

When is it best to interview? Why?

Who should we interview? Why?

Where should we conduct the interview?

Determining and understanding the cause(s) of the accident

- Start by analyzing the events to discover the surface cause(s) for the accident
 - Surface causes are usually obvious/evident and not overly difficult to determine
- Then, by working to understand the "WHY" behind the system factors, the related root cause(s) are uncovered
- Focus on the underlying causes (the root causes), not symptoms (the surface causes)

The WHAT and WHY factors of accident/incident investigation:

WHAT happened?

- Identifying/determining the <u>surface cause(s)</u>
 - What were the conditions?
 - What was the employee doing?

WHY did it happen?

Identifying/determining the <u>root cause(s)</u>

The **surface causes** of accidents are those hazardous conditions and <u>individual</u> unsafe employee/manager acts or behaviors that have directly caused or contributed in some way to the accident.

Hazardous conditions may exist in any of the following categories:

- Materials
- Machinery
- Equipment
- Tools
- Chemicals

- Environment
- Workstations
- Facilities
- People
- Workload

Most hazardous conditions are the result of an unsafe behavior(s) that produced them. Examples of unsafe employee/manager behaviors include:

- Failing to comply with rules
- Using unsafe methods
- Taking shortcuts
- Horseplay
- Failing to report injuries
- Failing to report hazards

- Allowing unsafe behaviors
- Failing to train or inadequate training
- Failing to supervise
- Failing to correct
- Excessive workload

The **root causes** for accidents are the underlying system weaknesses that have somehow contributed to the existence of hazardous conditions and unsafe behaviors that represent surface causes of accidents.

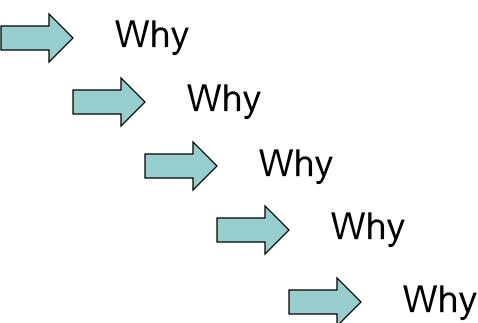
A **root cause** is the cause that, if corrected, should prevent recurrence of this and similar occurrences.

Root cause analysis is a systematic technique that focuses on <u>finding the real cause of a problem and dealing with that, rather than just dealing with its symptoms (surface causes)</u>.

Scale the scope of the analysis to suit the seriousness or complexity of the accident / incident.

Multiple Root Cause Analysis: "WHY" Analysis





There are two categories of root causes:

- System design weaknesses
 - Missing or inadequately designed policies, programs, plans, processes or procedures will affect conditions and practices generally throughout the workplace.
 Defects in system design represent <u>hazardous</u> <u>system conditions</u>.
- System implementation weaknesses
 - Failure to initiate, carry-out or accomplish safety policies, programs, plans, processes or procedures.
 Defects in implementation represent ineffective management behavior.

System Design Weaknesses

- Missing or inadequate safety policies/ procedures
- Missing or inadequate training program
- Poorly written plans
- Inadequate process
- Lack of procedures

System Implementation Weaknesses

- Safety policies/rules are not being enforced
- Safety training is not being conducted
- Lack of adequate or appropriate supervision
- Incident/accident analysis is inconsistent

The "Accident Weed"

Unsafe Conditions

Unsafe Practices

Missing guard

Poor housekeeping

Defective tools

Equipment failure

No MSDS's

Horseplay

Ignored safety rules

Didn't follow procedures

Did not report hazard

Don't know how

Poor work procedures

No follow-up/feedback

Lack of Training

Poor safety management

Purchasing unsafe equipment

Lack of supervision

Rules not enforced

Lack of safety leadership

Poor safety leadership

Root Causes

Corrective Action

Developing corrective or preventative actions is the most important step in the accident/incident investigation process.

All the efforts leading up to this step culminate with <u>recommendations to prevent similar</u> <u>accidents from happening in the future</u>.

If root causes are not corrected, it is only a matter of time before a similar accident occurs.

Corrective Action

- Identify and address multiple root causes
 - Not just the apparent, immediate causes
- Develop system controls to address or solve the causes
 - If this is corrected, will the likelihood of recurrence be eliminated?
 - Are the controls systematic <u>and</u> sustainable?
- Multiple root causes need multiple controls
 - Avoid focus on a single solution
- Identify those persons who are responsible for corrective/preventative actions

Follow-up

- Establish a timeline and process to follow-up on corrective actions
 - Who is responsible for implementing?
 - Who is responsible for following-up on that person?
- Evaluate to find out or determine if the corrective actions are effective in preventing similar accidents from occurring
- Modify or revise corrective actions as needed
- Share / communicate the results

Tips on Investigating Accidents and Injuries

When investigating we want to GAIN knowledge!

- 1) **G**o to and secure the accident scene
 - Accident / investigation report/ form (FILL OUT COMPLETELY!)
- 2) **A**sk
 - Open ended questions; <u>Tell</u> me how...
 - For a demonstration; <u>Show</u> me how…
 - For employee input; What do you think can be done?
- 3) Interview accident victims / witnesses separately
- 4) Never place blame; look for FACTS ONLY!

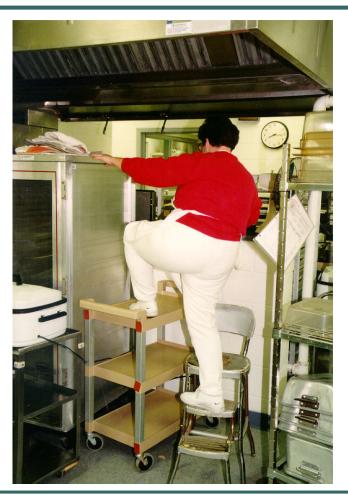
A food service employee for Yourtown School District was injured during the 2010-11 school year while cleaning filters in the exhaust hood system. The injury was serious and resulted in a torn rotator cuff, surgery, and extended time away from the job. The eventual cost of the claim was \$149,678.

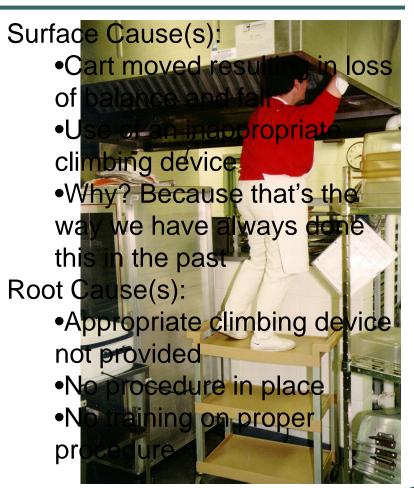
What was this employee doing to get so severely injured?

If no investigation of this incident occurs, could a similar accident happen in the future?

Let's investigate!

- Interview the injured employee
- Interview witnesses
- Interview the supervisor
- Inspect the accident site/scene/equipment
- Determine:
 - Surface causes Unsafe acts and/or unsafe conditions / hazards
 - Root causes Policies/procedures, decisions, personal factors, environmental factors







Remember the cost?

- \$149,678 in medical costs and wage replacement

In addition:

- Substitute costs
- \$21,990 in additional WC Premium

If future occurrence of this activity is eliminated through accident investigation is it worth it?

Only in a School.....



Thank You

Thank you for your on-going efforts and leadership in helping to provide a safe environment for the students, staff and parents/visitors to your schools!!!!!