

# Section 5: Safety Management Systems

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**Policy # TBD:** Incident Reporting and Investigation

**Effective Date:** April 8, 2016

**Last Revision Date:** Original

## I. Purpose

The Incident Reporting and Investigation policy outlines requirements and standard practices in relation to recording and reporting of health and safety related incidents that occur at the Town of Mooresville, as well as any associated injuries and illnesses. It outlines statutory obligations in regard to reporting of notifiable work-related injuries, illnesses, or hazardous occurrences. Additionally, it is intended to support the Town's Manager, department directors, supervisors, and the Risk Management Department by providing comprehensive procedures for incident notification, adequate investigations, and required reporting. It is imperative that all incidents, near-misses, and hazards are reported and properly documented to ensure:

- Adequate investigations are consistently performed and appropriate corrective actions are taken to prevent recurrence of the incident;
- Data is consistently collected in order to provide trend analysis, enabling the Town to concentrate on preventative measures and efficiently allocate its resources to better safeguard employees;
- A formal record has been completed and retained as may be required by North Carolina statute or Occupational Safety & Health Administration (OSHA) regulations, or should it be required at a later date, for evidence or reference; and
- All legal requirements in relation to the reporting of workplace injuries and Workers' Compensation have been met.

## II. Scope

This policy shall apply to all persons holding a paid position as an employee of the Town, as well as temporary employees routinely supervised by Town. Exceptions to this policy may include members of any volunteer board or committee, or any others that may be hired or appointed by the Town Board. For this purpose, and subject to the exceptions set out herein, Town employees shall be defined as those employees in departments and offices for which the Town Board serves as the final budget authority.

## III. Definitions

**Corrective Actions:** These are the actions taken after an incident to either prevent or reduce the risk of the same or similar incident from reoccurring. Generally, these actions are taken after the *Root Cause (see below)* of the incident has been identified and by implementing one or more *Hazard Control Methods (see below)*.

**Documentary Evidence:** includes paper and electronic information, such as records, logs, reports, photographs, policies, procedures, and other documentation relevant to the injury or incident.

**Emergency Responders:** Those responsible for immediately responding to the scene of an accident or emergency to provide assistance and secure the scene of the emergency. These generally include Fire/Rescue personnel, Law Enforcement Officers, and Emergency Medical Technicians (EMTs) or paramedics.

**Environmental Incident:** An incident that results in harm, or potential harm, to the environment by means of excessive noise, accidental release or spill, or excessive consumption of a specific resource.

**Eye Witness:** Participants or observers of the incident or of the events immediately preceding, during, or following the incident.

**Hazard:** Any unsafe condition, which if left uncontrolled, may contribute to an incident.

**Hazard Controls & Hierarchy:** Controlling exposures to occupational hazards is the fundamental method of protecting workers. Traditionally, a hierarchy of controls has been used as a means of determining how to implement feasible and effective control solutions. Understanding hazard control is especially important for the correct implementation of corrective actions to prevent repeat or similar incidents from reoccurring.

The most effective way to control a hazard is to Eliminate it completely (physical removal of the hazard). Another effective method is the Substitution of the hazard (replace or reduce hazard). An example of this is chemical substitution by replacing more harmful chemicals with those that present a lesser hazard. After this, Engineering Solutions must be considered. This is the reduction of severity or the isolation of people from the hazard. For example, a noisy machine could be placed on vibration dampening pads to lessen the noise exposure to the operator.

Administrative Controls, which are far less effective than engineering solutions, are taken into consideration. These are controls that change or dictate how people perform a task. This can include measures such as task rotations, shift rotations, limitations on particular tasks, and prohibitions from certain activities and are often seen in the forms of policies, procedures, safe operating procedures, or even verbal instructions from supervisors or managers. Effectiveness is lost in this measure as it requires operational discipline, oversight, and constant monitoring for consistency.

The least effective control method of all is Personal Protective Equipment, or PPE. In all cases, PPE should be considered the “last line of defense” for employees after substitution, engineering solutions, and administrative controls still present a potential hazard.

