Incident Reporting and Investigation

Projected Implementation Date: December 2013

This module includes:

- Understanding and reporting of recordable/reportable incidents.
- Investigating all incidents, including relevant near misses, to establish root cause, as appropriate.
- Capturing lessons learned/root cause data for management review and communication to employees.

Integrity in reporting and timely investigation are critical steps for the prevention of future occurrences. Laws and regulations result in two incident categories that mandate different types of reporting:

Incidents reportable to regulatory authorities: All safety and health incident investigations that are mandated to be reported should be promptly examined to identify means to prevent reoccurrence and communicated to the respective regulatory authorities.

Incidents that are non-reportable to regulatory authorities: Non-reportable safety and health incidents should also be investigated, analyzed and corrective actions developed and integrated into the safety and health management system. Such incidents include:

- Near miss events
- Property damage
- Operational, maintenance or process integrity incidents that could have a negative outcome

The Role of Reporting and Investigations

Incidents cannot be investigated if they are not reported.

All personnel should be aware of what a reportable incident is within each company and as defined by regulatory requirements and company policy. All personnel should also understand the expectation to report an incident to management in a timely manner.

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The quality of any root cause analysis is directly related to the quality of the incident investigation. Companies should ensure personnel are adequately trained to conduct required investigations or maintain close coordination with external resources capable of doing so. Incident investigation should focus on fact-finding—not fault-finding—with incident investigations focusing on root cause.

Expectations

14.1 Ensure all personnel are trained and understand the company's and regulatory authority's definition of a recordable/reportable incident and their obligation to comply.

14.2 Investigate all incidents, including near misses, to a level of detail appropriate to their maximum likely outcome. All full investigations should reach root cause.

14.3 Ensure that a sufficient percentage of company personnel, representing all company functions, are trained in effective incident investigation and root cause analysis.

14.4 Develop or adopt a root cause analysis procedure that is integrated with the structure of the SHMS, i.e., root causes should relate to the SHMS, as a minimum.

14.5 Capture the lessons learned and ensure they are communicated to all personnel with a need to know.

14.6 Compile root cause data and forward to management for their review of the SHMS (See Module 19 Engineering and Construction).

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Regulation

Partial or full MSHA and/or OSHA regulatory requirement: ✓ Yes ☐ No

Metrics

Percentage of recordable/reportable incidents (and high potential near misses) that undergo incident investigation and root cause analysis.

Resources

CORESafety resources can be found with the latest updates at:
coresafety.org/resources/module14

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Notes