



## FESHM 3020: INCIDENT INVESTIGATION AND ANALYSIS

## Revision History

Author	Description of Change	Revision Date
John P. Cassidy	<ul style="list-style-type: none"><li>• Added HPI language to Sections 1, 4, 5.4, 5.6, and 6.0.</li><li>• Added the Incident Reporting Process Flowchart in Section 5.3.</li><li>• Added the requirement for conducting and documenting HPI evaluations for recordable cases as well as for first aid and near misses when applicable.</li><li>• Updated the Injury and Illness Prevention Subcommittee review of incident report requirements.</li><li>• Updated the Investigation and Analysis Procedure to include the documentation of reports.</li></ul>	June 2013
John P. Cassidy	Employees will only have to report to medical after a motor vehicle incident if there is an injury.	July 2011
Nancy Grossman	Definitions and terms were standardized between each of the FESHM chapters and the CAPA procedure. Particularly Corrective Action, Preventive Action, Root Cause Analysis, ESHTRK became iTRACK, Causal analysis was replaced with root cause analysis (from our earlier work on the Root Cause Analysis Procedure) and carried forward. We also added reference to (1004.1001 Fermilab Corrective & Preventive Action Procedure) and (1004.1002 Fermilab Root Cause Analysis Procedure) if they were not already present in FESHM chapters. In Section 5.6 we also added items from the Injury and Illness Subcommittee (taken from their charter).	March 2011



## TABLE OF CONTENTS

<b>1.0</b>	INTRODUCTION.....	2
<b>2.0</b>	PURPOSE .....	2
<b>3.0</b>	SCOPE .....	2
<b>4.0</b>	DEFINITIONS AND ABBREVIATIONS .....	2
<b>5.0</b>	RESPONSIBILITIES.....	4
<b>5.1</b>	Employees .....	4
<b>5.2</b>	Supervisors .....	4
<b>5.3</b>	D/S/C Heads.....	5
<b>5.4</b>	D/S/C Senior Safety Officer (SSO) or designee .....	5
<b>5.5</b>	ESH&Q SECTION.....	6
<b>5.6</b>	Injury and Illness Prevention Subcommittee.....	6
<b>5.7</b>	Occupational Medicine Office .....	7
<b>6.0</b>	LESSONS LEARNED.....	8
<b>7.0</b>	REFERENCES.....	8



## 1.0 INTRODUCTION

This chapter applies to all Fermilab employees, subcontractor personnel and visiting experimenters.

## 2.0 PURPOSE

1. To outline incident/near miss reporting, investigation, and root cause analysis procedures.
2. There are many benefits from an incident and near miss investigation, with one ultimate purpose – **Prevention of injuries and future incidents**. For this reason, incident reports, i.e., HPI incident evaluations, should be written so that persons not familiar with the activity may understand and gain knowledge from the report.
3. Trending analysis of all incident investigation reports will be done and used to evaluate:
  1. Frequency/severity of incidents;
  2. Effectiveness of safety programs and work procedures; and
  3. Current incident prevention and awareness activities.
4. Incident/near miss prevention is most effective when all incidents and near misses are promptly reported, thoroughly investigated, the root causes identified, and corrective and preventive actions identified. An HPI incident evaluation report must be completed within a reasonable amount of time following knowledge of an incident.

## 3.0 SCOPE

All incidents and near misses shall be investigated, analyzed, and recorded. This also applies to property damage and vehicle incidents. The depth of a near miss investigation is dependent on its potential to cause severe damage or personal injury should the incident occur. Those incident reports that meet DOE's reporting criteria will be submitted to DOE.

## 4.0 DEFINITIONS AND ABBREVIATIONS

1. Corrective Action (CA)  
Action to eliminate the cause of a detected nonconformity or other undesirable situation.  
*Note: There can be more than one cause for a nonconformity. Corrective action is taken to prevent recurrence whereas preventive action is taken to prevent occurrence.*
2. Incident -  
An unplanned event that interrupts the completion of an activity or causes injury and/or property/vehicle damage or near miss. Sometimes referred to as an "accident".
3. CAIRS -  
Computerized Accident Incident Reporting System
4. Human Performance Improvement



A set of concepts and principles associated with a performance model that illustrates the organizational context of human performance. The model contends that human performance is a system that comprises a network of elements that work together to produce repeatable outcomes. The system encompasses organizational factors, job-site conditions, individual behavior, and results.

5. HPI Incident Evaluation Form

An evaluation form residing in the AD database used to evaluate and document incidents using HPI principles.

6. Lessons Learned (LL) –

A “good work practice” or innovative approach that is captured and shared to promote repeat application. A lesson learned may also be an adverse work practice or experience that is captured and shared to avoid recurrence.

