Incident Reporting, Notification, and Review Procedure

1. Purpose and Scope

1.1. The purpose of this procedure is to require incident reporting and notification and to aid the University of Notre Dame in preventing or mitigating future incidents through the use of an incident investigation process. Incident investigations require identifying incident causes and developing corrective actions that address those causes.

1.2. This procedure applies to all workplace injuries/illnesses, environmental releases, and near misses that occur with faculty, staff, students, and visitors at the University of Notre Dame.

2. Responsibilities

2.1. Faculty, staff, and student employees shall comply with this procedure, report all incidents in a timely manner including property damage or near miss events regardless of the extent of incident, and participate in the incident investigation process as appropriate.

2.2. Deans, Provost, Department Heads, Center/Institute Directors, or Designees shall:
   2.2.1. Enable enforcement of these requirements and take prompt, effective corrective action when necessary.
   2.2.2. Identify resources needed to address risk mitigation efforts that exceed the ability of the responsible personnel.
   2.2.3. Make appropriate notifications of incidents occurring in their college, center, department, unit, etc.

2.3. Department Managers, Supervisors and others in supervisory roles shall:
   2.3.1. Ensure all personnel reporting to them receive communication that this procedure shall be adhered to within their area(s) of responsibility.
   2.3.2. Implement immediate corrective actions such as retraining if it is discovered that this procedure is not being followed.
2.3.3. Participate in all incident investigations that occur within their area of responsibility or that occur to personnel reporting to them.

2.3.4. Make appropriate notifications within their organization of incidents occurring in their area of responsibility.

2.3.5. Ensure the Safety Incident Reporting form is completed for all workplace injury accidents occurring to personnel working for them.

2.3.6. Assign training as required by this procedure.

2.4. ND Police / Fire shall:

2.4.1. Make appropriate external notifications as required by local, state, or federal mandate.

2.4.2. Make internal notifications to ensure the appropriate level of University leadership is notified.

2.4.3. Inform Risk Management & Safety (RMS) or the RMS on-call staff member during off-hours of all incidents, as required by this procedure.

2.4.4. Take control and/or command of an incident scene depending on type and severity.

2.4.5. Facilitate or participate in incident investigations and root cause analysis (RCA) of incidents pertinent to their area of expertise.

2.4.6. Input incident reports into the On-Base system when complete.

2.5. Risk Management and Safety (RMS) shall:

2.5.1. Make appropriate external notifications as required by local, state, or federal mandate.

2.5.2. Make internal notifications to ensure the appropriate level of University leadership is notified.

2.5.3. Maintain Federal and State record keeping requirements.

2.5.4. Assign incident investigations in accordance with this procedure.

2.5.5. Facilitate or participate in incident investigations and root cause analysis involving incidents pertinent to their area of expertise.

2.5.6. Coordinate the incident investigation program and provide technical expertise as necessary.

2.5.7. Assist in developing Safety Alerts and forwarding them to affected groups.

2.5.8. Track incident report corrective actions to closure.

2.5.9. Report incident information and the status of open corrective actions to University leadership.
2.5.10. Notify the Wellness Center at (631-2371) of any work-related injury resulting in transportation to an emergency room when the Wellness Center may not have knowledge of the incident.

2.6. The University Health Services (St. Liam’s Hall) shall contact RMS as soon as reasonably possible after any incident that may warrant an investigation (e.g. student injured in a lab, student fall from height).

2.7. The Wellness Center shall contact RMS within one hour or as soon as reasonably possible after any University employee reports a work-related Tier 1 or Tier 2 injury, illness or campus accident.

3. Definitions

3.1. Accident – An unplanned work-related event resulting in injury or illness, equipment or property damage, or an environmental release. An accident does not necessarily include equipment failures that are the result of electrical, mechanical or structural failures not caused by human intervention and that are controlled by system shutdown, malfunction or safety devices.

