

## **Incident Investigation Process**

### **1.0 PURPOSE**

The Incident Investigation Process (IIP) is designed to:

- Provide organization learnings to prevent incidents from occurring
- Outline investigation requirements based on classification of severity (minor, significant, major, or critical)
- Focus on facts and continuous improvement, not fault finding
- Provide context for collaborative investigation of incidents which affect multiple business divisions
- Ensure investigations are directed at identifying evidence, determining root causes and contributing factors
- Direct the development and implementation of appropriate corrective or preventative measures, where appropriate
- Determine facts and if necessary, to obtain legal advice in anticipation of litigation or regulatory action

### **2.0 DEFINITIONS**

#### **Dangerous Occurrence**

Any occurrence or condition or circumstance set out in the Occupational Health and Safety Regulations.

#### **Environment**

The surroundings in which SaskPower operates including air, water, land, natural resources, flora, fauna, humans and their interrelation.

#### **Emergency**

A present or imminent event that requires prompt coordination of actions or special regulation of persons or property to protect the health, safety, or welfare of people, or to limit damage to property and the environment.

#### **Incident**

An occurrence that did, or could have, resulted in injury, damage, environmental impact or loss. Or an occurrence that caused a breach of corporate policy, legislation or other requirement. The classification will be either: Minor, Significant, Major or Critical as defined in the Incident Reference Chart – Health and Safety or Incident Reference Chart – Environment.

#### **Incident Owner**

Is the individual who is accountable for the investigation that approves corrective actions that are created in response to recommendations arising from an investigation.

#### **Investigation**

Gathering of evidence for analysis of an incident with the intent of establishing root cause, contributing factors and providing recommendations for preventing future incidents.

#### **Lead Investigator**

The Lead Investigator for Minor and Significant incidents shall be the Incident Owner or designate. The Lead Investigator for Major and Critical incidents shall be assigned from the Health and Safety or the Environment department depending on if the severity is higher based on the Environmental or Health and Safety Reference Chart.

**Near Miss**

An incident that could have, but did not, result in unintended harm or damage.

**Privileged and Confidential**

A document which is produced for the purpose of using its contents to obtain legal advice or to aid in the conduct of litigation or defence of a regulatory action is privileged and must be kept confidential.

**Recommendation**

A potential solution issued as part of an investigation to prevent future incidents and used to develop corrective actions.

**Root Cause**

The most basic cause (or causes) that can reasonably be identified that management has control to fix and, when fixed, will prevent (or significantly reduce the likelihood of) the problem's recurrence.

**Corrective Action**

Corrective actions are developed in response to a recommendation to prevent future incidents from occurring.

**3.0 APPLICATION**

The IIP applies to all health, safety, and environmental incidents that occur involving SaskPower assets, properties, and/or individuals working on SaskPower's behalf.

**4.0 ROLES****Incident Owner:**

- Own the incident that occurred in the assigned operational area of responsibility
- Act as the primary contact for the incident and development of corrective actions
- Assign staff to the Corrective Action Team (if required)
- Review draft investigation reports prior to being finalized for Major and Critical level incidents
- Responsible to create the investigation report for Minor and Significant level incidents
- Approve all developed corrective or preventative actions upon completion of the investigation
- Accountable for ensuring the completion of corrective actions resulting from the investigation
- Maintain confidentiality of records including the Formal Investigation Report, if required

**Lead Investigator:**

The Lead Investigator is not required to be a subject matter expert in the operational area where the incident occurred. However, the Lead Investigator should ensure that supporting subject matter experts are identified prior to the start of the investigation.

Lead Investigator shall:

- Set the terms of reference for the investigation with the Incident Owner, including communication expectations
- Act as the primary contact for the investigation
- Work with the Incident Owner to set the investigation team and coordinate the investigation team, when appropriate
- Conduct interviews and analyse evidence
- Identify root causes and provide recommendations based on evidence gathered throughout the investigation.
- Hold a formal review of the incident and present findings and recommendations to the Incident Owner (and Corrective Action Team, if applicable) and participate on the Corrective Action Team

In addition, lead investigators have the authority for making any reasonable recommendations they believe will assist in preventing future incidents. This is to ensure lead investigator independence and to promote openness and transparency in incident investigations.