7. Near Miss -

An unplanned event that did not result in injury, illness, or damage but had the potential to do so. Only a break in the chain of events prevented an injury, fatality or damage. Other familiar terms for these events is a "close call", or in the case of moving objects, "near collision".

8. Nonconformity -

Non-fulfillment of a requirement.

*Note: A nonconformity can be any deviation from work standards, practices, procedures, legal requirements, or applicable code of federal regulations.*

8. Investigation Team –

Individuals responsible for conducting and documenting the incident investigation. The team shall include at a minimum, the SSO as lead, the employee involved in the incident, and the supervisor.

9. OSHA -

Occupational Safety and Health Administration. An agency under the US Department of Labor.

10. OSHA Recordable Injury/Illness -

Any occupational injury or illness resulting in death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid.

11. Preventive Action (PA) -

Action to eliminate the cause of a potential nonconformity or other undesirable potential situation.

*Note: There can be more than one cause for a potential nonconformity. Preventive action is taken to prevent occurrence whereas corrective action is taken to prevent recurrence.*



## 12. Root Cause (RC) -

An identified reason for the presence of a defect or problem. The most basic reason, which if eliminated, would prevent recurrence. The source or origin of an event. Root Cause is also known as the system cause.

## 13. SME -

Subject Matter Expert

## 14. Motorized Vehicle -

For the purpose of this chapter, a motorized vehicle is any conveyance that transports people or objects. This includes automobiles, trucks, mobile cranes, fork trucks, golf carts, tow motors, magnet movers, riding lawn mowers, tractors and electric carts.

# 5.0 RESPONSIBILITIES

## 5.1 Employees

- Report to their supervisor any injuries/illnesses or any involvement in an incident regardless of how minor it may initially appear.
- Report motorized vehicle incidents and near-miss events.
- Deliver the [Form-5 Injury/Illness Evaluation](#) to the supervisor immediately upon return from the Medical Department. A Form-5 is used to inform the supervisor of any medical restrictions placed upon the employee.
- Complete an [Incident Involvement Form](#) as soon as possible for any incident or near miss in which they were involved or witnessed.
- Participate in the investigation as directed by the supervisor.

## 5.2 Supervisors

- Direct injured employees to the Medical Department. Dial x3131 if necessary.
- Immediately report any incident or near miss to your line manager and SSO.
- Complete documentation of the incident [[Supervisory Form 3020/1](#)] and submit to the D/S/C SSO. The supervisory Form must be completed within a reasonable amount of time after the incident.
- Review the Form-5. If restrictions have been identified, determine if such restrictions will affect the employee's ability to perform normally assigned duties. Complete and sign the Form-5.
- Forward the Form-5 to the D/S/C SSO for signature.



- Ensure the preventive and corrective actions identified by the incident investigation are implemented.

### 5.3 D/S/C Heads

- Immediately report any incident or near miss to the COO and ESH&Q Head in accordance with the [Incident Reporting Process Flowchart](#).
- Ensure investigations are completed within a reasonable amount time.
- Review the final incident investigation report to ensure that the root, direct and contributing causes and the corrective and preventive actions (1004.1001 Fermilab Corrective & Preventive Action Procedure) are appropriate.

### 5.4 D/S/C Senior Safety Officer (SSO) or designee

- Lead the investigation team.
- Review the Form-5 and provide signature. If medical restrictions have been placed on the employee, the D/S/C SSO signature on the Form-5 signifies concurrence with the supervisor's assessment of whether the restrictions are job limiting. The SSO then forwards the Form-5 to the Medical Department.
- For OSHA Recordable cases, enter investigation report containing all the information required by the OSHA 300 into CAIRS database as soon as practicable.
- For OSHA Recordable Cases, complete an HPI Incident Evaluation assuring a root cause analysis is performed using the [Causal Analysis Tree](#) found in FESHM 3010 and Human Performance Improvement (HPI) fundamentals. The 1004.1002 Fermilab Root Cause Analysis Procedure can also be used as a tool to assist in the root cause analysis. Assure that corrective and preventive actions are sufficient to address these causal factors.
- For first aid cases, enter pertinent information into the CAIRS database. The extent of the information required will be proportional to the potential for the injury having been more serious. A root cause analysis review using the HPI Incident Evaluation form may be warranted depending on the nature of the first aid case.
- For near misses, enter into the CAIRS database a summary of the incident, root cause(s), findings if applicable, and any corrective and preventive actions taken. A root cause analysis review using the HPI Incident Evaluation form may be warranted depending on the nature of the near miss.



- Monitor cases with continuing lost or restricted time to ensure restrictions are accommodated. Update CAIRS database as necessary to reflect accurate days lost or restricted, or other new information.
- Enter into iTRACK the corrective and preventive actions and link the iTRACK report to the CAIRS report.