3.2. Critical Infrastructure – Systems and assets, whether physical or virtual, vital to the safety and health of ND faculty, staff, students, visitors, or contractors and the continuity of research, teaching, or business operations. Examples of critical infrastructure include:
   - Electrical (generation, transmission and distribution).
   - Telecommunication (phone, internet, etc.).
   - Water (chilled water, potable water, wastewater/sewage and storm water).
   - Heating (steam, condensate, and natural gas).

3.3. Environmental Release – An unplanned release of chemical, biological, radioactive materials, or petroleum products to the air, water, or ground.
   3.3.1. Water is defined as any natural (above or below ground) or manmade waterways, e.g., lakes and sewer systems.
   3.3.2. The ground is defined as soil, outdoor paved area, or uncontained areas inside buildings such as floors, bench tops, etc. Spills inside buildings include releases that could have resulted in contamination to the air, water
(e.g., sewer), or soil. Secondary containment areas such as a dike or laboratory ventilation hood are not included in this definition.

3.4. Incident – An event that either did or could have (near miss) resulted in injury or illness, equipment or property damage, or an environmental release.

3.5. Near-miss (good catch) – An unplanned work-related event or condition that could have reasonably resulted in injury or illness, equipment or property damage, or an environmental release. A near-miss can be any severity tier.

3.6. Root Cause(s) – Personal or job factors that allow unsafe behaviors to occur or unsafe conditions to exist.

3.7. Reportable Environmental Release – Any release of a hazardous substance to the environment in an amount equal to or greater than a regulatory reportable quantity. A release is defined as any spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, or disposing into the environment.

3.8. Student Employee – Any student who receives compensation from the University of Notre Dame for performing work activities.

3.9. Tier 1 (Critical Incident)
   3.9.1. Any incident resulting in:
   - A fatality on University of Notre Dame property.
   - A fatality to a University of Notre Dame faculty, staff, or student while traveling on University business.
   - A fire, explosion or other failure reasonably expected to cause greater than $25,000 in loss or results in the cancellation of multiple classes, research activities, or a major campus activity.
   - Critical infrastructure failure affecting daily operations. This is not intended to necessarily include end-of-service life failures (e.g. pump, water main, etc.).
   - National media attention.
   3.9.2. Police or security events resulting in:
   - Shots being fired (does not include training or animal euthanasia).
   - Life threatening incident.
• University property damage or theft reasonably expected to cause greater than $25,000 in loss.
• Large disturbance or riot with significant impact to University operations.

3.10. Tier 2 (Significant Incident)

3.10.1. Any incident resulting in:
• A life threatening or serious work-related injury, illness, or accident resulting in hospitalization, amputation, or loss of an eye or a near-miss that could have resulted in these outcomes.
• A faculty, staff, or student exposure to a biological Class 3 or unprotected contact (e.g., needle stick with a Class 2 biological hazard).
• A fire, explosion or other failure reasonably expected to cause between $5,000 and $25,000 in loss or any extended interruption of teaching, research, or other activities.
• A fire resulting in the discharge of a fire suppression system or the use of a fire extinguisher to control or extinguish the fire.
• A reportable environmental release to the air, water, or soil.
• On-scene local media attention.
• Regulatory agency contact.
• Threats to public health that could impact the larger community (e.g. communicable disease or foodborne illness outbreak).

3.10.2. Police or security events:
• Property damage or theft resulting in $5,000 to $25,000 in loss or any extended interruption of teaching, research or other activities.

3.11. Tier 3 (Minor Incident)

3.11.1. Any incident resulting in:
• Faculty, staff, or student injury or illness requiring medical treatment or evaluation at a medical facility.
• Faculty, staff, or student injury or illness not requiring evaluation at a medical facility or one that was self-treated.
• Fire or other failure reasonably expected to cause less than $5,000 in loss.
• Police or security events not listed as Tier 1 or Tier 2.

4. Incident Reporting

4.1. Injury / Illness (Refer to Appendix E for flow chart)
4.1.1. In the event of a work-related injury or illness requiring treatment, personnel are required to immediately seek medical evaluation.

