



SAFETY NEWSLETTER



We Demand Safety-

By insisting on a safety culture, we provide a safe work environment where we look out for each other.

WorkSafeBC Covid-19 Inspections



A WorkSafeBC (WSBC) officer may call or unexpectedly visit your job site to evaluate how well you are protecting yourself and others against Covid-19.

What you can expect during an inspection

The officer will ask to see the company's Covid-19 Safety Plan. Mott's Covid-19 Safety Plan is entitled, **Covid-19 ECP Rev. 02 June 2020**, and is located in the S-Drive (Folder 16.2) and in SiteDocs (Resources Tab). All workers should be able to pull this up when requested.

You should also be able to answer the following questions:

- What safety protocols are you following to reduce the risk of Covid-19 exposure?
- How were the company's Covid-19 safety protocols communicated to you?
- When are you required to wear a face mask/covering?
- Where are the hand wash / sanitizer stations located on site?

If you are unsure how to answer the questions above, please ask your supervisor to clarify. The officer will send your site an inspection report with details about the inspection. If the officer identifies any health and safety violations (e.g. Covid-19 safety infractions) they will issue an order and follow up to ensure the violations have been corrected.

How will the officer maintain safety during the visit?

While onsite, the WSBC officer will follow specific protocols to protect you, your coworkers and themselves. These include maintaining physical distance, frequent handwashing and minimizing touching of high-contact surfaces.

Please have your mask / face covering with you while showing the WSBC officer around the site, in case you may need to come within 2m of each other. If you still haven't received your Mott Electric face covering, please contact Claire Sham immediately (csham@mottelectric).

Effective Incident Investigations

The employee should have been more careful. They lifted the wrong way, or they should have been wearing safety glasses. These are just some examples of what the Safety Department too often reads in Mott's Incident Investigation Reports. While you could argue that any of these might be true statements, they do not add much value to the investigation process. Instead they are indications that the value of root cause analysis for accident investigations is not well understood.

For starters, what is a root cause analysis? The American Society for Quality (ASQ) defines **Root Cause Analysis** as a range of techniques used to uncover the true, or root causes of problems. Note the word "problem" in this definition. All organizations must address "problems" from time to time, such as late shipments, defective parts, or substandard customer service. Problems such as these require real solutions. It is unlikely that saying "The employee should have been more careful" would be a satisfactory solution for defective products shipped to a customer. So why then should it be satisfactory to the "problem" of an employee injury? The answer of course is that it should not be.

So then, how do we identify the "root or true" cause of incidents? One common approach is called "**5-Why**".



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This technique begins with a problem statement and then starts asking the question “Why?” Why questions are repeated a number of times (generally around 5 times, thus the name of this technique), until the root causes become more apparent.

Here’s an example:

Problem: An employee broke his arm when he fell in the shipping area.

1. Why did the employee fall?
 - He slipped on hydraulic oil that was on the floor
2. Why was there hydraulic oil on the floor?
 - It leaked from the forklift that was used during the shift
3. Why was the forklift used with a hydraulic oil leak?
 - The forklift operator didn’t know it was leaking
4. Why didn’t the forklift operator know it was leaking?
 - He didn’t check for oil leaks before operating the forklift
5. Why didn’t he check for oil leaks?
 - Because checking for oil leaks is not on the pre-operational inspection checklist that the operator completes each shift

You can continue to question further, but at this point a root cause is emerging. Specifically, checking for oil leaks is not part of the forklift operator’s daily forklift inspection. From here, corrective actions become clear: update the forklift daily inspection checklist to include a check for oil leaks and train employees on this updated procedure. However, is this the only possible conclusion in this situation? The answer is no. In most cases, there could be a number of different responses for each step along the way. For instance, we could have said, the oil was on the floor because it leaked from the forklift AND because no one took the time to clean it up. We can then ask, “Why didn’t anyone take the time to clean it up?” and can continue down this other path to yet another root cause.

This brings us to an important point; **there is very often more than one root cause to a problem.** This means that different people could reach different conclusions when it comes to identifying root causes. And that’s ok. It does not necessarily mean that one conclusion is correct and the other is wrong. Conversely, chances are that both conclusions are correct offering the opportunity to make multiple improvements in response to a single problem. In our example, we might be able to prevent oil leaks from occurring AND improve the process for cleaning up spills throughout the facility.

Accident Investigations that do not involve root cause analysis tend to address the symptoms of problems rather than the problems themselves. As such, corrective actions tend to be quick fixes that are not effective in preventing the problem from reoccurring. So, while Root Cause Analysis using the 5-Why Technique often takes more time, it is well-worth the effort. When root causes are identified, corrective actions are more effective, leading to a continuously improving and safer workplace for Mott employees.



Phases of an Investigation

1. Initial Response

- *Respond promptly and positively*; take charge and give specific instructions to specific people & secure the scene
- *Ensure First Aid and during an emergency, call 911*; people’s well being and lives come first and we secure the scene to control any potential secondary incidents and be able to properly investigate what happened
- *Identify sources of evidence at the scene*; identify the essential information before it can be disturbed or destroyed. Four categories of evidence exist;



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- 1) People / witness
 - 2) Positions of people, equipment or items (including environmental conditions)
 - 3) Parts of items (physical items)
 - 4) Paper, any documentation which has a bearing on the incident (e.g. policies, procedures, records, pre-use inspections)
- *Preserve evidence from alteration or removal*; keep people away from the incident scene so nothing is disturbed
 - *Determine the loss potential*; determine how bad the incident could have been and how likely it is to occur again to determine how the investigation should proceed
 - *Notify appropriate personnel*; managers/ supervisors and the General Contractor need to be made aware of the situation immediately

2. Gather Information

- *Get the big picture first*; a large amount of information exists at the incident scene
- *Document the scene*; take notes, pictures, sketches, measurements, etc.
- *Identify witnesses*; direct witnesses (eyewitness), and indirect witnesses (supervisor, co-worker). Witnesses are more likely to forget the details if not questioned promptly. The first details give the investigator the starting point to identify the causes
- *Interview witnesses*; interview separately, in an appropriate place and put the person at ease. Get the individual's version and ask necessary questions at the right time. Record key points by taking notes. Remember to end in a positive note and keep the lines of communication open
- *Equipment examination*; have a close look at the tools, equipment and materials that were used. Look for proper guards, safety features and hazard warning labels. Check records for training, maintenance, work schedule, work instructions, practices and procedures

3. Analyze for Root Causes using the 5-Why Technique (as described on the previous page)

4. Determine Corrective Actions

- *Prioritize by risk*; identify which actions must be done immediately and which can wait. Set reasonable timelines
- *Hold someone accountable* for fulfilling each corrective action
- *Ensure corrective actions are SMART*; specific, measurable, attainable, realistic, and timely.

5. Follow up with Corrective Actions

- *Make sure all corrective actions get done*; The supervisor must monitor when each of the corrective actions get completed and revise the Incident Investigation Report so that completion dates get recorded. **Following up is one of the most crucial steps to the incident investigation process!**

If you have any questions on how to improve your incident investigations, please contact the Safety Department for assistance.

#SafetyQuotes

An incident is just the tip of the iceberg, a sign of a much larger problem below the surface. - Don Brown



Any questions, comments or concerns?

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