**Health Care Provider:** For purposes of this policy, the Health Care Provider is the provider contracted by the Town to provide medical care and treatment of employees for work-related injuries, follow-up care, evaluations, return to work, fit for duty, annual work required examinations, and all other work related medical processes, procedures, and care. The current provider for the Town is:

Iredell Occupational Medicine  
128 E. Plaza Drive (Aldi's Shopping Plaza)  
Mooresville, NC 28117  
(980) 444-2630 (office) (980) 444-2631 (fax)  
<http://www.iredellhealth.org/Occupational-Medicine.aspx>

**High Impact Incident “Major Incident”:** These are incidents that require timely reporting to a regulatory agency, or incidents that pose a significant risk to the Town, its citizens, its assets, or its employees. This includes any occupational fatality, as well as an injury that reaches the Occupational Safety & Health Administration (OSHA) definition of a catastrophe, amputation, or hospitalization. Additionally, these incident types could include hazards which present an immediate threat to life and safety, or a potentially significant environmental incident.

**Illness:** Any work-related illness, including disease.

**Investigator:** For purposes of this policy, the investigator is the supervisor or manager tasked with initial response to the incident, for gathering relevant evidence and information, filing the initial investigation report, and for working with Risk Management to implement suitable corrective actions.

**Near-Miss Incident:** An event that could have resulted in a work-related injury, property damage, or adverse environmental impact, but ultimately did not.

**Personal Protective Equipment (PPE):** refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment include physical, electrical, heat, chemicals, biohazards, and airborne particulate matter. PPE should be considered a "last resort" and the least effective of all the *Hazard Control Methods*.

**Physical Evidence:** These are the gathering or inspection of objects and items relevant to the incident. Workplace incident scenes are all different, and certain physical evidence may need to be left undisturbed at the scene, while other forms of physical evidence may require sampling and/or complete removal. Physical evidence for workplace incidents could include; damaged/failed PPE, tools, machinery or machine fragments, physical samples for analysis, or industrial hygiene samples.

**Potential Witnesses:** Those who are in the vicinity of the incident with knowledge of preceding events or conditions. These can include emergency responders, supervisors, other employees, citizens, or passersby. Generally, emergency responders should be considered witnesses and statements should be requested from them if possible.

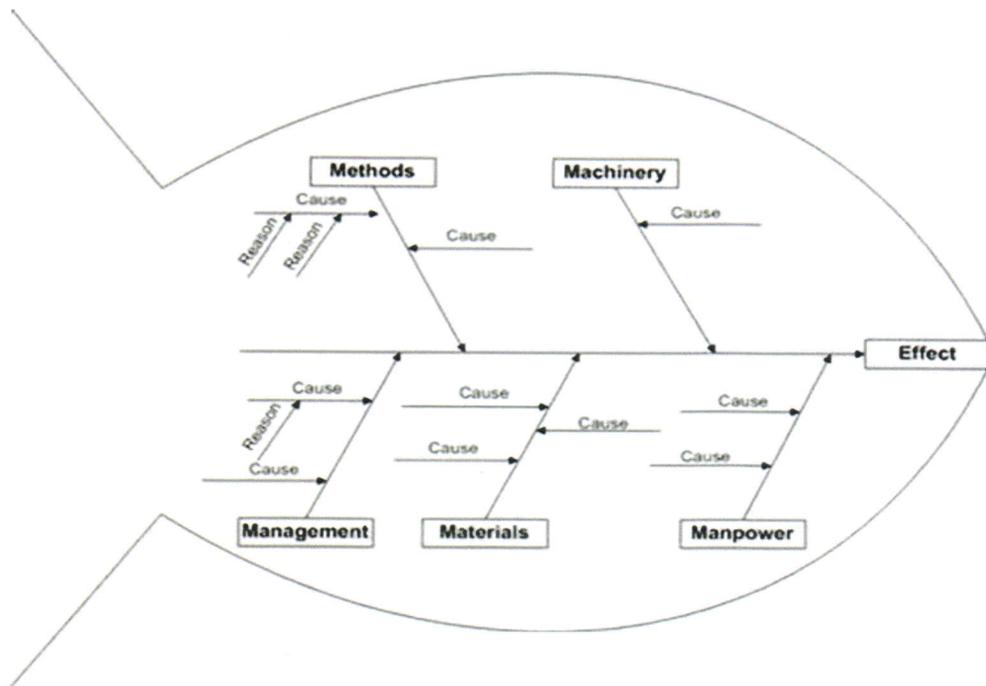
**Preventative Action(s):** Are actions taken to reduce or eliminate the likelihood of incidents and injuries from happening in the future. The implementation of preventative actions are a proactive approach to injury avoidance and normally less costly than mitigating the effects of negative events after they occur.

