Town of North Yarmouth

INCIDENT REVIEW PROGRAM & POLICY

APPROVED BY:

_____

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I. INTRODUCTION

Incident Review - what is it?

The purpose of an "incident review" is to determine why that specific incident took place. Incidents may involve bodily injury, damage to property or cause interruption in your normal operations. There may also be "near miss" incidents and not cause any of the above.

After an incident occurs, it is important to determine how and why an incident took place. By fully investigating how and why an incident occurred, the root cause can be established, and measures can betaken to prevent a similar incident from happening again.

The purpose of Incident Review is to objectively identify and address the root cause to prevent the same situation from taking place again.

Why should I take time and resources to do Incident Review? How does my organization benefit?
A thorough incident review can prevent employees or members of the public on your premises from being seriously injured- or worse- killed.
An incident review may be able to identify weaknesses in your operations to prevent your organization from being disrupted from a future incident causing injuries to employees, injuries or damage to members of the public or damage to your critical equipment.
Will help can lower workers' compensation costs by reducing the frequency and severity of incidents at the workplace.
It can be difficult to ask "what in our organizational structure contributed to systemic failures that caused this incident", but the benefits noted above far outweigh the difficulties.

Why do I need to investigate a near miss?
A series of close calls means it is just a matter of time before someone is hurt and/or property gets damaged. These near misses present an opportunity for an organization to examine the how and why's of what happened in order to prevent a more serious incident in the future.

II. INCIDENT REVIEW PROGRAM

The purpose of this program is to define and document the incident review process at the Town of North Yarmouth.

This program defines the responsibilities of management and supervisory staff in investigating the causes of incidents and implementing appropriate corrective actions to prevent similar situations from recurring.

Definitions

Accident - An unplanned, unwanted event that causes injury, illness or property damage or the probability of injury, illness or property damage.

Incident - An unplanned or unwanted event that does not result in an injury, illness or property damage. often times called a "close call" or "near miss".

Hazard - Anything that presents a danger to employees or property.

Hazard Control - Any method used to reduce or eliminate a hazard, such as:

- Eliminating the hazard.
- Substitute the hazard with a less dangerous method or process.
- Engineering Controls (isolate people from the hazard).
- Administrative Controls (policies, procedures, training, housekeeping, safe work practices).
- Personal Protective Equipment (PPE).

OSHA 300 Log - The Log and Summary of Occupational Injuries and Illnesses, on which all injuries and illnesses that occur in the workplace during the year must be recorded; also used to complete the OSHA 300A summary at the end of the year to satisfy employer posting requirements.

MDOL - Maine Department of Labor

Responsibilities

The Program Administrator, Debbie Allen Grover, Human Resources Manager. This person is responsible for:

- Administering program and issuing written materials to support it.
- Reviewing the program annually and updating as appropriate.
- Analyzing incident records to identify program deficiencies.
- Scheduling managers, supervisors and (if applicable) safety committee members for training.
- Coordinating all activities related to hazard control, insurance, state and local regulatory compliance.
- Reporting incidents to the Maine Department of Labor when required:
    - All incidents resulting in fatalities must be reported to MDOL within eight (8) hours of the incident.
    - All serious injuries requiring immediate hospitalization must be reported to MDOL within 24 hours of the incident.
    - Reports can be made electronically or by telephone at incident.bls@maine.gov or 207-592-4501 (24 hours).

This person or their designee is also responsible for:

- Maintaining training recordkeeping.
- Maintaining OSHA Recordkeeping on OSHA 300 Log and Summary of Occupational Injuries and Illnesses.
- Posting the OSHA 300A Summary Work-Related Injuries and Illnesses form February 1 to April 30 of the year following the year covered by the form.

Supervisors and Managers are responsible for:

- Establishing incident reporting policies and procedure.

- Training employees on procedures and policies.
- Ensuring all incidents and injuries are properly investigated and provide appropriate corrective actions in a timely manner.
- Ensuring immediate and long-term corrective actions are taken to prevent reoccurrence.
- Coordinating the reporting of claims to applicable insurers in compliance with Maine's Workers Compensation laws.
- Maintaining incident reports on file.
- Providing or arrange for all necessary medical care for injured workers.
- Initiating incident reviews immediately upon notification and completing them within 24 hours of occurrence if they involve an employee injury or illness that requires a physician's care.
- Ensuring review interviews are conducted in a professional manner. (The purpose of the interview is to gather facts, not to find fault or assign blame.)
- Taking action to protect people and property from secondary effects of incidents.