**Executive / Directors:**

Executive shall:

- Monitor incidents and investigations for their respective areas of responsibility
- Cooperate, stay informed and provide resources from respective areas to support and increase the effectiveness of investigations
- Allocate resources to ensure the implementation of incident corrective actions

Directors shall:

- Take on the role of Incident Owner for Critical incidents in their area of responsibility or assign designate
- Ensure the required information is maintained in the Safety and Environment Management Systems
- Cooperate and ensure participation in the investigation
- Evaluate and cooperate in recommendations stemming from the incident investigation and initiate corrective or preventative actions as required
- Ensure corrective or preventative actions and verification of effectiveness have been appropriately prioritized and completed as scheduled
- Discuss the details of incidents with legal counsel as required

**Managers (Out of Scope) or designate shall:**

- Act as the Lead Investigator for any Minor or Significant incident investigations
- Act as Incident Owner for any Minor, Significant or Major incident investigations

**Occupational Health Committees (OHC) shall:**

- Be involved in relevant incidents as required
- Participate in investigations when required
- Participate in other investigations at the request of the Incident Owner
- Have access and review incident reports and investigations for all health and safety incidents at regular meetings. Except for those marked privileged and confidential

**Employees shall:**

- Report all incidents
- Complete incident investigation forms when requested
- Cooperate during the incident investigation process including participating in interviews as requested

**Corrective Action Team:**

- Is formed for Major and Critical level incidents at the direction of the Incident Owner to develop appropriate corrective or preventative actions in response to the recommendations outlined in the investigation report
- Shall develop the verification of effectiveness criteria for each corrective action

**Contractors shall:**

- Report all incidents to the designated SaskPower Contract Administrator and Project Manager and to regulators, as required
- Ensure corrective or preventative actions have been fully implemented and perform verification of effectiveness and provide updates on corrective actions when requested
- Ensure corrective or preventative actions have been appropriately prioritized and completed as scheduled
- Investigate their own incidents and provide a copy of the investigation report to SaskPower
- Co-operate with SaskPower investigators if a SaskPower lead investigation is assigned for Major and Critical investigations

**Health and Safety and Environment Departments shall:**

- Own the investigation process and methodology
- Provide administrative and technical support for the application of the Incident Investigation Process for all incidents
- Assign a Lead Investigator for major and critical investigations
- Provide support to operational staff that lead minor and significant investigations as requested
- Provide centralized distribution of incident statistics and related key indicators, and conduct regular trending and analysis for incidents
- Communicate information and findings for incidents
- Participate in the monitoring of the identified corrective or preventative actions and verification of effectiveness
- Provide support in relation to Health and Safety or Environment regulatory requirements relevant to incidents.
- Maintain confidentiality of records including the Formal Investigation Report, if required
- Consult Law to obtain legal advice in contemplation of litigation and/or regulatory action

**Health and Safety shall:**

- Ensure that the business area reports serious injuries, fatalities and dangerous occurrences to the Ministry of Labour Relations and Workplace Safety

**Environment shall:**

- Ensure that regulated environmental incidents/impacts are reported to Environment Canada, Ministry of Environment and/or any other applicable regulatory agency

**Law shall:**

- Provide legal advice in contemplation of litigation and/or regulatory action
- Provide legal advice to ensure compliance with laws and regulations
- Review incidents to determine if they should remain privileged and confidential
- Review communications for prior to release for privileged and confidential investigations

**Communications shall:**

- Lead media contacts if required
- Assist in internal and external key messaging / communication activities as required at the time of an incident occurrence or post incident follow-up

**Human Resources shall:**

- Identify human behaviour issues and indicate what triggers should initiate when investigator should consult with Human Resources
- Conduct a separate investigation when human behaviour issues are identified in an Health and Safety or Environment investigation

## 5.0 METHOD

### 5.1 Incident Reporting

After an incident occurs, the following general steps shall be followed:

1. Initial Response
2. Report the Incident

Refer to the appropriate management system procedures for specific requirements.

#### 5.1.1 Initial Response

1. Recognize that an incident has occurred.
2. Complete an initial assessment of the incident to determine the following:
  - What has occurred;
  - When the incident occurred;
  - Who was involved;
  - What resources have responded thus far (if any); and
  - What is required to control the scene and prevent further loss?

