

Workers' Comp Accident Investigation Introduction

Accident investigations are a critical part of your safety procedures and Workers' Compensation program.

An in-house accident investigation will provide the following benefits:

- ❖ Secure witness and injured worker statements
- ❖ Provides evidence against fraudulent or denied claims
- ❖ Preserves the accident scene at the time of the loss
- ❖ Obtains valuable information for any 3rd party recovery efforts
- ❖ Provide trend information for identifying problem areas
- ❖ Document corrective action taken to prevent future accidents

It is every employers responsibility to provide a safe work environment and prevent accidents from occurring and reoccurring. Workers' Compensation Law states that all claims are compensable unless there is substantial evidence to the contrary. Documenting the facts and obtaining statements immediately after an accident can provide the proof needed to deny a fraudulent claim. Identifying and eliminating hazards will not only help in reducing your Workers' Compensation loss history and premium but is every employers responsibility under the Occupational Safety and Health Administration (OSHA). Section 5 of The Williams-Steiger Occupational Safety and Health Act of 1970 reads as follows:

- (a) Each Employer
 - (1) Shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or likely to cause death or serious physical harm to his employees.
 - (2) Shall comply with OSHA standards promulgated under this Act.
- (b) Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this Act which are applicable to his own actions and conduct

This is more commonly known as "The General Duty Clause". Violation of this clause will result in a OSHA "general duty clause" citation, see OSHA penalty section for more information.

An important phrase under 5 (a) (1) is *recognized hazards*. This will include any mention of a hazard by employees, safety personnel, records on the 200 or 300 log, workers' compensation reports of injury (C2), industry customs and trade organizations. Therefore, accident investigations play an important role for your safety department. Once an accident or near miss occurs it is a recognized hazard and it is important to identify the cause of injury, implement corrective action and document all findings and measures taken.

This presentation will cover the basics of accident investigations. It is up to your designated safety personnel to determine the best procedures and protocol for your organization.

Types of OSHA penalties

Other Than Serious Violation has a direct relationship to job safety and health, but probably would not cause death or serious physical harm. Penalties are up to \$7,000 for each violation but may be adjusted as much as 95% downward depending on the employer's good faith (demonstrated efforts to comply with the Act), history of previous violations, and size of business (see below).

Number of Employees	Percentage Reduction
1-10	80%
11-30	60%
31-100	40%
101-250	20%
251 or more	0%

There can be an additional 10 % reduction based on the employer's history. The adjustment can be made if the employer has not been cited by OSHA for any serious, willful or repeat violations in the past three years. There is no adjustment for good faith.

Serious Violation is where there is a substantial probability that death or serious physical harm could result and the employer knew, or should have known, of the hazard. Penalty of \$1,500 up to a maximum of \$7,000 for each violation is proposed. A penalty for each violation may be adjusted downward depending on the employer's good faith, history of previous violations, the gravity of the alleged violation and size of the business.

Willful Violation is one which the employer intentionally and knowingly commits. The employer either knows that what he or she is doing constitutes a violation, or is aware that a hazardous condition existed and made no reasonable effort to eliminate it.

Penalties of up to \$70,000 may be imposed for each willful violation, with a minimum of \$5,000 for each violation. A penalty for each violation may be adjusted downward depending on the size of business and its history of previous violations. Usually, no credit is given for good faith.

If an employer is convicted of a willful violation of a standard that has resulted in the death of an employee, the offense is punishable by court-imposed fine or by imprisonment for up to six months, or both. A fine of up to \$250,000 for an individual, or \$500,000 for a corporation, may be imposed for a criminal conviction. A second conviction doubles the prison term.

A **Repeat Violation** is any standard, regulation or rule or order where, upon re-inspection, a substantially similar violation is found. Repeat violations bring a fine of up to \$70,000 for each violation. To be a repeat citation, the original citation must be final. A citation under contest may not serve as the basis for a subsequent repeat citation. The initial penalty is adjusted by size of the employer and multiplied by a factor 2 or 5, depending on their size. A multiplier of 10 is used for a second repeat if more than 250 employees.

