# How did it happen? by Tim Governor

# CAUTION

## Introduction

Before you begin

in an adjacent hallway.

It happens. Whether it is an injury, property damage or an unexpected, unwanted consequence of some activity - it happens. The crane topples, the worker gets injured and the material becomes damaged. These are examples of the it. However, the focus of this discussion is not the it. We are too familiar with the it. During our discussion, we will focus on the behind-the-scenes factors that permit the it to occur.

For discussion, select an accident or incident that

You may consider this example for discussion. While walking back to the office from the break room, an employee reports he or she slipped and fell in a hall-way on a wet floor. You can see a custodial cart with a mop, bucket of water and a *Caution Wet Floor* tent

you are familiar with at your work site.

### Discussion

A reporter's questions of who, what, when, where, how and why are the best tools for common incident analyses. Think again about the selected incident or accident and ask these questions. To gather the relevant information, sometimes you need to ask a question repeatedly.

### Who

If someone becomes injured, he or she is one of the who's in the incident-analysis process. But, what about others who may be involved at the scene or who may have left the scene? For example, hours before an incident occured someone may have left a hazardous condition.

In our example, in addition to the unnamed employee, a custodial worker is part of the incident analysis.

### What?

This would include tools, equipment, environmental factors like the weather, noise, a vehicle, etc. In our example the environmental conditions are a hard, smooth floor and water on the floor.

### When?

This may include the day of the week, the time of day, shift change, sunrise, sunset, a return from a break, late in the shift or the workday.

In our example the incident occurs around the lunch break.

### Where?

The location of an incident may be an area, in a vehicle like a semi-trailer, a room or an equipment-operator position. The location may provide information as to whether a person is caught between equipment or in an area where he or she could be struck by vehicles or machinery.

In our case, the location is a hallway. However, it may be important to note whether the hallway runs east to west or north to south.

### How and why?

These questions are the most important to ask those involved. You may need to ask these questions repeatedly. They provide more details and descriptions as to what happened. In our example, the floor is wet. However, when you ask the custodian about the floor and why the *Caution Wet Floor* tent is not posted, the custodian says he or she mopped the hallway floor the first thing that morning. It should have dried within 15 minutes.

The cart is in the adjacent hallway because the custodian plans to mop it after the lunch break. When the floor is wet, the custodian posts the *Caution Wet Floor* tent until the floor dries. In addition, the custodian explains the hallway frequently has stains from coffee and tea spills.

When asked, the employee says he or she carefully watches the nearly full coffee mug when the employee carries it. This is so the mug does not spill. As a result, the employee is not looking closely at the floor. The employee also notes that the hallway runs north to south.

In addition, around lunch time on sunny days, the light comes directly into the hallway from a window at the end of the hall. The sunlight causes glare on the floor.

Upon later inspection, the worker says his or her clothing has coffee stains where the clothing contacted a small coffee spill on the floor.

### Group actions

Take five minutes to look around your workplace. Identify, discuss and take corrective actions where it is feasible to eliminate hazards or actions that can cause or result in an accident or an incident. Ask what permitted these hazards or actions to exist. Ask the group: Is there a need to develop training, policies or standard operating procedures?

### Summary

As discussed, there may be many actions in a chain of events. Furthermore, many chains of events or even a single action can lead to incidents or accidents. Preventing accidents may be as easy as recognizing and correcting situations before the chain of events starts. The next time you recognize an action, object, or condition that could trigger an accident or an incident, take time to do what you can to eliminate it. You may help prevent it from happening to you. Discuss the incident's how and why at your work site. What can you do to prevent a recurrence?

In our example, to help prevent an incident recurrence, you place a blind on the window to help minimize the glare. In addition, the company banned employees from carrying open-beverage containers through the hallways. Along with a sign asking employees to promptly wipe up spills, the break room now has paper towels and napkins.

### References

Accident/Incident Investigation (OSHA): http://www. osha.gov/SLTC/etools/safetyhealth/mod4\_factsheets\_accinvest.html

**Tim Govenor** is a certified industrial hygienist and a certified safety professional employed by The Ohio State University as the director of research safety. He served as president of the local chapters of the American Society of Safety Engineers, American Industrial Hygiene Association and the Society of Professional Engineers. He has more than 30 years of occupational safety experience.

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