3. Determine if emergency response is required. If the incident is an “emergency”, follow the applicable Emergency Response Plan or Incident Command System (if initiated). If the investigation occurs within the framework of the Incident Command System, the Incident Commander takes over the role typically assumed by the Incident Owner for approval of reports and corrective or preventative actions. In the event emergency response is activated, the out of scope manager must notify Health and Safety and/or Environment departments.
4. Prevent further loss by determining and implementing an interim measure to mitigate the risk of reoccurrence if required. Ensure injured people receive medical attention if required. It is advised to not disturb the incident scene more than is necessary to make the scene safe, stop and contain the spill or to secure the facility or area. The Secure the Scene checklist may be used as a tool.
5. Verbally notify the responsible manager of the incident. Note that for all Critical incidents, where involved employees are in a safety sensitive position, a drug and alcohol test must be done as detailed in the Drug and Alcohol Policy. See Drug and Alcohol Policies and Procedures for more information.

### **5.1.2 Incident Reporting**

*NOTE: It is expected that an incident will be entered in the management system software within 8 business hours.*

#### **SaskPower Employees**

After verbally notifying the responsible manager of the incident, as soon as practical, that manager should consult the applicable Incident Reference Chart to determine further communication requirements.

For Significant, Major and Critical incidents the manager or designate shall obtain statements from anyone involved in or witnessing the incident. Statements can be obtained but are not required for Minor incidents. The form must be filled out individually, not in a group, and returned to the manager or designate.

The manager is responsible to ensure the incident is entered into management systems software (ESMIS), but may delegate an employee to enter the incident. Attach any relevant documents, pictures and filled out forms to the submission. Preliminary incident Severity Classification is mandatory and must be completed by the person entering the incident.

The Incident Owner is required to verify the preliminary incident severity classification in the management systems software (ESMIS). Timelines for submitting information are identified in the Incident Reference Charts for Health and Safety and Environment.

If the verified incident severity is changed from the initial incident severity, changes will be communicated to all parties including Health and Safety and/or Environment as required by the adjusted severity rating in the Incident Reference Chart. Safety and/or Environment staff will also ensure that confidential information is properly restricted and/or vetted (if required) prior to widespread communication of an incident.

#### **Contractors**

Contractors will follow a very similar series of actions to that of employees, except the Contractor Administrator functions as the manager. There may be the additional requirement to also verbally notify the SaskPower Project Manager (if applicable). In the event, neither the Contract Administrator (nor Project Manager, if applicable) cannot

be verbally notified, the contractor shall verbally notify SaskPower via the Safety and Environment Care Line (306-566-6200).

After verbally notifying the responsible Contract Administrator (and Project Manager, if applicable) of the incident, as soon as practical, that Contract Administrator should consult the Incident Reference Chart as to which additional staff to be verbally notified.

For Significant, Major and Critical incidents the Contractor Administrator or designate shall obtain statements from anyone involved in or witnessing the incident. Statements can be obtained but are not required for Minor incidents. The form must be filled out individually, not in a group, and returned to the Contractor Administrator or designate.

The Contractor Administrator is responsible to ensure the incident is entered into ESMIS, but may delegate an employee to enter the incident. Attach any relevant documents, pictures and filled out forms to the submission. Preliminary incident Severity classification is mandatory and must be completed by the person entering the incident.

The Incident Owner(Contract Administrator) is required to verify the preliminary incident severity classification in management systems software (ESMIS). Timelines for submitting information are identified in the Incident Reference Charts for Health and Safety and Environment.

If the verified incident severity is changed from the initial incident severity, changes will be communicated to all parties including Health and Safety and/or Environment as required by the adjusted severity rating in the Incident Reference Chart. Safety and/or Environment staff will also ensure that confidential information is properly restricted and/or vetted (if required) prior to widespread communication of an incident.

## **5.2 Investigation**

Investigations will be prioritized and performed in accordance with the verified incident severity rating.

The incident severity rating may be re-evaluated throughout the investigative process as new information presents itself. For example, multiple lower risk incidents may have the incident severity classification elevated through consultation with the Health and Safety or Environment departments.