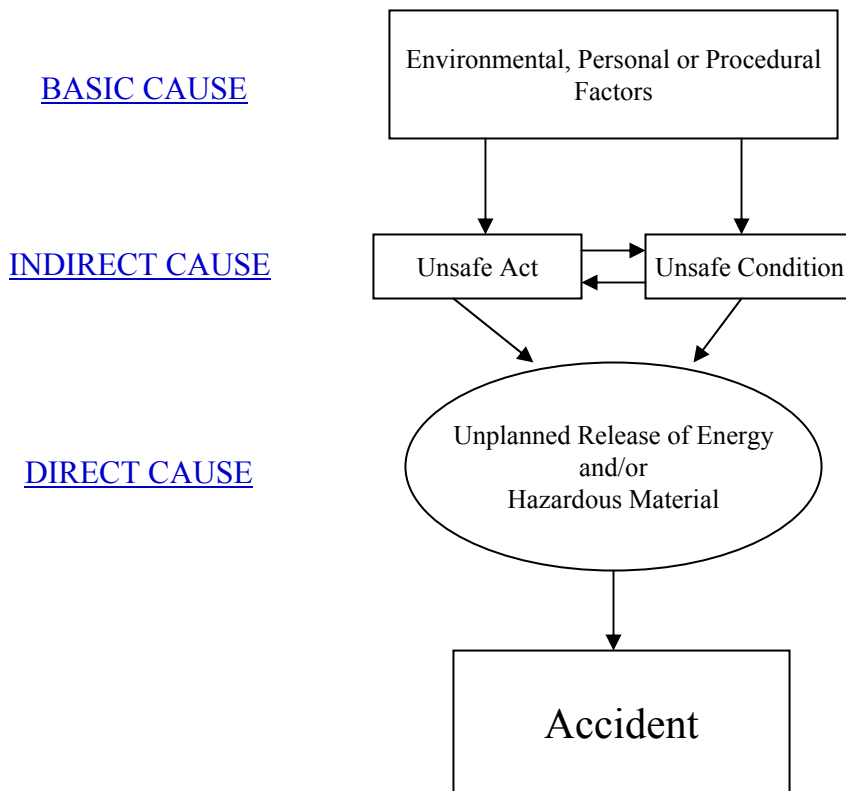
Accident Levels

In most cases there are several events that lead to an accident. Removing one or more of the events can prevent the accident from occurring. Accidents are broken down into three levels: Basic, Indirect & Direct.

Basic Cause – involves the environmental factors, personal factors and/or management safety policies and decisions. For example: An employee is tired or preoccupied by personal problems; Poor lighting in the work area; Management does not enforce the use of personal protective equipment – these conditions can lead into an accident, but alone will not necessarily result in an accident.

Indirect Cause – is the unsafe act or unsafe condition. For example: Bypassing the guard to get a task completed quicker; Not following proper procedures for lock out/tag out; Failing to use proper equipment for a particular task.

Direct Cause – is the unplanned release of energy and or hazardous material. This is the result of combining the above two causes and is what will result in the accident.



Accident investigations are designed to determine not only what happened, but also how and why. The person conducting the investigation should identify every factor and event that contributed to the accident. Identifying all the events leading to the accident will also help identify all of the corrective actions that can be implemented to prevent the reoccurrence of the accident. Some time preventing an accident from re-occurring does not require the most expensive solution but simply removing one of the contributing factors.

Accident Procedures

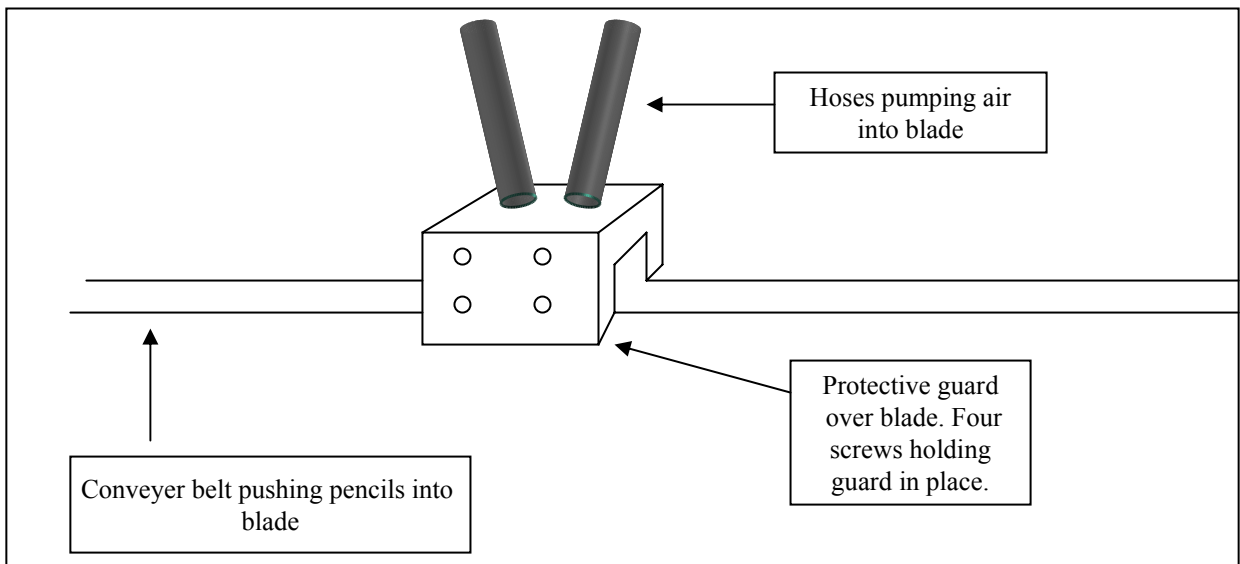
The intent of an Accident Investigation is **NOT** to assign blame, but to prevent reoccurrences. This needs to be understood by top management, supervisors and employees in order to understand all the events leading up to the accident and implement successful corrective actions.