**Principle Witness:** Are those who were directly involved in or who sustained injury from the accident.

**Recordable Injury:** Any work-related injury that meets OSHA's Injury and Illness Recordkeeping and Reporting Requirements as outlined in 29 CFR § 1904. These injuries must be kept, or recorded, on the Town's OSHA 300 Log of the department in which the injury originated.

**Root Cause:** The originating cause of a condition or causal chain that led to an injury or incident. Generally, the root cause will describe the depth of the causal chain, or the point at which reasonable intervention could have been implemented to avoid the incident or injury. *For example: An employee was injured by falling off a piece of equipment that required a seatbelt to be worn. The root cause analysis of the investigation noted that the employee knew it was best to wear the seatbelt, but there was no actual policy or written procedure for this. No formal training had been given to the employee and the seat belt was not made of high-visibility material and hard for supervisors to enforce its use. Even though the employee may have known better, several contributing factors still remain including inadequate training, incorrect seatbelt type, and lack of written programs. Additionally, the root cause would be determined to be a lack of a seatbelt interlock system on the equipment. This engineering solution would have been at the core, or root, of the causal chain. Had the interlocks been installed, the machine would not have started and the injury avoided completely.*

**Root Cause Analysis:** A wide range of approaches, tools, and techniques used to uncover the root cause(s) of an incident. The Town's Intalex software utilizes an effective cause and effect approach, called the "Fishbone" approach, due to similarities of the diagram (see example below). This considers contributing or causal factors of the incident, such as the environment, people, processes, management, equipment/machinery, materials, and policies/procedures to help determine the effect, or root cause. This allows further implementation of effective corrective actions.



**Witness:** A witness is anyone who either directly observed or was affected by the incident, or who was directly or indirectly involved in the process, equipment, or system affected. Witness types can include; *principle witnesses, eye witnesses, and potential witnesses* (individually defined in this section). Statements from all witnesses should be taken as soon as possible, preferably before they leave the incident scene, to ensure that initial observations and impressions are not lost or altered.

**Work-Related Injury:** A personal injury by accident arising out of or in the course of employment, or while an employee is acting on the employer's behalf or instruction.

#### IV. Assignment of Responsibility

- A. **Individual Employees** including full-time, part-time, intermittent, or temporary employees that have been involved with or witnessed a work-related injury, property damages or loss, environmental incident, or near-miss shall:
  1. Report the incident or injury to their immediate supervisor as soon as possible,
  2. Ensure all required witness statement forms (Attachment A) have been completed and returned to their immediate supervisor within 24 hours,
  3. Participate as requested in all aspects of the incident investigation process, and
  4. Provide accurate and detailed information relevant to the incident.
  
- B. **Department Directors and Management** will be responsible for:
  1. Ensuring all work-related injury, property damage or loss, environmental incident, or near-misses involving their respective employees are reported, properly investigated, and all corrective actions provided in an incident outcome have been implemented in a timely manner to prevent similar incidents or injuries from reoccurring,
  2. Designating an incident investigator from their supervisory staff and ensuring that the designee has been provided the time, materials, facilities, and assistance required to adequately perform that function,
  3. Confirming that all employees in their respective department have understood this policy and the procedures it contains, have been provided suitable training, and can demonstrate competency to carry out their roles as policy requires,

4. Review incidents and confer with the Risk Management Department as needed to adequately address incidents and injuries, as well as implement necessary corrective actions,
5. Providing support, cooperation, and necessary resources to both Risk Management and designated supervisor(s) during the incident investigation process, and
6. Notifying the next of kin in the event of a workplace fatality.

