Incident Investigations

Four Critical Stages

By David G. Lynn

When I was an OSHA compliance officer, I performed several fatality investigations. One of my early investigations involved a fatality in a grain silo. The silo's bottom part had an auger that transported corn. The corn had formed a crust over the auger and prevented the flow of corn. Two teenage cousins entered the silo to shovel the corn to another opening in the side of the silo. They had to walk on top of the 15-ft pile of corn to do so.

While they moved the grain to the side opening, they dislodged the crust above the bottom auger. As corn began to funnel through the bottom auger, the flow created a whirlpool effect and the boys could not escape. It was as if they were stuck in quicksand. They screamed for help but the response was too slow. One boy stood on a board on top of the corn holding his cousin's hands as he was sucked into the grain funnel. He could not hold him and he watched as his cousin was pulled into the corn where he suffocated.

The incident happened in the early 1990s, and I remember the investigation as if it were yesterday. I had to relive the incident in an interview with the surviving cousin. That was one of the hardest conversations I ever had because I could picture every word he described and I could feel the pain he felt for his loss. My memories of the investigation are vivid; but can you imagine how vivid the memory is for the cousin who lived?

Incident investigations are designed to answer the question "why" so that we can prevent future incidents. No one wants to investigate an incident because it is a reminder that injuries impact people. An investigation process is vital to the success of any SH&E program because it turns a reactive process into a proactive tool. Investigation processes driven by systematic urgency and discipline prevent future problems when they identify the real cause of the problem—and management takes action to solve the problem(s). We learn from mistakes to avoid future interviews similar to the one I had with the survivor.

What characteristics do great investigation programs have? Great programs maximize the benefit of four critical stages in an investigation process.

Stage 1: Reporting

Organizations cannot correct what they do not know. Effective incident investigation programs encourage personnel to report all incidents, including first-aid injuries, recordable injuries and near hits. When a workforce embraces the importance of reporting, it has an opportunity to correct small problems before they escalate to larger issues. Had the grain silo investigated near hits earlier, would the outcome have been different? Successful organizations create a transparent work environment where employees want to share the potential risk they observe so that the company can make adjustments to prevent future injuries.

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Incident reporting also has different dimensions. There is the initial report from the injured employee to the supervisor, then there are the notifications from the supervisor to the appropriate leaders in the organization. Both elements are important. Supervisors cannot correct a problem they do not know about, and management cannot demonstrate its commitment to sustainable improvement without knowledge of the issues. Communication from the injured employee to leadership creates awareness and focus on injury prevention.

Critical Considerations

Employers should implement several critical practices with respect to incident reporting:

- Promote the importance of reporting all incidents (e.g., first aid, recordables and near hits).
- Eliminate any punitive action for reporting. Workers should feel free to share what they experience.
- Establish time frames for how quickly workers should report incidents.
- Develop a protocol that defines who will be notified in the organization for all situations. Include time frames for how quickly people should hear about incidents.
- Instill urgency and importance into each step of the process.

Stage 2: Investigation

Effective investigation involves more than filling out a report or checking boxes on a form. A paper exercise does not facilitate long-term improvement. Dig deeper and pursue the details that surround an incident. Multiple prepackaged investigation tools are available that can help identify root causes. However, the brand on the tool does not make the process successful. The most successful investigation tool is the one that gains the full support of the company's leaders. All layers of an organization must understand the process and provide their collective authority to make it successful. Management support is more important than the investigation tool itself.

Become an expert on the collection of information and analyze the impact of each detail. For example, evaluate steps that led to the actual event. Do not focus on the immediate circumstances that surround the event. Look upstream and determine what steps (and details) contributed to the failure. Draw a road map from the start of the injured worker's day (or before) to the moment of the incident. The goal is to create a storyboard that explains, step-by-step, how and why conditions and behaviors exist. People make choices and conditions exist for a reason. Investigators should peel back the layers of every step to determine what led to the event.

A good investigator collects detailed data in stages and organizes notes so that s/he can write a coherent report with ease. The key is to ask questions about each step to populate the event details. Discover why that step made sense to the employee and document everything related to the step.

When organizations invest in a full circle process that focuses on the small things, they can turn a reactive process into a proactive tool.

Critical Considerations

An effective investigation explores several critical points when analyzing each step of an event; describe examples of:

- why the action made sense to the employee;
- how training impacted each step;
- how communication impacted each step;
- how planning impacted each step;
- how procedures impacted each step;
- how management and supervision impacted each step;
- how employees took ownership;
- how the organization impacted each step;
- how work practices impacted each step;
- how the work environment impacted each step.

Utilize the value of multiple perspectives to answer the appropriate questions. The employees, direct supervisor, manager and senior manager should always participate in the investigation process; other subject-matter experts or employee representatives should participate as well. If the supervisor and manager fail to participate, they minimize their accountability for the incident and their lack of visibility contributes to a negative safety culture. Active participation from leadership establishes the importance of the incident.

Stage 3: Corrective Action

Make sustainable corrective action your goal. The investigation phase will paint a storyboard that led to the incident. Each step in the storyboard represents an opportunity to change the outcome. Corrective actions should address elements of the storyboard that failed or contributed to the incident. Sustainable corrective actions change the appropriate details throughout the sequence of events.

How do you put corrective actions in place? The event analysis will usually reveal a series of unwise choices or contributory causes that led to the final poor decision that caused the incident. The contributory causes can also include latent organizational weaknesses. Corrective measures should address the source of these weaknesses.

Critical Considerations

When applying corrective action, consider the following critical points:

- Address all appropriate elements on the storyboard with sustainable corrective actions.
- Ensure that corrective action measures address any similar circumstances.
- Track corrective actions on a log.
- Include target dates for completion on the log.
- Define who is responsible for corrections.
- Follow up every week to assess progress.
- Establish a method to monitor long-term improvement.

Stage 4: Communication

The communication phase is easy to overlook. Once the investigation is over and the problem is solved, the natural reaction is to move on to the next challenge. Great programs maximize the knowledge gained from the incident experience and communicate the lessons learned. Incidents should not happen in a vacuum, and leaders should tell others about the event to help ensure that a similar incident does not occur. The communication goal is to learn from the incident experience and prevent future incidents by communicating what happened.

Make Lessons Learned Memorable

Following are several ways to make lessons learned memorable:

- Convince workers that it can happen to them.
- Make the topic vivid with the story; share a personal example of how it applies to the audience.
- Help people visualize the consequences. Share examples of related injuries and the impact it has on families.
- Create triggers that will prompt people to think about the incident throughout the day.
- Make workers imagine, think about and feel the impact of the incident.

Conclusion

The same incident should not happen twice. Put principle to practice and build an incident investigation process around the four pillars: report, investigate, correct and communicate. When organizations invest in a full circle process that focuses on the small things, they can turn a reactive process into a proactive tool.

Do you think the two cousins in the grain silo were the first to experience such a situation? Was that the first time corn had crusted over an auger? Was it the first time they had to use alternative methods to remove grain? Was it reasonable to think that the corn would dislodge at some point? What would have happened if the company had investigated previous near hits—if it had recognized the potential for future incidents through past investigations? Most certainly the situation could have been different if the company had.

Minor incidents that occur every day have the potential to become future tragedies. Investigate the small things with relentless consistency so that you do not have to conduct hard interviews like I did with OSHA.

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