

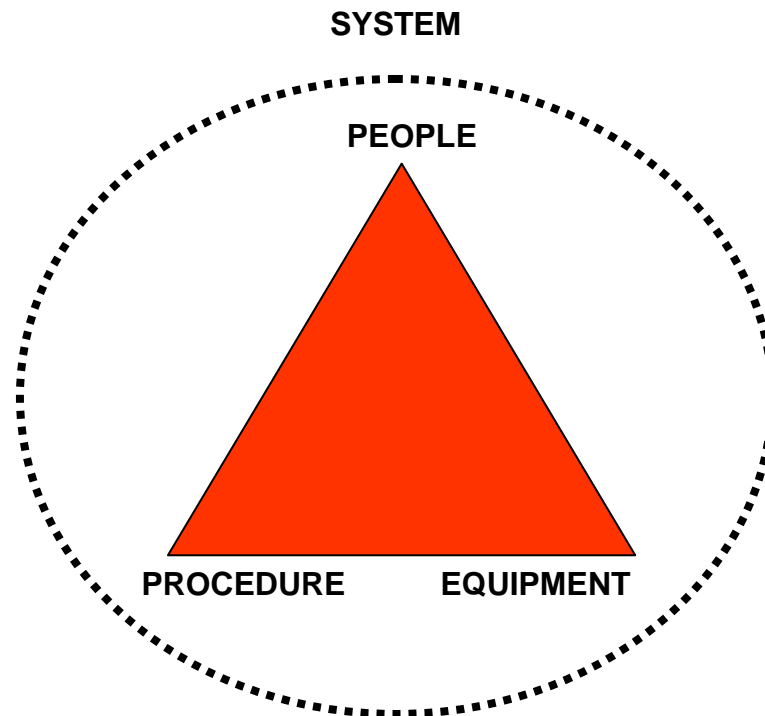
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# Incident Investigation

What does a thorough incident investigation look like and what purpose does it serve?

# Definition

- Incident: unplanned or unintended occurrence that caused or had the potential to cause injury, illness, property, material and/or environmental damage



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# Incident Investigation Purpose

- Fact finding, not fault finding
  - Learn what, how and WHY it happened to prevent repeat occurrences
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# All Incidents Need to be Investigated

- Near miss events and small incidents
    - Potential for injury or loss
    - Might have different consequences another time
    - Treated as if injury or loss had occurred
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Date: \_\_\_\_\_ Time(s) : \_\_\_\_\_ am / pm

Name of Person(s) Reporting Odor: \_\_\_\_\_

Odor Report Received By: \_\_\_\_\_

Location Of Odor(s) Reported: \_\_\_\_\_

Text Message Alert(s) Received By: (25 ppm and above) \_\_\_\_\_

Location of Text Alert(s): \_\_\_\_\_

Responder(s): \_\_\_\_\_

Ammonia Concentration Reading(s) : \_\_\_\_\_ PPM

Method(s) to Determine PPM: Manning \_\_\_\_\_ Portable Manning \_\_\_\_\_ Other \_\_\_\_\_

Was Odor Report/ Notification Alert(s) Valid: \_\_\_\_\_

If No, Explain: \_\_\_\_\_

Cause: \_\_\_\_\_

Actions Taken If Required (corrective or preventive): \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

### Follow-Up:

**Estimated Loss:** \_\_\_\_\_ **Pounds Of NH<sub>3</sub>** Immediately Report loss Of 100 Lbs Or Greater To Refrigeration Manager, Engineering Director and Environmental/Safety Manager.

After repairs are completed, contact personnel in the work area affected by the odor to make them aware of the repairs and have a representative(s) sign below:

