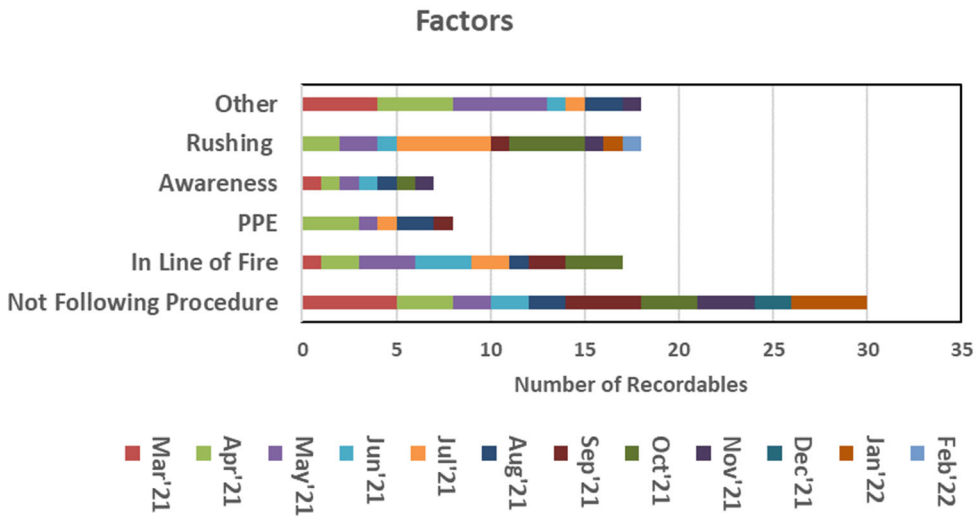
Plastics Pipe Institute
The Voice of an Industry.

SAFETY BULLETIN – APRIL 2022

The theme this month is **Accident Investigation and Analysis**

For the past year, the PPI Safety Committee has been collecting data on primarily recordable case injuries. The committee greatly appreciates those member companies (7) who have stepped forward to provide important incident information. Based on the data submitted to date the leading causal factor identified has been failure to follow procedures.



Let's take a more in-depth review of this leading causal factor. Before we do that a brief review of the foundational aspects of a good accident investigation and analysis process. The safety committee sponsored a webinar on this very topic in 2021.

1. **Incident reporting** – anything that happened during the shift that was not planned or scheduled. This is inclusive of not just injuries, but also fires, property damage, exposures, etc.
2. **Make it easy to report**. The easier the better as it encourages reporting which in turn provides the information needed to identify and eliminate risk. Establish a near miss process to support early intervention.
3. **Investigation** – creating the factual path of what happened.
    a. Interviewing the injured and witnesses
    b. Utilizing video, picture and observations of the work area before and after the event.
    c. Reviewing documentation such as blueprints, operational & safety procedures as well as training records.
4. **Analysis** – taking facts to conclusions. RCA is defined as a method of problem solving used to identify primary causes of faults or problems. Just following the OSHA form is not sufficient. The process requires use of a proven RCA methodology such as the following as examples:
    a. Five Whys
    b. Fishbone Diagram
    c. FMEA – Failure Mode and Effects Analysis
    d. Apollo Root Cause
    e. Fault Tree

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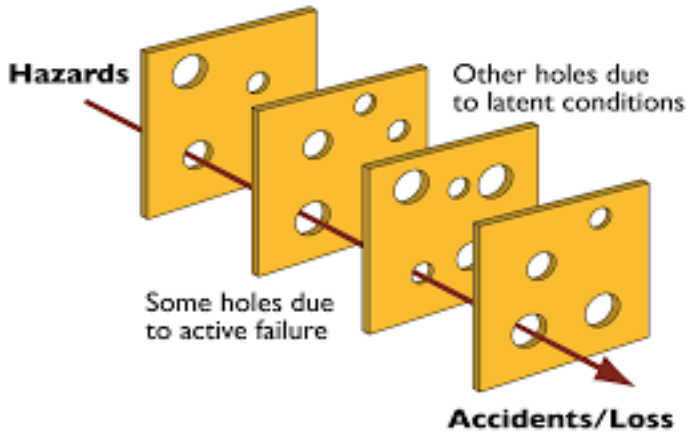
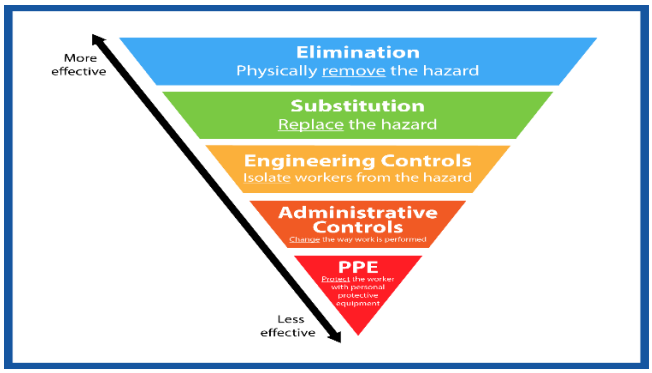
Keep in mind there is normally more than one causal factor contributing to the outcome of an incident.



5. **Corrective Actions** – Once the causal factors are determined actions are required to mitigate the risks. Essential to this step is establishing accountability of who will do what by when. Utilize the hierarchy of controls shown below.



6. **Close the Loop** – Provide communication throughout the organization about what happened and what was done to prevent recurrence. An important step to establishing credibility with the workforce.

So back to our number one causal factor, not following procedures. Working from the premise that workers do what makes sense to them or what influences their activity and behavior, it would be prudent that an accident investigation dig deeper and go beyond not following procedures by asking those next questions that lead us to understand why the procedure was not followed. One way an organization can challenge itself in this regard is to pursue the analysis until a management system factor is identified that requires addressing. For example, the procedure may not be clear enough, equipment specs have not been updated, training has been insufficient, or the culture encourages risk taking. The opportunity to take that next step will pay dividends for your accident prevention process.

Reminder - Recordable Tracking and Sharing of Corrective Actions:
PPI is encouraging your company to participate in this monthly report. Background on this process and the template are attached for your reference. Questions should be directed to David Fink at dfink@plasticpipe.org. We look forward to your company's participation so that together we can support each other in continuous improvement of our safety performance.