Accident Investigations should take place immediately following the accident. Supervisors of the department plus the safety personnel should take an active role in the process. The results of the accident investigation should be reviewed by the Safety Personnel and/or Safety Committee to ensure the corrective actions were implemented and is appropriate. Follow ups should also be completed to ensure the hazards have been removed entirely. The following are the basic steps necessary to complete a thorough investigation:

1. **Obtain preliminary information**
 - a. Description of the accident.
 - b. Normal operating procedures and equipment.
 - c. Location of the accident site.
 - d. List of witnesses.
 - e. Event that preceded the accident.
2. **Inspect the accident site**
 - a. Secure the area. Do not disturb the scene unless a hazard is still present.
 - b. Prepare necessary sketches and photographs. Label each document carefully.
3. **Interview the employees involved in the accident and all witnesses** – document all statements and obtain information regarding the events prior to and after the accident occurred. Recorded statements should only be taken with the consent of the interviewee. A sample of the Employee Accident Statement form can be found at the end of the section.
4. **Analyze the accident**
 - a. What events were not normal prior to the accident.
 - b. At what point did the abnormality occur.
 - c. What events lead to the accident.
 - d. What was the probable cause of the accident (basic, indirect, and direct).
5. **Determine what events could have been removed or altered to prevent the accident.**
6. **Prepare a report documenting all findings, statements, photos and recommendations to be reviewed by the safety personnel and/or Safety Committee.** You will find a sample *Supervisor Accident Investigation* form at the end of this section.

Example

A pencil manufacturer employed Joe Smith as a machine operator. Joe was employed for over a year and is in charge of a pencil shaving machine. Joe's daily task was to place unfinished pencils on to the conveyer belt and monitor the flow of pencils into a machine which shaves the pencil into it's round shape. Quite frequently pencils would jam the machine or the blade would wear down and Joe was instructed to call maintenance for the repairs. The blade that shaved the pencils was incased in a metal box which was secured with four screws. One day Joe noticed a pencil jam in the machine and called maintenance. It was ten minutes before the lunch break and the maintenance person was in the bathroom washing his hands and not available for the repairs. Joe saw the procedure done a hundred times and on a few occasions attempted the repair himself. Joe decided to hit the emergency stop and shut the machine down. He then removed the four screws with his hands and lifted the air pumps away from the machine. Joe was now able to open the guard box and access the blade. Joe was wearing cloth gloves (which protected him from the unfinished pencils giving him splinters) and reached in to remove the jam. The blade rotated at such a fast speed it was difficult to see any movement and it took a five minutes for the blade to come to a full stop. The blade caught the glove and pulled his hand into the cutting surface. Joe lost his thumb, first and second fingers, plus half of his palm. Can you identify the events that contributed to the injury and what corrective actions can be made?



After the accident the line was shut down and everyone was sent home. The machine was not secured and blocked from all personnel. Blood born pathogens contaminated the equipment and the next shift was not protected.

Events Contributing to the Accident:

1. Pencil Jam
2. Screws which were able to be removed with bare hands
3. Gloves
4. Lack of supervision
5. Lack of “No Tolerance” Policy
6. Available maintenance
7. Lock Out / Tag Out procedures
8. Refresher training on procedures

Corrective Actions:

1. Soft woods which lead to more machine jams was eliminated from the process
2. Screws were replaced with screws that require a special tool to be removed. The tool is kept locked up in the maintenance department.
3. Gloves were eliminated, although the risk of splinters has increased, gloves can be very hazardous if working in the vicinity of quick moving parts.
4. Having supervision / “No Tolerance” Policy would have eliminated the risk the first time he attempted to bypass the guards and break company policy by reprimanding or terminating the employee. In the investigation it was determined that this was not the first time he attempted this.
5. Having two maintenance employees per shift reduces the chance of someone having to wait for assistance. Production employees tend to be under pressure to produce.
6. Although it was the company's policy for the supervisor and maintenance to be the only personnel authorized to perform lock out/tag out, all personnel should be aware of the policy.
7. In this case the employee was not inexperienced, but rather too comfortable with his job. It is a good idea to hold refresher classes every 6 months to remind employees about company policies and safety issues.
8. Procedures were put in place to secure contaminated accident sites and proper clean up procedures to prevent exposure to blood borne pathogens such as Hepatitis B.