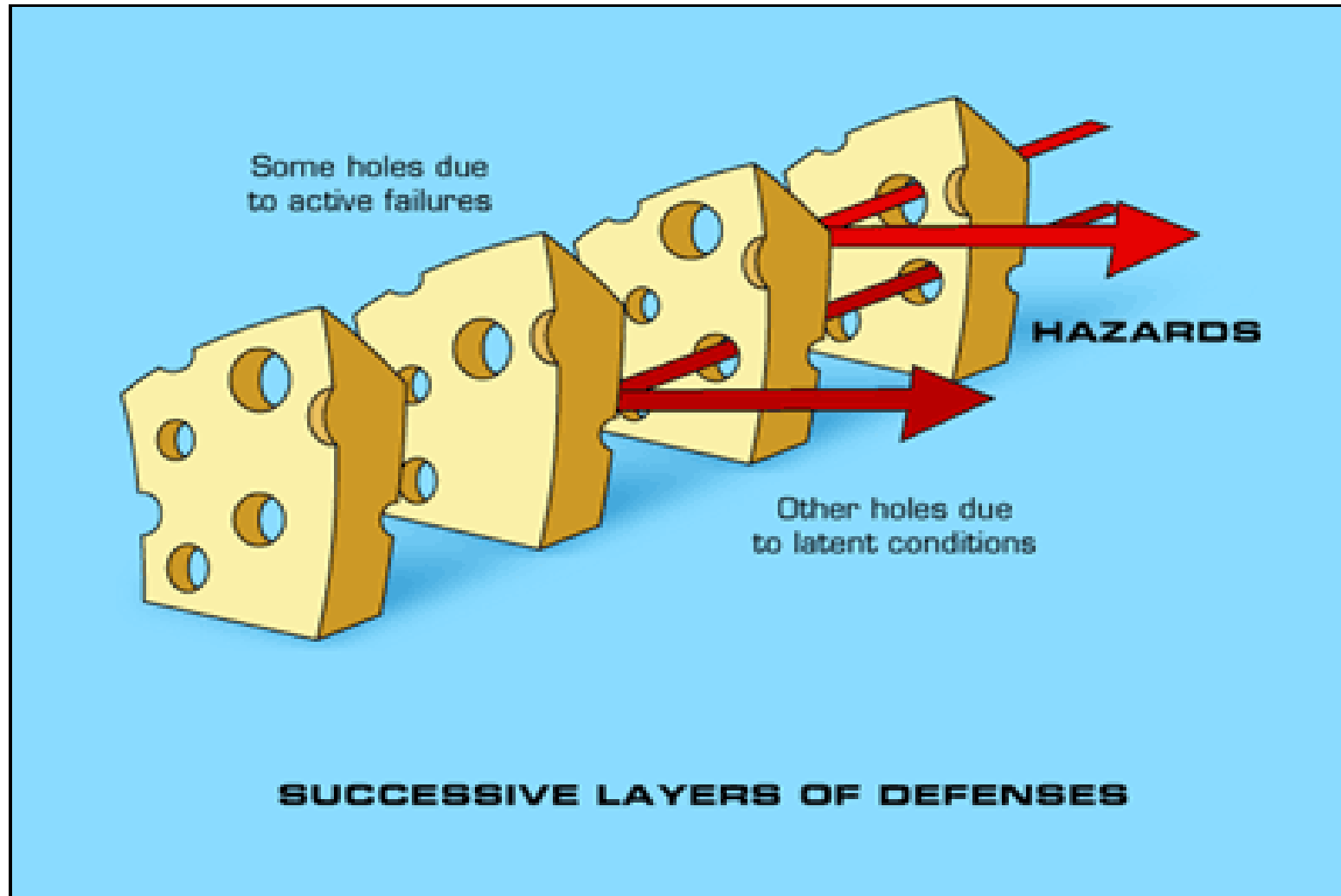
Signature of Employee who reported the Odor/Alert: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Employees Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

