All DeLong's Facilities	Procedure #: CS-013	Incident Investigation Procedure

Rev 1

1. Purpose:

1.1 The purpose of this procedure is to outline the procedure for investigation of incidents and near misses and creating corrective actions to prevent the incident from occurring again.

2. Responsibility:

2.1 The Environmental Health and Safety (EHS) Manager is the program coordinator, with overall responsibility for the program, including reviewing and updating this plan as necessary.

2.2 The EHS Manager and/or Supervisors are responsible for implementation of this procedure and training all employees with regard to this procedure.

3. References:

3.1 NA.

4. Procedure:

4.1 Preserve/Document the Scene

4.1.1 Preserve the scene to prevent material evidence from being removed or altered.

4.1.2 Document the incident facts such as the date, location, employees involved, witnesses, injury description, and equipment. Pictures, videos, and sketches should also be used to document the scene.

- If mechanical failure of any type is suspected in the root cause, the equipment will be de-energized according to procedure CS-009 Lockout/Tagout, and the area in question will be cordoned off until the full investigation is complete.

4.2 Collect Information

4.2.1 Interview witnesses.

4.2.2 Review other sources of information such as:

- Equipment manuals
- Company policies and records
- Maintenance schedules, records, and logs
- Training records
- Safety audit/observation records

- Enforcement policies and records
- Previous incident or near miss records
- Previous corrective and preventative actions

4.3 Root Cause Analysis

4.3.1 Utilize "5 Why" method to go beyond the immediate factors and identify root cause of the incident.

Example:
Immediate Factor – Employees finger was crushed.

1. Why was the worker's finger crushed?

His finger was caught between a moving pulley and belt.

2. Why was the finger caught between the pulley and the belt?

The guard on the pulley was missing.

3. Why was the guard missing?

A mechanic had overlooked replacing it.

4. Why was it overlooked?

There is no written equipment servicing checklist.

5. Why is there no checklist?

Root Cause – No hazard assessment has been completed.

4.4 Create and Implement Relevant Corrective and Preventative Actions

4.4.1 Create a corrective and preventative action that addresses the root cause and will keep it from happening again.

4.4.2 Create corrective and preventative actions using the SMART Model.

- **S**pecific
- **M**easureable
- **A**ttainable
- **R**ealistic
- **T**ime Bound

4.4.3 Follow-up to ensure the corrective and preventative actions are working as planned.