Safety Committee Meetings

Once an accident investigation is completed it should be forwarded to the safety department to be reviewed at the next monthly Safety Committee meeting. The Safety Committee should consist of management, employees and the safety coordinator. Members should be rotated periodically to allow for maximum involvement and increased safety awareness.

The Safety Committee should have an open discussion on the past accidents to determine if all the events leading up to the accident were identified, if corrective action was implemented and if the corrective measures are appropriate to prevent future incidents. Witnesses, maintenance, supervisors, even the employees involved in the accident could be invited to the meeting to discuss the events and provide additional preventative recommendations. Again, this is not a process to assign blame, but rather a group effort to learn from the past and use that knowledge to prevent future accidents. The Safety Committee should also be looking for trends or problem areas while reviewing the accident investigations.

The committee will have several roles, such as assist in the development, implementation, and periodic evaluation of the safety and health activities. Meeting should be held monthly and all committee members must attend. Minutes of the Safety Committee meeting should be recorded.

The committee should be responsible for the following tasks:

- ❑ Review existing safety and health rules and procedures to ensure that these rules are current, pertinent, and being followed.
- ❑ Provide suggestions for employee training.
- ❑ Review all accident reports to identify its root cause and determine appropriate corrective action by implementing one or more E.S.P. techniques:
 - **E**ngineering Controls
 - **S**afe Work Practices
 - **P**ersonal Protective Equipment
- ❑ Audit the results of all safety inspections conducted.
- ❑ Review training programs with particular attention being given to training involved in the following areas:
 - New or transferred employees.
 - New safety and health regulations.
 - New or modified procedures or processes.
 - New equipment or chemicals.
- ❑ Be involved in preliminary hazard analysis for new equipment, new processes, and new designs.
- ❑ Conduct periodic in-house safety inspections.
- ❑ Provide recommendations to management on safety and health issues.
- ❑ Evaluation of the safety and loss prevention program.

SUPERVISORS ACCIDENT INVESTIGATION

This form is to be used after an accident and near misses, whether resulting in injury or not.

Immediately upon completion, this form should be sent to: _____

Division/Branch/Department	Date of Accident	Time AM / PM	Date Reported	Supervisor Reported to
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Person Injured

Name	Job Title	Nature of Injury	Location of Injury
Part of Body Injured	Type of Accident	Equipment, Object or Substance Causing Injury	

Description of Accident

Describe how the accident occurred (use diagram if necessary):

Witnesses

Name of Witness	Job Title	Department
Statement Taken:		

Analysis

Check off **ALL** circumstances which may have contributed to incident:

- | | | |
|---|---|---|
| <input type="checkbox"/> Lack of procedures | <input type="checkbox"/> Equipment not maintained | <input type="checkbox"/> Procedures not followed |
| <input type="checkbox"/> Wrong equipment used | <input type="checkbox"/> Procedures not known or understood | <input type="checkbox"/> Poor equipment design |
| <input type="checkbox"/> Task too difficult to perform | <input type="checkbox"/> Correct equipment not available | <input type="checkbox"/> PPE not used/not available |
| <input type="checkbox"/> Location of employee | <input type="checkbox"/> Training inadequate | <input type="checkbox"/> Temperature extremes |
| <input type="checkbox"/> Distraction or fatigue | <input type="checkbox"/> Poor lighting | <input type="checkbox"/> Poor housekeeping |
| <input type="checkbox"/> Inadequate ventilation | <input type="checkbox"/> Excessive vibration | <input type="checkbox"/> Excessive noise |
| <input type="checkbox"/> Condition of work surface | | <input type="checkbox"/> No management system to control hazard |
| <input type="checkbox"/> Supervision did not detect unsafe condition/behavior | | <input type="checkbox"/> Lack of supervisor training |
| <input type="checkbox"/> Supervision did not take corrective action | | <input type="checkbox"/> Lack of accountability for safety |

Specific unsafe acts:
Hazardous conditions:

Corrective Action

Action to be taken:
Action already taken:

Person doing the investigation: _____ Date: _____

Reviewed by: _____ Date: _____