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INCIDENT INVESTIGATION

OCCUPATIONAL SAFETY AND HEALTH

MANAGEMENT SYSTEM PROCEDURE

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# Purpose

### To define requirements for a systematic method of conducting incident investigations within the organization.

# Terms and Definitions

### Refer to document OTH-001 for terms & definitions.

# Responsibility

### QHSE Manager is responsible for ensuring that the procedure is being implemented across the organization

### Project Manager / Department Head is responsible for implementing this procedure

### Site HSE Representative is responsible for supporting the Project Manager / Department Head in implementing this procedure

# Procedure

## Recording OSH Incidents

### Serious incidents are categorized as Fatalities, Permanent Total Disabilities, Permanent Partial Disabilities, Lost Time Injuries, Restricted Work Cases, Medical Treatment Cases, Dangerous Occurrences, Road Traffic Accidents and Major Environmental Incidents.

### Minor incidents are categorized as Property Damages, Near Misses, First Aid Cases and Environmental Incidents.

### OSH Incidents shall be recorded in the Accident and Incident Register which shall be maintained in the corporate office.

### The Accident and Incident Register is a live document which is continuously maintained.

### Serious incidents that occur on the projects shall have the details submitted to the corporate office to be included in the accident and incident register.

### Projects shall maintain an Accident and Incident Register which registers serious and minor incidents.

## Investigating OSH Incidents

### Incident investigations are a time-critical activity, so the investigation must begin immediately after the incident occurs and the area has been secured.

### Gather Information: The initial step of an incident investigation is to gather as much information as possible. This includes both relevant and what may seem as irrelevant information. Type of information to be gathered includes:

* Medical Reports
* Sick Leaves
* Police Reports
* Witness statements
* Activity Method Statement and Risk Assessments
* Permits and NOC’s
* Training Records
* Photographs

### Develop a timeline of events: Establish a timeline of events that led to the incident. For more complicated incidents, a flowchart can be used.

## Analyzing OSH Incidents

### With the information gathered in the investigation stage, analysis of the OSH incident must be conducted.

### Identification of Immediate Causes: The immediate causes that led to the incident occurring must be identified. These can include:

|  |  |  |  |
| --- | --- | --- | --- |
| **EXAMPLES OF IMMEDIATE CAUSE(S)** | | | |
| Failure to wear PPE | Wrong tool for the job | Inadequate PPE | Inadequate guards or barriers |
| Using defective tool/equipment | Improper use of tool/equipment | Inadequate ventilation | Inadequate warning systems |
| Working at unsafe speed | Working on live equipment | Poor housekeeping | Bad weather |
| Tampering with safety devices | Horseplay | Obstructed vision | Improper lighting |
| Operator condition | Working without a permit | Excessive exposure to noise | Failure to secure |
| Improper placement, lifting, positioning | Improper operation of machinery | Dust |  |

### Identification of Root Causes: The root causes that led to the incident occurring must be identified. These can include:

|  |  |  |  |
| --- | --- | --- | --- |
| **EXAMPLES OF ROOT CAUSE(S)** | | | |
| Insufficient supervision | Incompetent supervision | Inadequate program / procedure / WI | Inadequate tools and equipment |
| Inadequate planning | Not enough training | Inadequate compliance with standard | Inadequate maintenance |
| Inadequate engineering | Not enough skill | Lack of discipline | Hazard not identified |
| Ineffective purchasing | Lack of motivation | Shortcuts not discouraged |  |

### Root causes are considered as the underlying system failures that allowed conditions for the immediate causes to exist.

### Identification of root causes can be done with the help of any of the common tools for root cause analysis, such as:

* 5 Why’s method
* Fishbone Diagram Method
* Taproot method

## Incident Investigation Team

### The incident investigation team leader shall be the most senior OHS practitioner on the site, this is usually designated as the Lead HSE Advisor.

### The investigation team leader will involve key stakeholders in the incident investigation if this adds value to the investigation effort.

### Key stakeholders that can be included in the incident investigation are authority, client, subject matter specialists, supervision teams and workers.

## Opportunities for Corrective and Preventative Control Measures

### Once the immediate and root cause are identified, the lead investigator shall identify corrective and preventative control measures

### Corrective Actions shall be included in the incident investigation report. If there are opportunities for preventative actions, these shall be included too.

## Communication to Relevant Stakeholders

### Once complete, the investigation report shall be submitted to:

* Authorities as required by regulation
* QHSE Manager
* Project Manager
* Clients and Client Representatives

# Annexure

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