Incident Investigation and Root Cause Analysis Procedure

1.0 Policy Purpose & Scope

The purpose of this policy is to establish a consistent, thorough, and legally defensible process for investigating all workplace incidents, including near misses, injuries, illnesses, and property damage events. The primary objective is to identify root causes and contributing factors—not to assign blame—and to implement effective corrective actions that prevent recurrence. This policy applies to all employees, contractors, subcontractors, temporary workers, and visitors under the operational control of the organization, at all worksites and facilities. It covers incidents that result in injury, illness, environmental release, fire, explosion, or significant property damage, as well as high-potential near misses that could have led to serious harm.

2.0 Regulatory Context & Compliance

This policy is driven by the following regulatory requirements:

(a) Workers Compensation Act (WCA), Part 3, Division 6 – Incident Investigation, which mandates that employers investigate all incidents resulting in injury or illness requiring medical treatment, and all incidents that could have caused serious injury or damage;

(b) WorkSafeBC Occupational Health and Safety Regulation (OHSR), Sections 3.1 to 3.5, which specify the requirements for incident investigation reports, timelines, and corrective action tracking;

(c) OHSR Section 3.6, which requires that investigations be conducted by a person knowledgeable in the work process and with the authority to implement corrective actions;

(d) OHSR Section 3.7, which outlines the content of the investigation report, including root cause analysis;

(e) OHSR Section 3.8, which requires that reports be made available to the joint health and safety committee or worker representative; and

(f) applicable federal regulations under the Canada Labour Code, Part II, for federally regulated workplaces. Compliance with these regulations is mandatory and non-negotiable.

3.0 Roles & Responsibilities

Employer/Management:

(a) Ensure that a written incident investigation procedure exists and is implemented;

(b) Provide adequate resources, including trained investigators, time, and tools;

(c) Ensure that all incidents are reported and investigated promptly;

(d) Review and approve corrective action plans;

(e) Ensure that corrective actions are implemented and tracked to completion;

(f) Ensure that investigation reports are completed and retained as required by regulation.

Supervisors: (a) Immediately secure the incident scene to prevent further harm and preserve evidence;

(b) Report the incident to management and the joint health and safety committee;

(c) Participate in the investigation as a team member or provide relevant information;

(d) Implement interim controls to protect workers while the investigation is underway;

(e) Ensure that workers involved in the incident are offered support and not subject to reprisal.

Workers: (a) Report all incidents, including near misses, to their supervisor immediately;

(b) Cooperate fully with the investigation team, providing truthful and complete information;

(c) Do not disturb the incident scene unless necessary to prevent further harm;

(d) Participate in corrective action implementation as directed;

(e) Report any hazards or unsafe conditions identified during the investigation.

4.0 Program Execution & Procedures

4.1 Incident

Reporting: All incidents must be reported immediately to the supervisor. For serious incidents (e.g., fatality, critical injury, major fire), the scene must be secured and WorkSafeBC notified as per regulatory timelines. 4.2 Investigation

Team: For all incidents requiring investigation, a team of at least two persons shall be appointed, including a lead investigator trained in root cause analysis (e.g., TapRooT, 5 Whys, Fishbone). The team must include a supervisor from the affected area and a worker representative from the joint health and safety committee. 4.3 Investigation

Process: (a) Secure the scene and gather physical evidence (photos, measurements, equipment);

(b) Interview all witnesses and involved parties separately and confidentially;

(c) Review relevant documents (training records, procedures, maintenance logs);

(d) Analyze the sequence of events using a timeline;

(e) Identify immediate causes (unsafe acts/conditions) and root causes (systemic failures in management systems, training, or design);

(f) Use a recognized root cause analysis tool (e.g., 5 Whys, Fishbone Diagram, Event and Causal Factor Charting) to drill down to underlying causes. 4.4 Corrective

Action Development: For each root cause, develop one or more corrective actions that are specific, measurable, achievable, relevant, and time-bound (SMART). Assign a responsible person and a target completion date. Prioritize actions based on risk level. 4.5 Report

Completion: The investigation report must be completed within 30 days of the incident.

The report shall include: incident description, timeline, evidence collected, immediate and root causes, corrective actions, and lessons learned. The report must be signed by the lead investigator and reviewed by the joint health and safety committee. 4.6 Communication: Findings and corrective actions shall be communicated to all affected workers through safety meetings, toolbox talks, or written notices. Lessons learned shall be shared across the organization to prevent similar incidents elsewhere.

5.0 Review & Recordkeeping

5.1 Record

Retention: All incident investigation reports, including supporting documentation (photos, interview notes, evidence logs), shall be retained for a minimum of 10 years from the date of the incident. For incidents involving serious injury or fatality, records shall be retained indefinitely. Records shall be stored in a secure, confidential manner, accessible only to authorized personnel. 5.2 Record

Location: The master copy of all investigation reports shall be maintained by the Corporate Safety Department in the organization's safety management system (e.g., SafeDesk). Copies shall also be provided to the joint health and safety committee and the affected supervisor. 5.3 Policy

Review: This policy shall be reviewed annually by the Corporate Safety Director in consultation with the joint health and safety committee. The review shall assess the effectiveness of the investigation process, the timeliness of corrective action implementation, and any changes in regulatory requirements. Revisions shall be approved by senior management and communicated to all stakeholders. 5.4 Continuous

Improvement: The organization shall track key performance indicators (e.g., number of investigations completed on time, percentage of corrective actions closed within target date, recurrence rates) to drive continuous improvement in the incident investigation program.