If a higher severity classification is applied to an existing incident after the investigation is started, this may require reassigning roles to meet the higher severity classification investigation requirements. Additional notification may also be required.

### **5.2.1 Conflict of Interest**

For Major and Critical investigations prior to accepting the roles of Incident Owner, Lead Investigator or a member of the investigation team, the individual must fill out a Conflict of Interest form. If a conflict is declared, forward copies of the form to the division Director and the Director(s) of Health and Safety and/or Environment.

For Minor and Significant investigations, it is assumed there is no conflict of interest and the form is not filled out. In the event there is a conflict of interest, the form must be filled out and a copy forwarded to the division Director and a copy is attached to the incident report in the management system software.

The Conflict of Interest form is used to assist in determining if someone has a conflict of interest in an investigation. In general a conflict may exist if:

- a direct or indirect relationship (former employee, friends of employee, extended family or shareholders), with parties involved in the incident (financial, professional or personal interest), as defined in SaskPower's Code of Conduct Policy
- an individual involved directly, present, and on-site on the job that resulted in the incident
- an individual whom developed the policies/standard procedures involved in the incident when it appears the policy/standard procedure was insufficient
- any other relationship or interest that could result in a conflict of interest

Managing the staff involved in an incident doesn't mean that Manager has a conflict of interest, unless the Manager's actions or direction caused the incident.

Note that filling out the Conflict of Interest form at the start of the investigation does not excuse a person from declaring a conflict of interest later on once additional information is available.

### 5.2.2 Investigation Requirements

Incidents as defined in Incident Reference Charts will be investigated at a minimum as follows:

- **Minor** – Requires a brief investigation by the manager (or designate) of the employee involved in the incident. The manger (or designate) acts as both Lead Investigator and Incident Owner. This may be as short as a few minutes to understand what occurred and fill out the appropriate incident report in management system software (ESMIS). Environmental incidents must have at least one root cause identified. Health and Safety incidents do not require a root cause.
- **Significant** – Requires an investigation by the manager (or designate) of the employee involved in the incident. The manger (or designate) acts as both Lead Investigator and Incident Owner. The manager will fill out an incident report in the management system software(ESMIS)which will serve as the investigation report. The manager must identify at least one root cause plus at least one action which could prevent future incidents. Please note that a procedure by itself is not considered an adequate recommendation.

Minor and Significant investigations shall use the '5 Why' methodology to determine the root cause(s). A sampling of minor and significant reports can be used by their respective departments to assist in improving the quality of these investigations. Health and Safety and Environment departments are to support Managers (or designate) in performing investigations as requested.

- **Major** – The Incident Owner is assigned and must be at a Manager or higher level. A Lead Investigator is assigned from either Health and Safety or Environment. A summary of the events leading to the incident should be created and root causes identified. At least one recommendation shall be created for each root cause identified by the Lead Investigator.
- **Critical** – The Incident Owner is assigned and must be a Director or higher level. A Lead Investigator is assigned from either Health and Safety or Environment. A summary of the events leading to the incident should be created and root causes identified. At least one recommendation shall be created for each root cause identified by the Lead Investigator. A recommendation to address systematic issues that go beyond the incident under investigation should be considered if applicable.

### 5.2.3 Assign Roles



If the incident was classified as a minor or significant incident the out of scope manager (or designate) of the employee involved in the incident is assigned both Lead Investigator and Incident Owner roles.

An Incident Owner shall be assigned to all major and critical investigations. Investigations will be led by the supporting business unit (Safety or Environment) with the highest incident rating. For example, if an incident was significant for Health and Safety, but Major for Environment, then Environment would lead the investigation

Typically the Incident Owner is the individual with the most to gain from the recommendations and is empowered to approve and execute the corrective or preventative actions. This role will be collaboratively determined by the operational areas involved in the incident. In the event a discrepancy arises, a final decision will be made by the next senior organization level.

In the event there are equal incident ratings from multiple departments, the Incident Owner will decide the department that will lead the investigation.

The Incident Owner, Lead Investigator and their manager(s) shall agree on any scope reduction of the investigation, as well as on the communication requirements that will be followed during the course of the investigation and outline this in a Terms of Reference. An example of a Terms of Reference is included in the Formal Report Templates. This action is completed so as to ensure that all parties are adequately informed, prior to the issuance of a final report. If this cannot be resolved it will be evaluated to the next highest level of management.