C. **The Risk Management Department** will be responsible for:

1. Providing technical assistance, resources, information, and guidance throughout the investigation process as needed,
2. Contact and reporting to regulatory agencies including, N.C. Dept. of Labor (NCDOL), the Occupational Safety & Health Administration (OSHA), N.C. Industrial Commission (NCIC), N.C. Dept. of Environment & Natural Resources (NCDENR), N.C. Dept. of Health & Human Services, the Environmental Protection Agency (EPA), N.C. Dept. of Transportation (NCDOT), N.C. Dept. of Agriculture & Consumer Services (NCACS), Iredell County, or any other regulatory body in regards to an injury, incident, or environmental release,
3. Review and approval of all incident reports and investigations,
4. Final determination of an incident's root cause, corrective actions, and corrective action timeframes, and
5. Providing conclusions regarding incident preventability (if and when applicable).

D. **Department or Shift Supervisors** designated by the Department Director or Manager to conduct an investigation must be trained in the use of Risk Management's Intelex software for Incident Management and Injury Reporting. They must also be provided with training in Injury Case Management, Workplace Incident Investigations, and Root Cause Analysis. They will be responsible for:

1. Providing an immediate response to the scene of major incidents and injuries,
2. Securing the incident scene as needed in order to obtain evidence, gather information, and collect potential witness statements,
3. Immediate notification to Risk Management of all **major** incidents or injuries,
4. Notifying Risk Management before the end of shift of any minor employee injuries,
5. Notifying Risk Management of all other incidents and near-misses within 24 hours,
6. Concluding incident investigations, recommending corrective actions, and submitting reports via Intelex to Risk Management within 72 hours,
7. Gathering and reviewing all witness statement forms (Attachment A) from all involved parties,
8. Using investigation conclusions to suggest possible root cause(s) and corrective actions for both major and minor incidents, and
9. Following up to ensure all final corrective actions have been implemented properly and within given timeframes.

V. **Legislation and References**

1. 29 CFR § 1904, Occupational Injury and Illness Recording and Reporting Requirements
2. The North Carolina Workers' Compensation Act. (1929 c. 120, s. 1; 1979, c. 714, s. 1.)
3. Haight, J. M. (Ed.). (2012). Workplace Hazard Prevention Management (2 ed.). Des Plaines, IL: American Society of Safety Engineers.
4. McNeely, A. (2013). Public Sector Establishments for Recordkeeping. Division of Occupational Health and Safety. Raleigh: North Carolina Department of Labor.
5. NSC. (2011). Incident Investigation: Root Cause Analysis. Itasca, IL: National Safety Council.

VI. **Policy and Compliance Methods**

1. Provide Emergency Response: At any incident the primary focus should be the health and safety of our people. When required, ensure injured employees are given the care they need first.
  - a. Notify 911, medical, fire, rescue as appropriate.
  - b. Make sure that a timely first-aid response is available to injured employees including Basic First Aid, CPR, and AEDs by those trained to provide them.
  - c. If non-emergent, off-site medical treatment is required, ensure that another employee or supervisor accompanies those who might not be able to take care of themselves. Injured employees must never be required to transport themselves to approved medical care facilities.
  
2. Secure the Scene & Make Notifications: Remember never to rush into the scene of an incident. Every year would be rescuers become victims. Take a moment to survey the scene and assess the situation, then provide assistance and make the necessary notifications.
  - a. Get the big picture before acting.
  - b. Isolate the incident scene (rope, tape, guard, etc.).
  - c. Lockout/Tagout any machine(s) or equipment that might have been involved.
  - d. Work to prevent another occurrence while preserving all evidence for the investigation. Determine if there are similar actions or issues that could lead to another injury or incident and intervene if needed.
  
3. Identify Witnesses: Employees directly injured or affected by the incident are principle witnesses and may not conduct their own incident investigations. Statements from any eye witnesses should be taken as soon as possible, preferably before they leave the incident scene, to ensure that initial observations and impressions are not lost or altered. A Witness Statement Form (Attachment A) must be completed, signed, digitally scanned, and attached into the Intellex software reporting system.
  
4. Investigative Equipment: Supervisors assigned to an incident investigation may need tools, equipment, or materials to conduct an adequate investigation. Depending on the incident type and severity, these can include a digital camera, digital video recorder, digital voice recorder, measuring devices, temperature gauges, containers, sealing bags, flashlights, barricades, caution tape, traffic cones, permanent marker, pens, Lockout/Tagout padlock, Witness Statement forms, or other department specific items.
  