## 5.5 ESH&Q SECTION

- Maintain a staff of formally trained investigators to provide investigation technical assistance when requested.
- Develop and maintain incident investigation/analysis policies.
- Ensure notification of the Laboratory Director, Office of Public Affairs, and the Legal Department of any incident that may result in an independent DOE investigation.
- Review all completed incident investigation forms to ensure consistent quality across the Laboratory.
- Forward completed CAIRS forms and hours worked to DOE, as required by DOE M 231.1-1a.
- Maintain the OSHA 300 form.
- Maintain CAIRS database for trending and training, and statistical information such as incident rates.
- Review incident reports for adverse programmatic trends that should be reported to DOE through the Noncompliance Tracking System ([FESHM 3030](#)).
- Assume the investigative readiness role in the event that an incident is severe enough to warrant an independent DOE investigation. The Directorate, supported by the ESH&Q Section, will coordinate the readiness effort. The incident scene will be secured and control of the scene will be given to the ESH&Q Section. Investigation readiness shall be in accordance with the latest issue of DOE Order 225.1B. Readiness activities include: securing the scene, photographing the scene, preserving evidence, collecting witness statements, and maintaining close coordination with the DOE investigation board chairperson to ensure efficient transfer of information and continued support of DOE activities.

## 5.6 Injury and Illness Prevention Subcommittee

- Review incident reports for the purpose of ensuring a complete investigation including:
  - Inputting the necessary data into CAIRS
  - Completion of the Causal Analysis Tree
  - Application of HPI fundamentals



- Identifying corrective and preventative actions
  - Add the necessary HPI information into the CAIRS Report
  - Enter into iTRACK the corrective and preventative actions
  - Link the iTRACK report to the CAIRS Report
  - Enter any improvements or lessons learned to their respective databases
- Share information lab-wide from investigations, including root causes, corrective and preventative actions
  - Identify trends to the Fermilab ESH&Q Committee
  - Identify and recommend to the Fermilab ESH&Q Committee changes in policies and procedures to enhance lab-wide safety performance

### 5.7 Occupational Medicine Office

- Assess occupational injuries and illnesses to determine extent of injuries, provide for treatment, and place medical restrictions, when necessary, to ensure quick and complete recovery.
- Inform the supervisor and D/S/C SSO of each employee who has reported to the Medical Department with an injury or illness. This is normally done through electronic mail.
- Enter incident information into the CAIRS database if,
  - the incident resulted in an occupational injury, or
  - illness is alleged by the employee to be the result of an occupational injury or illness, or
- Provide the Incident Involvement Form to the employee for completion.
- Provide the employee with a Form-5 to document the employee's visit to the Medical Department.
- Retain all completed Form-5's in the employee file.
- Maintain injury/illness database (for worker's compensation purposes.)

### 6.0 INVESTIGATION and ANALYSIS PROCEDURE

Incident investigations and analyses are conducted to identify unsafe acts and conditions and then formulate corrective and preventive actions to prevent recurrence. Besides a root cause investigation, CAIRS reports must also state corrective and preventive actions identified during the investigation. The process described below is to be applied to all incidents, first aid cases and near misses:

- Preserve the incident scene, if necessary
- Photograph the incident scene, if necessary
- Supervisor completes [incident report](#)
- Interview witnesses



- Collect evidence
- Using the HPI Incident Evaluation Form:
  - Analyze incident, consulting with SMEs as needed.
  - Identify causes (root-direct-contributing)
  - Determine needed actions (corrective-preventive)
- Make CAIRS data entry
- Enter the final HPI Incident Evaluation Report and all issues where there are corrective and preventive actions into iTrack
- Identify lessons learned

## 6.0 LESSONS LEARNED

The ESH&Q Section will review incident reports to identify whether there are lessons learned to be shared throughout the Laboratory or externally with other US DOE Laboratories. The D/S/C's will develop the written lessons learned and enter the information in the [Lessons Learned Database](#). The Quality Assurance Manager of ESH&Q will process in accordance with 3903 Contractor Assurance Lessons Learned Program. The ESH&Q Section will review CAIRS and other investigation and lessons learned reports to identify trends. The results will be shared with the other divisions/sections represented in the Injury/Illness Prevention Subcommittee and other subcommittees of the Fermi ESH&Q Committee (FESHCOM). Other forms of communication may be used as well.

## 7.0 REFERENCES

5. [DOE M 231.1-1A - Environment, Safety and Health Reporting Manual](#)
6. [DOE O 225.1B – Accident Investigations](#)
7. [Contractor Assurance Lessons Learned Program](#)
8. [Fermilab Corrective & Preventive Action Procedure](#)
9. [Fermilab Root Cause Analysis Procedure](#)