



Project Management & Construction Services

Standard Operating Procedures

Incident Investigation

When to Conduct an Investigation?

- All injuries (even the very minor ones)
- All accidents with a potential for injury
- Incidents involving product or property damage
- All Near Misses where there was a potential for serious injury

The Goal or Objective of the Investigation

The goal is determine the events and causal/contributing factors leading to, during and after the incident in order to determine root cause and corrective actions to prevent recurrence of the incident.

Create a Defined Plan and Trained Personnel!

Consider the following:

- Who should be notified of the incident
- Determine who is authorized to contact outside agencies (Fire, EMS, PD, OSHA, EPA, TCEQ, etc.)
- Define emergency response procedures/prepare an investigation kit (flip charts, post-it's, RGB Markers, Mort Chart, Mort guide and questions book, investigation and interview guides, forms and questions, yellow - caution/red -danger marking tape , camera)
- Mechanism for initiating an incident investigation
- Who is assigned to conduct investigations
- Define level of training for investigators
- Who receives and acts on investigation reports
- Define acceptable time tables for correcting the hazards

INCIDENT HAS OCCURRED. WHAT DO YOU DO?

1. **Responder(s):** If personnel are injured, CALL UTPD (911 on a landline or 512-471-4441), Notify Management
2. **Responder(s):** Attend to and stabilize the injured, DO NOT TRANSPORT on your own
3. **Responder(s):** Secure the scene (protect the evidence) (OSHA may inspect)
4. **Management:** to convene and charter the investigation committee via memorandum & assign duration (5 working days)
5. **Investigation Committee** to:
 - a. Gather information



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- b. Interview Witnesses separately
- c. Interview other interested persons.
- d. Review records
 - i. Training records
 - ii. Disciplinary records
 - iii. Medical records
 - iv. Maintenance records
 - v. Injury and Illness Records (OSHA 300), previous investigations
 - vi. Photos, sketches, videotape, measurements
- e. Develop a sequence of events using events and causal/contributing factors diagram
 - i. Someone unfamiliar with the incident should be able to clearly determine the facts and contributing factors and root cause of the incident.
- f. Analyze the accident and collected data
 - i. Focus on causal and contributing factors
 - ii. Ask why or how this could have happened?
 - iii. Consider hazardous conditions
 - Materials
 - Machinery
 - Equipment
 - Tools
 - Chemicals
 - Facilities
 - Workstations
 - Environment
 - People
 - Workload
 - iv. Consider unsafe behavior of employee/supervisor
 - 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 attend training
 - Failing to supervise or follow procedure
 - Failing to correct others
 - Scheduling too much work pushing production
 - Ignoring worker stress
 - v. Consider root causes (Use a Fault Tree Diagram or Management Oversight and Risk Tree)
 - a. System design/control weaknesses
 - b. Missing or inadequate safety procedures and rules



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- c. Training program not in place or less than adequate
 - d. Poorly written operating procedures
 - e. Inadequate process, work phasing, facilities layout
 - f. No operating procedures in place
 - g. Non-existent preventative maintenance or less than adequate
 - h. Consideration of human factors
 - i. Operational readiness
 - j. Barriers & controls
 - k. System Implementation Weaknesses
 - i. Safety & departmental policies/procedures/rules not enforced
 - ii. Safety and craft/technical training not conducted
 - iii. Adequate supervision not conducted
 - iv. Incident/analysis less than adequate not conducted
 - v. Risk assessment and control systems
 - vi. Design and development of process/equipment
 - vii. Proactive assessment of programs/procedures
 - vi. Recommend corrective actions to prevent recurrence
6. **Actionee(s):** to implement corrective actions
7. **Safety Committee:** to follow-up on corrective actions