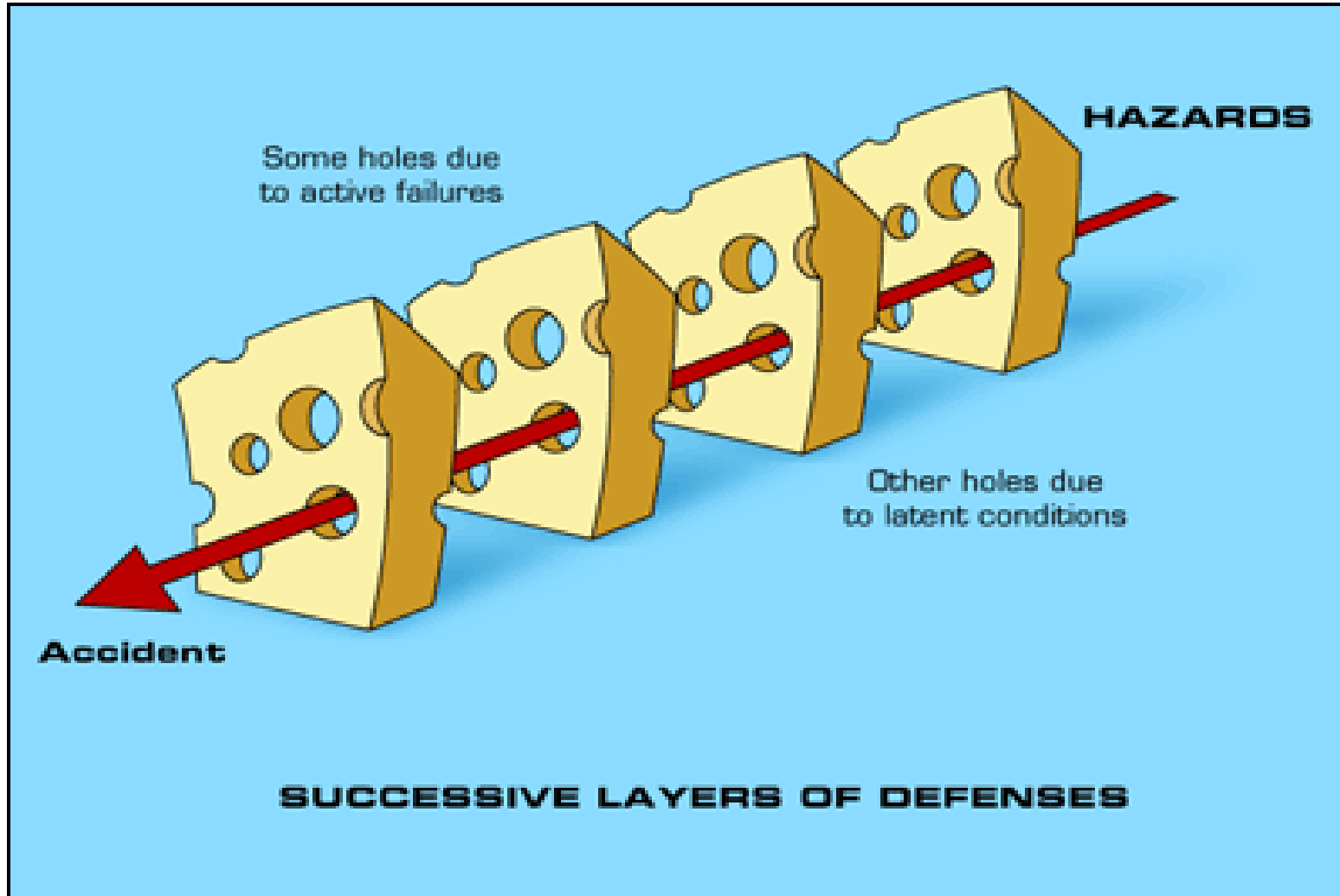
Signature of Employee who investigated the Odor/Alert: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Ammonia Refrigeration Manager/Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

# Professor James Reasons Swiss Cheese Model of Error



# Professor James Reasons Swiss Cheese Model of Error



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# Benefits, Roles & Attributes of an Investigation Team

What type of team am I looking for?

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# The Benefit and Role of the Team

- Investigations, small or large, benefit from a team approach
  - Size / Composition will depend on severity of the incident / complexity
  - Benefits include:
    - Different perspectives
    - Constructive critique
    - Shared workload
    - Shared learnings
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# Lead Investigator Role

- Direct / manage the team
  - ID and control access zones
  - Principle spokesperson
  - Prepares reports
  - Sets task priorities, schedules meetings
  - Organizes witness interviews
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What attributes would you look for in a lead investigator?

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## Wanted: Lead Investigator With The Following Qualities

- Objective, independent, competent in administrative, managerial and investigative skills
  - Effective communicator
  - Interpersonal skills to handle strong personalities / sensitive to others emotions
  - Can influence at several levels in the Company
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What do you look for in a  
investigation team member?