Employees are responsible for:

- Immediately reporting all incidents and injuries to their supervisors.
- Promptly reporting all hazardous conditions and near misses to supervisors.
- Assisting, as requested, in all incident reviews.

III. INCIDENT REVIEW GENERAL POLICY

The Town of North Yarmouth considers employees to be our most valued asset and as such we will ensure that all incident and incidents are analyzed to correct the hazardous conditions, unsafe practices, and improve related system weaknesses that produced them. This incident review program has been developed to ensure our policy is effectively implemented.

The Safety Committee will ensure this plan is communicated, maintained, and updated as appropriate.

Incident/Incident Reporting

Background. Incidents and incidents cannot be investigated or analyzed if they are not reported. A common reason that they go unreported is that the incident/incident analysis process is perceived to be a search for the "guilty party" rather than a search for the facts. We agree with current research that indicates most incidents are ultimately caused by system weaknesses. Management will assume responsibility for improving these system weaknesses. When incident/incident analysis is handled as a search for facts, all employees are more likely to work together to report incidents/incidents and to correct any procedural, training, human error, managerial, or other deficiencies.

Employees often are reluctant to report an incident because of fear, peer pressure, or concern that it may affect their job in some one way. To ensure that incidents will be reported, employee must be encouraged to participate in the "fact-finding" process. The purpose of the incident review then becomes one that will uncover system problems and provide solutions that will result in long term corrective action.

Consequently, our policy is to analyze incidents to primarily determine how we can fix the system. We will not investigate incidents to determine fault. A "no-fault" incident/incident analysis policy will help ensure we improve all aspects of our manufacturing process.

All employees will report immediately to their supervisor, any unusual or out of the ordinary condition or behavior at any level of the organization that has caused or could cause an injury or illness of any kind.

Supervisors will recognize employees immediately when an employee reports an injury or a hazard that could cause serious physical harm or fatality or could result in shutting down operations.

Department heads will ensure effective reporting procedures are developed so we can quickly eliminate or reduce hazardous conditions, unsafe practices, and system weaknesses.

Preplanning

Effective incident/incident analysis starts before the event occurs by establishing a well-thought-out incident/incident analysis process. Preplanning is crucial to ensure accurate information is obtained before it is lost over time following the incident as a result of cleanup efforts or possible blurring of people's recollections.

Incident Analysis

If applicable, the Safety Committee or the Incident Review Team is responsible for analyzing incidents.

Supervisors are assigned the responsibility for analyzing incidents in their departments. All supervisors will be familiar with this plan and properly trained in analysis procedures. Other staff may also investigate in conjunction with the supervisor.

All incidents (near misses) that might have resulted in serious injury or fatality will be analyzed. Incidents that might have resulted in minor injury or property damage will be investigated within four (4) hours of notification.

An incident/minor injury report will be submitted through management levels to senior level management. If within the capability/authority of the department supervisor, corrective actions will begin immediately to eliminate or reduce the hazardous condition or unsafe work practice that might result in injury or illness.

Management Responsibilities

When an incident/incident takes place resulting in injury or damage, management and/or supervisory personnel will:

- Provide medical and other safety/health help to personnel.
- Bring the incident under control.
- Investigate the incident effectively to preserve information and evidence.

To preserve relevant information, the assigned investigator(s) will do the following when it is safe to do so:

- Secure or barricade the scene.
- Immediately collect information that may be transient or time sensitive, such as debris, scuff marks, gouges, discoloration of surfaces or components, or other indicators that may fade or disappear with time.
- Interview personnel. The purpose of the interview is to gather facts, not to find fault or assign blame.

Incident Analysis Team

Background. It is important to identify and establish incident analysis staff or teams before an event occurs so they can quickly move into action if called on. The experience of staff or the team is another important factor affecting the quality of the analysis. Competent employees will be appointed who are trained,

and have the knowledge and skills necessary to conduct an effective analysis.

Training: Staff identified (The Safety Committee) as Investigators will undergo initial training for Incident Review, and an annual refresher training.

Incident Analysis Team Makeup. Although team membership may vary according to the type ofincident, a typical team analyzing an incident/incident may include:

- A first-line supervisor from the affected area.
- Personnel from an area not involved in the incident.
- An engineering and/or maintenance supervisor.
- The safety supervisor.
- Members of the Safety Committee.
- Occupational health/environmental personnel.
- Appropriate front-line personnel (i.e., operators, mechanics, technicians); and,
- Research and/or technical personnel.