Members of the investigation team must understand the process that will be followed as the team itself needs to maintain cohesiveness.

#### Additional Safety Requirement

A geographic convenient member of the relative Occupational Health Committee may sit as a member of the investigation team for safety incidents at the discretion of the Lead Investigator.

### **5.2.4 Privileged and Confidential Investigations**

Some investigations have the potential to have legal implications and as such then must be kept privileged and confidential.

In order to support the consistent application of “legal use of privileged and confidential in contemplation of litigation and solicitor-client communication with regards to investigations” associated with major and critical incident investigations the following will be used.

#### *Notification*

- Copy Law on notifications of major and critical incidents to the Director of Environment or Director of Safety.
- Assume all major and critical incident investigations are privileged and confidential pending Law's evaluation of legal sensitivity.
- Law will advise if the incident investigation shall remain classified as privileged and confidential.

#### *Communication*

- Copy Law on all communication with regulators for privileged and confidential incident investigations.
- Email correspondence regarding investigations shall contain facts and will avoid opinion (this is good practice for all investigations).
- Emails regarding privileged and confidential incident investigations shall be marked as “Solicitor and client privileged investigation in contemplation of litigation-prepared at the request of and for the sole use of the

SaskPower Law Department“ in the subject line.

#### *Records Management*

- Draft versions and the final version of the investigation report shall be marked “privileged and confidential in contemplation of litigation and solicitor-client communication”.
- Segregate the investigation report, including all drafts whether hard copy or digital, from other records and restrict access to them.

#### *Sharing Reports*

- Requests from a regulator for a copy of the investigation report should be denied. If a report is seized during an investigation it should be placed in a large envelope, sealed and marked “Privileged and Confidential in anticipation of litigation and solicitor-client communication” and “Sealed on (date), signed by the SaskPower representative and the regulatory official.” Envelopes should be ready for this purpose.
- To maintain privileged and confidential, reports should be shared with just those central to the incident. Privileged and confidential investigation reports will only be shared at the Director level and above from the affected Division(s), Health and Safety, Environment, Law and the assigned investigation team and Incident Owner. If a Director believes that a copy must be shared to a direct report, Law will be consulted. Directors are able to provide a verbal summary of the information contained in the report to their direct reports involved in the incident.
- Corrective action tables for privileged and confidential incident investigations will not be shared beyond the corrective action team to maintain confidentiality of the recommendations. When entering Corrective Actions into the management system software, do not use the full description of the recommendation.

If the incident investigation is not classified as privileged and confidential by Law, the report may be shared within SaskPower.

#### *Communication of the Investigation Progress and Results*

- Corporate communications regarding privileged and confidential incident investigations will be reviewed by Law prior to release.
- Communications should be focused on facts and include a high level summary of corrective actions.
- Avoid communications around legally sensitive content such as contracts, human behaviour issues and statute violations.
- See section 5.5 for additional requirements.

### **5.2.5 Special Investigations**

Where reasonable grounds exist that an employee has maliciously ignored a known policy, standard, or procedure, or has been involved in a criminal act, the lead investigator will inform the Incident Owner, unless evidence suggests that the matter should be investigated “in confidence”. Such a requirement may include an incident where the Incident Owner has a conflict of interest, is alleged to be a participant/involved, etc. Together with the selected support branches such as Law, Human Resources, the Incident Owner will consult and determine an appropriate course of action utilizing the SaskPower Code of Conduct Policy or related Provincial or Federal Statute/Regulations as governance.

#### *Enterprise Security*

If an incident alleges a breach of the SaskPower Code of Conduct Policy or a Criminal Act, an investigation into the circumstances of the incident and the employee’s involvement in the incident shall be investigated by Enterprise Security. Collaboration with other business units including Law, Human Resources and Audit will occur as agreed upon by the respective business units, or in accordance with previously approved Policy or processes.

