:::::risk management



Six Steps for Reducing District Losses and Increasing Safety Awareness

By Tom Strasburger and Tom Wohlleber

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very school district strives to create a culture of safety. One way districts can do that is by implementing effective incident and accident prevention tactics. Preventing accidents helps lower the likelihood of staff and student injuries and district property damage and associated costs, but more important, it magnifies awareness and a culture of safety.

A district creates such a program by clearly defining and adhering to a process for identifying, reporting, and addressing the causes of incidents and accidents to prevent future accidents from occurring.

First, districts must recognize the difference between incidents and accidents.

An **incident** is an unplanned event that disrupts normal activities and has the potential for injury, harm, or damage to persons or property. For example, a teacher wants to hang decorations from his classroom ceiling but cannot reach it, so he stands on a chair with casters. The casters roll, causing him to fall; however, he is not hurt. Incidents act as a "wake-up call" because they are often the first of a series of events that lead to an accident.

An accident is an unplanned event that disrupts normal activities and results in injury, harm, or damage to persons or property. If the previously mentioned teacher fell and broke his arm, that would be an accident. Accidents are mostly predictable—and preventable —events. They are the logical outcome of unaddressed hazards and are often caused by things people do, or fail to do.

The Investigation Process

When an incident or accident occurs, the way a district reacts has a huge effect on the overall effect of the situation. A district that

begins to investigate swiftly and thoroughly is going to see the smallest effect.

An incident or accident investigation has three goals: (a) to determine the root cause(s), (b) to take the appropriate corrective action(s), and (c) to prevent a similar incident or accident from recurring. When conducted correctly, investigations do the following:

- Identify and eliminate hazards to help prevent future accidents or incidents,
- Expose deficiencies in a process or equipment,
- Increase worker morale by showing that the organization cares,
- Provide crucial facts and details in the event of litigation,
- Reduce injury and worker's compensation costs, and
- Create greater awareness of safety in the workplace, which is the cornerstone of an effective workplace safety and injury prevention program.

How can your district reap those benefits? Follow these six steps to conduct an effective investigation.

1. Notification

First, decide what types of incidents and accidents must be reported. For the best results, all incidents, accidents, and potential hazards should be reported, although not all districts require that all be reported. After deciding what needs to be reported, districts must outline the reporting process.

The actual reporting process is crucial to the success of the investigation. If a report is lost and not processed, the repercussions can be significant. Many districts rely on paper processes to report incidents and accidents. That approach can present three major problems: (a) administrators may lose or never see paper reports, (b) administrators may fail to process reports, and (c) employees may submit incomplete reports.

Many districts that use online applications or software to help manage the process and track reports see a decrease in those oversights. Middleton-Cross Plains Area School District uses an automated. web-based application to report and track incidents and accidents online, as well as to report (potential) hazards. The online report form requires the employee to fill in all requisite fields; it will not advance to the next page or be submitted until they are completed. Once submitted, the system is programmed to automatically email the assigned administrators to review the report and begin the investigation.

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2. Response

After an incident or accident, make sure the employee obtains medical treatment if necessary and then secure the scene. If there is an obvious hazard, eliminate it immediately so other employees avoid injury. If it is not easily fixed, rope off the unsafe condition.

To prepare for the investigation, preserve any critical evidence, contact emergency personnel if necessary, and identify who should be involved in the investigation.

3. Fact Finding

Collect evidence and information to aid the investigation. This step may include, but is not limited to, taking photographs or video of the scene, documenting the sequence of events, and interviewing the employees involved. The injured employee should be interviewed first, followed by any witnesses.

Interviews should be conducted separately to ensure that the injured employee and witnesses provide their own interpretation of the



event. It may be beneficial to ask all interviewees to demonstrate how the incident or accident occurred and to suggest how similar occurrences could be avoided in the future.

Remember that accidents rarely result from a single cause. Keep probing the interviewees for more information, and do not jump to conclusions and recommendations too quickly.

4. Analysis

The analysis step helps determine the "what" and "why" behind the incident or accident. The answer to "what" caused the accident is called a surface cause. Surface causes of accidents are those hazardous conditions and unsafe behaviors that directly caused or contributed to the accident. Identifying surface causes is important to correcting the issue, but to truly prevent similar occurrences, administrators must determine the root cause for the accident. Root causes are the underlying weaknesses that contributed to the hazardous conditions and unsafe behaviors.

A root cause can be placed in one of two categories: (a) system design weakness or (b) system implementation weakness. A system design weakness is the absence of a policy or procedure, such as training or safety plans, thus resulting in

hazardous system conditions. A system implementation weakness is the failure to accomplish safety policies and procedures, thus resulting ineffective management behavior.

To better explain the difference between a surface and root cause, go back to the example of the teacher standing on a chair with casters who fell and broke his arm. After interviewing him, the administrator found that the surface cause of his fall was his failure to use the appropriate ladder or step ladder.

By asking the teacher why he did so, the administrator will find the root cause. If the teacher did not know that his action was dangerous, a lack of training exists, making this is a system design weakness. However, if the district has slips, trips, and falls training in place, but the educator was not required to take the course or failed to complete it, this is a system implementation weakness.

Once the root cause or causes have been determined, corrective action should take place.

5. Corrective Action

When developing corrective actions to address the root cause, first determine the number of root causes. Multiple root causes require multiple corrective actions. If the administration focuses on only one of the

root causes, the others will continue to cause issues.

After identifying the actions that need to be taken to correct the root cause or causes, identify who is responsible for carrying out the corrective actions. Obviously, the teacher needs to take the slips, trips, and falls training, but who else needs to be trained or retrained? Who will be responsible for ensuring that those individuals complete the training? Once those questions are answered, the parties involved in the corrective action must be notified of their role.

6. Follow-Up

First, establish a time line and process for following up corrective actions. This step will ensure that the corrective actions have been completed. Next, evaluate whether those corrective actions are effective in preventing similar incidents and

accidents. This evaluation is easily accomplished when all records are online, and administrators can quickly pull reports to see whether the number of similar incidents or accidents has decreased since the corrective action.

If there is no sign of improvement, administrators need to modify the corrective actions for better results. For example, if the prevalence of staff members to stand on furniture and fall persists, it may be best to retrain the entire staff on slips, trips, and falls to bring awareness to the

Finally, share the results of the corrective actions. Doing so will not only help foster a culture of safety awareness, it will also help create a positive relationship between the district and its employees, because the employees will know that the district takes their safety seriously.

Learning from **Investigations**

As the saying goes, accidents happen. However, it is how districts address both incidents and accidents that will help them recover from and prevent similar occurrences. Preventing staff and student injuries as well as property damage will obviously help a district's bottom line, but most important, it makes schools a safe place for employees to work and students to learn.

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