5. Gather Evidence & Record Data: Not every incident or injury will require the gathering of evidence, statements, photographs, or written statements. However, when practical, gathering evidence such as photo documentation, security footage, damaged items, and written statements is critical in properly identifying root causes and implementing adequate corrective actions.
  - a. Collect, tag, record, and/or photograph all evidence that can or may be used for your investigation, such as cuts/scrapes/bruising, materials, machine parts, tools, and equipment.
  - b. Secure relevant video footage when available.
  - c. Work cooperatively with witnesses, other departments, Risk & Safety, and medical personnel in preparing necessary reports and written statements.
  
6. Conduct Interviews: In some cases an investigation may require the supervisor to conduct interviews with those involved. The objective of interviews should not be to determine fault, but rather to gather information and facts that can assist with determining a true Root Cause and implementation of good Corrective Actions. When conducting interviews, remember to:
  - a. Ask interviewees to provide as much clear and specific information as possible.
  - b. Ask open-ended questions.
  - c. Avoid bias. Added safety and prevention are the focus of the interview.

7. Review Data: It is not unusual for a detailed investigation to include a review of relevant paperwork and data relevant to the incident. For instance, a supervisor may need to review the maintenance records for heavy machinery that was being used when an employee was seriously injured. When data review is needed:
  - a. Look at inspection reports, maintenance reports, prior incident reports, and analysis.
  - b. Identify patterns or trends.
  - c. Analyze all data for completeness/accuracy.
  
8. Prepare Incident Report: All incidents and injuries must be submitted using Risk Management's Intelex software for Incident Management and Injury Reporting. The supervisor will be asked a series of questions based on the injury or incident type. All questions should be answered completely and as detailed as possible. This will help to ensure an adequate report is recorded and all information needed to improve programs and processes is available. In addition to required notifications, all incident investigations, including recommending corrective actions, must be made within 72 hours. In most cases, this should give supervisors ample time to conduct adequate investigations and will give Risk & Safety the time needed to review the report ahead of regulatory deadlines. If additional time is needed, arrangements should be made with the Risk & Safety Manager.
  
9. Root Cause & Corrective Actions: All investigation reports approved by the Risk & Safety Manager must include both a root cause analysis and corrective actions. Supervisors are instrumental in assisting Risk Management in the proper identification of Root Causes and working collaboratively to identify and implement meaningful corrective actions that work to prevent future incidents from recurrence.
  - a. Analyze all relevant facts and information available.
  - b. Determine contributing factors that lead to a Root Cause.
  - c. Determine and implement corrective actions to eliminate the root cause and contributing factors identified by the investigation.
  
10. Follow-Up Actions: Follow-up actions may be the most important aspect of the investigative process. Following up to ensure that all corrective actions have been completed, implemented, properly trained, conveyed to employees, and maintained are critical to injury prevention. This is our opportunity to improve our processes and procedures in areas of safety, health, and environment. Follow-up actions may include:
  - a. Checking corrective actions that are decided upon were properly implemented.
  - b. Verifying that corrective actions were completed within the necessary timeframes.
  - c. Check on their accuracy and effectiveness during follow-up.
  - d. Talk to people involved to ensure that necessary training was received and that the corrective actions work.

## VII. Revisions

- A. April 8, 2016: Original policy approval and implementation.

## VIII. Authorization

Approved by:



**N. Erskine Smith, Town Manager**

April 8, 2016

**Date**

IX. Attachments

Attachment A



**Town of Mooresville Witness Statement**

Full Name: \_\_\_\_\_

Address and/or Department: \_\_\_\_\_

Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Type of Incident (*please circle one*):    Vehicle    Property    Injury    Environmental    Near-Miss

Date of Incident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Time of Incident: \_\_\_\_ : \_\_\_\_

Person(s) Involved: \_\_\_\_\_

*In your own words, please provide an accurate and detailed statement regarding the incident in which you were involved in or witnessed.*

**Description of Incident:**

*I certify that I have completed the above statement and that it is true and accurately written to the best of my knowledge and ability.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date