### 5.2.6 Gather Evidence

During an investigation, the investigator and/or investigation team shall gather evidence to assist in determining root causes involved in the incident such as the following:

- Diagrams;
- Maps;
- Detailed and structured interviews of the involved persons and / or witness interview accounts;
- Photographs (preference for digital);
- Measurements;
- Videos;
- Plot / site plans;
- Hazard and risk assessments
- Samples of soil, water, or air or equipment and tools (as required);
- Electronic information (reports, monitoring data, emails, access logs, etc.)

Record details immediately as the incident site may be subject to rapid change or destruction. Include details such as:

- Witness Statement Forms are filled out ;
- Law enforcement or regulatory involvement (if applicable);
- Position of injured (e.g. worker, public);
- Position of equipment (e.g. hoists, vehicles, controls);
- Position of materials (e.g. chemicals, loads, spill);
- Preventative devices in use (i.e. guards, valves, locks);
- Ergonomic conditions (e.g. lighting levels, position of machinery controls);
- Environmental impacts (e.g. weather conditions, near a water body, at risk species);
- Housekeeping (e.g. debris);
- Physical evidence of drug or alcohol paraphernalia.

As part of an investigation, an investigator may seize any SaskPower owned asset as evidence.

All seized evidence should be documented within an Evidence and Chain of Custody Form. The form shall be retained with the seized exhibit, unless the exhibit is sent outside SaskPower for purposes of further analysis, regulator investigation or other circumstances where the exhibit is not likely to return to the custody of SaskPower.

Evidence which is retained by the investigator shall be affixed with a label or tag which describes the following information:

- Date, time and location of seizure
- Brief description of exhibit
- File number and Exhibit number
- Person who seized asset with initials

Seized evidence must be kept stored in an appropriate secure container. An exception would be the period of a time which an exhibit is being forensically acquired and analyzed at which time; the exhibit shall be stored within a secure room.

The SaskPower division responsible for the asset is to be notified when an asset is seized, and the functional location shall be changed accordingly (if required). Other divisions may also be notified in circumstances where temporary or loaner equipment must be deployed to minimize the impact to a division.

The disposition of all seized evidence should be documented within Evidence and Chain of Custody Form.

Document an initial sequence of events. The initial sequence of events should be compiled immediately so as to minimize confusion of the facts, and to allow for a detailed and accurate timeline. This will assist in the development of root causes of the incident.

### **5.2.7 Evaluate Data and Conduct Interviews**

Based on the initial evidence, such as Witness Statement form, a selection of interviewees will be required to verify information and clarify facts, and provide additional details for the investigation. It is best practice to conduct these interviews separately for each interviewee and not as a group.

Investigators are required to remind interviewees at the start of the interview the focus of the investigation process is to prevent future incidents and not assign blame. Investigators should ask each interviewee for their ideas on how to prevent future similar incidents. This is typically done at the end of the interview and can often provide ideas for effective recommendations.

All interviews should be documented in writing by the investigator(s) and record interviewer name, interviewee name, position and date of the interview.

If during an interview an investigator suspects there may have an intentional breach of company policies, standards or process the lead investigator will inform that Incident Owner and Human Resources. Unless there is a potential conflict with the Incident Owner then the Lead Investigator should inform only Human Resources. Human Resources will provide support for any additional required discussion with the employee and any disciplinary matters are outside the scope of the incident investigation.

### **5.2.8 Complete Root Cause Analysis**

For trending purposes all incidents require sub-classification when reported. For Health and Safety incidents this means identifying hazards while for Environment incidents this requires assigning a summary cause classification such as 'Procedural' or 'Equipment Failure'. These trending sub-classifications are not intended to replace a root cause(s) that are developed during an investigation.

It is important to find the root causes of the event and not focus on the superficial issues. For example, if a person was injured during a fall on a wet floor. The root cause would not be a wet floor, but rather what caused the floor to be wet in the first place such as a leaking valve.

For Minor and Significant investigations, the '5 Why' methodology will be used to determine root cause(s). The methodology uses an interrogative technique to explore the cause and effect relationships underlying a particular problem.