The Incident Analysis Team Leader

The incident Analysis team leader will:

- Control the scope of investigative activity by identifying which lines of analysis should be pursued, referred to another group for study, or deferred.
- Call and preside over meetings regarding the review and analysis.
- Assign tasks and establish timetables.
- Ensure that no potentially useful data source is overlooked; and,
- Keep management advised of the progress of the review and analysis.

Determining the Facts

A thorough search for the facts is an important step in incident analysis. During the fact-finding phase of the process, team members will:

- When safe to do so, visit the scene before physical evidence is disturbed.
- Sample unknown spills, vapors, residues, etc., noting conditions which may have affected the sample; (Be sure you sample using proper safety and health procedures).
- Prepare visual aids, such as photographs, field sketches, diagrams, and other graphical representations to provide data for the analysis.
- Obtain on-the-spot information from eyewitnesses, if possible. Interview with those directly involved and others whose input might be useful should be scheduled soon thereafter. The interviews should be conducted privately and individually; so that the comments of one witness will not influence the responses of others.
- Observe key mechanical equipment as it is disassembled. Include inspection logs, maintenance logs, operating logs, recorder charts, previous reports, procedures, equipment manuals, oral instruction, as-

built drawings (if available), change of design records, design data, records indicating the previous training and performance of the employees involved, computer simulations, laboratory tests, etc.

- Determine which incident-related items should be preserved. When a preliminary analysis reveals that an item may have failed to operate correctly, was damaged, etc., arrangements should be made to either preserve the item or carefully document any subsequent repairs or modifications. Photographs should be obtained before any alterations or modifications are done.
- Carefully document the sources of information contained in the incident report. This will be valuable should it subsequently be determined that further study of the incident or potential incident is necessary.

Determining the Cause

It is critical to establish the root cause(s) of an incident/incidents so that effective recommendations are made to correct the hazardous conditions and unsafe work practices and make system improvements to prevent the incident from recurring. The incident/incidents analysis team will use appropriate methods to sort out the facts, inferences, and judgments they assemble. Even when the cause of an incident appears obvious, the review team will still conduct a formal analysis to make sure any oversight, or a premature/erroneous judgment is not made. Below is one method to develop cause and effect relationships:

- Develop the chronology, timeline, or sequence of events, which occurred before, during, and after the incident. The focus of the chronology should be solely on what happened and what actions were taken. List alternatives when the status cannot be established because of missing or contradictory information.
- List conditions or circumstances which deviated from normal, no matter how insignificant they may seem.
- List all hypotheses of the causes of the incident based on these deviations.

Recommending Corrective Actions and System Improvements

Usually, making recommendations for corrective actions and system improvements follow in a straightforward manner from the cause(s) that were determined. A recommendation for corrective action and system improvement will contain three parts:

- The recommendation itself, which describes the actions and improvements to be taken to prevent a recurrence of the incident.
- The name of the person(s) or position(s) responsible for accomplishing actions and improvements.
- The correction date(s).

Follow-up System

To make sure follow-up and closure of open recommendations resulting from an incident, the Town of North Yarmouth will develop and implement a system to track open recommendations and document actions taken to close out those recommendations. Such a system will include a periodic status report to management.

Communicating Results

To prevent recurring incidents, we will take two additional steps:

- Document findings; and
- Review the results of the analysis with appropriate personnel.

Incident documentation will address the following topics:

- Description of the incident (date, time, location, etc.);
- Facts determined during the analysis (including chronology as appropriate);
- Statement of causes; and
- Recommendations for corrective and preventive action (including who is responsible and correction date).

Review and approval

Appropriate operating, maintenance and other personnel will review all analysis reports. Personnel at other departments may also review the report to preclude a similar occurrence of the incident.

Plan Reviewed by: *Deborah Grover*, Interim Town Manger Date: 8/12/2021

Program Updates

The written program will be reviewed annually and updated as appropriate.

Plan Reviewed Dates:	Reviewed By:	Signature
December 31, 2021		
December 31, 2022		
December 31, 2023		
December 31, 2024		
December 31, 2025		
December 31, 2026		
December 31, 2027		
December 31, 2028		
December 31, 2029		
December 31, 2030		
December 31, 2031		
December 31, 2032		
December 31, 2033		