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# Team Member Attributes

- Open, logical mindset
  - Questioning attitude
  - Knowledge/experience with the facility
  - Thorough
  - Effective communicator
  - Respectful of others
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# Investigation Guidelines & Process

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# Aim of Investigation

1. Collect the facts
  2. Determine the causes
  3. Root Cause ID
  4. Recommendation generation and implementation
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# What Can I Do To Prepare?

- Preparation is the key
  - In the heat of the moment you do not want to be shuffling to gather your tools
  - Consider having a bag loaded with tools:
    - Camera
    - Flashlight
    - Interview guidelines/sheets
    - Tape recorder for notes
    - Company forms
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# You Received the Call To Duty

- Get the What, When, Where
    - Activate in-house / agency notifications as required
  - Determine status of incident
  - If appropriate, request to preserve incident area
  - Start to define the scope of the investigation
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# On-Site: Timing

- Investigation should start as soon as possible  
(no later than 48 hours)
    - The cause may still be present
    - Scene may change
    - Witness may not be as clear on facts as time progresses
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# On-Site: Gathering Information

- Get witness statements, interviews and reports
  - Start to gather docs containing:
    - Normal operating procedures
    - Flow diagrams
    - Operator logs
    - Inspection / monitoring records
    - Alarm logs
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# On-Site: Gathering Information

- Keep notes
  - Record pre-incident conditions, sequence of events
  - Collect physical evidence
  - Photograph site, equipment involved
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# On-Site: Interviewing Witnesses

- Interviewed in private not as a group
  - Explain that frank and honest statements will assist in preventing recurrence
  - Questions should be open
    - “Tell me what you saw”
    - Avoid yes / no answers
  - Avoid questions that suggest blame to interviewee
  - Allow witness to read notes and sign
  - Thank them and invite further input if something comes to mind
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# On-Site: Event Timeline

- Start to group information from the many sources to create an event timeline

7:00 AM	Ammonia truck arrived on-site
7:30 AM	Driver completed safety checks on truck
7:45 AM	Completed off loading checklist
8:00 AM	Started to charge system
8:17 AM	Whooshing noise heard by many witnesses

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# Determine Cause: Meetings

- Set / write-up ground rules
  - Use a flat surface to place sticky notes
  - Record notable event / statement on sticky notes
  - Encourage open dialogue
  - Ask team members to identify primary causes
    - Theme is prevention, not blame
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# Determine Cause: Root ID

- Understanding WHY it occurred is the key to develop effective recommendations
- Most causes are identified where most stop asking WHY?

Example: An occurrence where an operator is instructed to close valve A; instead he closes valve B. What would a typical investigation conclude the cause was?

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# Determine Cause: Root ID

- Probably conclude operator error
    - Accurate description of what happened and how
  - Not probed deeply enough to understand the reasons for the mistake
    - Do not know what to do to prevent recurrence
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# Solutions & Recommendations

- What do you think the recommendations from the example investigation would be?
  - Retrain the operator on the procedure
  - Remind operators to be alert when manipulating valves
  - All personnel should maintain careful attention to the job at all times

Such recommendations do little to prevent future occurrences.

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# Solutions & Recommendations

- To find useful solutions, should ask:
    - ❑ Was the procedure confusing?
    - ❑ Were the valves clearly labeled?
    - ❑ Was the operator familiar with this particular task?
  - Answers to these will help prevent future occurrences
    - ❑ Revise procedure; perform procedure validation to ensure correct valve tagging, etc.
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# Solutions & Recommendations

- Provide solutions for each cause
    - Use a brainstorm style, don't be too strict
  - Don't stop with your favorite solution
  - Consider solutions that add value
  - Ensure solutions are within your goals / objectives
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# Recommendation Implementation

- Develop a corrective action plan
    - Specific actions assigned to individuals with realistic due dates
  - May be required to complete actions prior to returning to normal operations
  - Actions tracked to completion
  - Monitor effectiveness of implementation; look for ways to improve
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# Reports

- Results of the investigation should be shared with all employees
- Sharing with other sites may help others eliminate potential exposures without paying the price of an incident.

Remember, the primary purpose of incident investigation is to prevent further incidents.

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Questions?

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