As an example, the vehicle will not start. (the problem)

1. **Why?** - The battery is dead. (first why)
2. **Why?** - The alternator is not functioning. (second why)
3. **Why?** - The alternator belt has broken. (third why)
4. **Why?** - The alternator belt was well beyond its useful service life and not replaced. (fourth why)

5. **Why?** - The vehicle was not maintained according to the recommended service schedule. (fifth why, a root cause)

Investigators are free to use any root cause methodology for Major and Critical incidents for which they have received training to utilize. For each root cause identified at least one recommendation must be developed which is likely to prevent future incidents. Investigators should keep in mind that it is normal to have several root causes in Major and Critical incident investigations.

In critical investigations a recommendation to address or identify any potential or actual systematic issues that go beyond the incident under investigation should be considered. While this may not apply to every investigation, it is important to consider wider application of recommendations to help drive improved corporate performance. Systematic recommendations may be issued as part of any incident investigation.

### 5.2.9 Develop Recommendations

Once the investigation interviews and root causes are completed, appropriate recommendations can be identified to preventing similar incidents from occurring.

These should address each root cause (if applicable), and can be of two types:

- *Recommendations* are typically more permanent solutions and may require more time to accomplish. Consideration should also be given to develop systematic recommendations to address issues that go beyond the scope of the specific incident; where applicable.

Recommendations should be written with the context that they will be used to develop corrective actions. As such if the investigator is unsure if the business division can execute the recommendation they should use the word 'consider' in front of the recommendation. The recommendation must focus on preventing incidents or conditions to cause incidents. Please note that a procedure by itself is not considered an adequate recommendation. There must be an additional recommendation which includes a physical action such as an inspection, install a guard or other barrier.

In the event a recommendation does not directly tie to the incident, an investigator may include it in the report as an ancillary recommendation. Ancillary recommendations may also be added at the request of the Incident Owner with agreement of the Lead Investigator.

### 5.3 Investigation Reporting

Formal investigation reports are not required for Minor and Significant incidents; instead this function is met by filling out the incident report within the management system software. The management system software reports are due within 14 business days. Major and Critical investigations require a formal written report.

The formal written report for Major and Critical incidents will be completed with the use of the Formal Investigation Report Template for either Safety or Environment. These templates at a minimum should include:

- Summary of the incident (including who, what, where, when)
- Description of root causes of the incident
- Recommendations to prevent a similar incident
- List of interviewees
- Relevant photos and diagrams (as required)

If the Formal Investigation Report is privileged and confidential distribution is to be limited (as per section 5.2.4).

Once the report is drafted for Major and Critical investigations it will be reviewed by both the Lead Investigator's manager and the Incident Owner for feedback and comments. The final report is approved by either the Director of Environment or Director of Safety (as determined by which department assigned the Lead Investigator) and the Incident Owner.

The final report is due within 30 business days unless an extension is granted by the Incident Owner and the Director of Safety and/or Director of Environment.

Incident summary reviews for Safety and Environment incidents shall reside as a standing agenda item on EMS/SMS management review meetings and for all OHC and local safety meetings.

#### **5.4 Corrective Actions**

Corrective or preventative actions are developed in response to a recommendation and must be approved by the Incident Owner. Depending on the complexity of actions a Corrective Action Team may be formed by the Incident Owner to assist in developing corrective or preventative actions.

For Minor or Significant investigations, the Incident Owner may draft and approve the corrective action with input from any affected stakeholders.

For Major and Critical, a meeting will be held to formally review the root causes and recommendations with the Incident Owner, Lead Investigator and the Corrective Action Team (if required). After the review the group should develop Corrective Actions to address the Recommendations in the report.

When corrective actions are developed they must be assigned to a person, by name not position, for completion by an identified date. Staff are encouraged to consider using SMART (Specific, Measureable, Achievable, Realistic and Time bound) wording to ensure the proposed action addresses the recommendation. Effectiveness criteria maybe applied to corrective actions.

In the event that the Incident Owner has insufficient resources to address the correction actions assigned they should prepare a request to their Director or Vice President outlining their requirements.

For those investigations that demonstrate a systematic issue that is beyond the scope of the incident investigation the Lead Investigator should issue a recommendation to further evaluate the issue.

The Incident Owner must respond to each recommendation with a corrective or preventative action. They may modify the wording of the corrective action to account for Operational issues or indicate that the recommendation is already being addressed by an existing corrective action or that another corrective action will address multiple recommendations. For example, if there are business reasons not to follow the exact wording of a recommendation due to removing a piece of equipment from service in the next month, this should be documented in the corrective action.

Corrective or preventative actions will be tracked separately by Safety and Environment departments to ensure completion and these results will be reported to senior management.

Corrective Actions will be tracked to completion in accordance with each department applicable systems which are designed to:

- Identify and notify individuals accountable for corrective or preventative action implementation;
- Assign responsibility to individuals to action specific items;
- Track implementation progress by providing status updates on targeted completion dates; and

- Confirm the incident has been managed until all actions are completed including verification of effectiveness

### **5.5 Communication of the Incident**

Information identified and documented throughout the management of the incident may assist others (internal or external) in preventing similar incidents from recurring. SaskPower employees, contractors and external parties may learn from incidents and prevent recurrence in the future.

Investigations will be communicated by the following tools: Incident Information – Action, Incident Information - Update and/or Incident Information – Final. Refer to the management system procedure on communication for additional information.

For privileged and confidential investigations, the Lead Investigator shall ensure the required review by the Law department occurs of those communications (see section 5.2.4).

#### **5.5.2 First Communication “Incident Information – Action”**

This communication is used all incidents if there is a valuable and/or time sensitive safety or environment message to share. The communication should include what happened, date and time, location, and who was involved. Do not use names, but rather workgroup or titles. The communication should provide clear direction on what action they need to take and include the tracking number for the incident.

#### **5.5.3 Communication “Incident Information – Update”**

This communication is used all incidents after the ‘Incident Information – Action’ communication has been distributed or when new information is available. Refer to previous communication and include any new information to be shared. If no new information is available to share, then inform people when additional information is expected to be available and the tracking number for the incident.

#### **5.5.4 Communication “Incident Information – Final”**

This communication is used all incidents after the investigation has closed and the corrective actions have been identified. State that the investigation is closed and include all relevant and shareable findings and associated corrective actions. Include the tracking number for the incident.

## **6.0 TRAINING REQUIREMENTS AND MATERIAL**

Those staff responsible for the using the Incident Investigation Process shall be trained in the requirements outlined in this process.

There is no single training course for investigators to take to cover all the skills required for an investigation. Instead training opportunities should focus on developing the following skills:

- Writing
- Interviewing techniques
- Project Management

- Team leadership
- Management System Software.

Investigators for Critical and Major Investigations must be trained in the root cause methodology that they are utilizing.

## 7.0 RESOURCES

For more information regarding the Incident Investigation Process, you should contact your local Safety or Environmental Specialist.

5 Whys ([https://en.wikipedia.org/wiki/5\\_Whys](https://en.wikipedia.org/wiki/5_Whys))

Tripod Beta ([https://en.wikipedia.org/wiki/Tripod\\_Beta](https://en.wikipedia.org/wiki/Tripod_Beta), <http://publishing.energyinst.org/tripod> )

## 8.0 REFERENCES

### 8.1 Internal References:

- SaskPower Incident Investigation Policy
- SaskPower Code of Conduct Policy
- SaskPower Drug and Alcohol Policy

#### Tools

- SaskPower Safety Incident Reference Chart
- SaskPower Environment Incident Reference Chart
- SaskPower Witness Statement Form
- SaskPower Conflict of Interest Form
- SaskPower Secure the Scene Checklist
- SaskPower Corrective Action Table Template
- SaskPower Environment Formal Investigation Report Template
- SaskPower Safety Formal Investigation Report Template
- SaskPower Evidence and Chain of Custody Form

### 8.2 External References:

- Environmental Management and Protection Act, 2010
- Saskatchewan Occupational Health and Safety Regulations, 1996.
  - Part II, Section 8 – Accidents Causing Serious Bodily Injury
  - Part II, Section 9 – Dangerous Occurrences
  - Part III, Section 22 (h) – Occupational Health and Safety Program
  - Part III, Section 29 – Investigation of Certain Accidents
  - Part III, Section 30 – Prohibition re: Scene of Accident
  - Part III, Section 31 – Investigation of Dangerous Occurrences
  - Part III, Section 32 – Injuries Requiring Medical Treatment
  - Part III, Section 44 – Special Meetings
  - Part V – First Aid

## 9.0 APPENDICES



None