- For injuries or illnesses requiring emergency medical care, call 911 (from a campus phone) or 574-631-5555 (from a mobile phone) to receive emergency medical response from the Notre Dame Fire Department (NDFD).
- If emergency transport to the emergency room or Wellness Center is necessary or requested, NDFD shall evaluate to determine the appropriate mode of transportation and ensure transport is provided.
- If emergency transportation to an emergency room is required for a member of the general public injured at the University of Notre Dame, NDFD shall evaluate to determine the appropriate mode of transportation and ensure transport is provided.
- For minor injuries or illnesses incurred during work hours or University-sponsored events, faculty, staff, or student employees shall contact their supervisor, if able, and report to the Wellness Center. If after hours, use the Wellness Center’s on-call option by calling 574-634-9355 and selecting the on-call option. As a final alternative, seek treatment at the St. Joe Regional Medical Center (SJRMC) Emergency Room. Contact NDFD for assistance.

4.1.2. Faculty, staff, and student employees shall report all incidents to their immediate supervisor or designee (Example: Department/Unit Head, PI, Lab Manager, Supervisor, etc.) immediately upon discovery or knowledge of an incident or after receiving medical attention.

4.1.3. Upon notification of an incident, the supervisor shall ensure that the condition, hazard, or area is isolated or the hazard is eliminated to prevent further incident(s).

4.2. In event of a fire, any environmental spill or release, or security matter, employees shall contact NDPD at 911 (from a campus phone) or 574-631-5555 (from a mobile phone) or activate the building fire alarm as appropriate.

4.3. Campus Safety Notification Requirements

4.3.1. Tier 1 (Critical Events)
- NDFD or NDPD shall immediately notify the VP of Campus Safety & University Operations and RMS.
• The VP of Campus Safety & University Operations shall immediately notify:
  ➢ Executive Vice President,
  ➢ Provost,
  ➢ VP of Communications (for campus notification as deemed appropriate by the VP of Communications), and the
  ➢ Division VP or Office of Research / Dean of the area involved.

4.3.2. **Tier 2 (Significant Incident)**
• NDFD or NDPD shall notify the VP of Campus Safety and RMS as soon as practical.
• The VP of Campus Safety shall notify the following individuals as soon as practical during business hours:
  ➢ Executive Vice President, and the
  ➢ Division (A)VP or Dean of the area involved.

4.3.3. **Tier 3 (Minor Incident)**
• RMS shall notify department heads of recordable injuries.

4.4. Department Notification Requirements:
4.4.1. **Tier 1 (Critical Events):** The manager or supervisor shall immediately inform the VP/Dean, department head, center/institute director, or department/unit manager for incidents within their area of responsibility.
4.4.2. **Tier 2 (Significant Incidents):** The manager or supervisor shall inform the appropriate department head, center/institute director, department/unit manager as soon as reasonably possible.
4.4.3. **Tier 3 (Minor Incident):** The manager or supervisor shall inform the appropriate department head, center/institute director, department/unit manager or designee of the incident within one business day of incident knowledge.
4.4.4. If a Department Safety Coordinator is informed of an incident, he/she will initiate notifications as indicated above.

5. Incident Investigations Requirements

5.1. An investigation shall be conducted for all Tier 1, 2 and 3 incidents. Investigations of near-miss cases may be assigned depending on the incident’s severity.
5.1.1. Incidents shall be investigated following this procedure or as directed by Campus Safety.
5.1.2. Fire investigations shall be directed by NDFD.
5.1.3. Police/security events shall be investigated as directed by NDPD.
Examples include: Campus crimes, motor vehicle crashes, and public or residence accidents.

5.2. Incident investigations shall be initiated as soon as reasonably possible following the event or upon receiving knowledge that an event has occurred.

5.3. Except as noted in 5.1.2 and 5.1.3 incident investigations shall have a documented root cause analysis with corrective actions addressing the causes (Appendix C). The VP of Campus Safety & University Operations has the authority to suspend this requirement.

5.4. Reporting format.
5.4.1. Except as noted in 5.1.2 and 5.1.3, all incident investigations shall be documented in the On-Base system using the Investigation Complete Form.
5.4.2. Due to their complexity, the following incidents shall be documented using the Incident Investigation Report (Appendix D or similar format) and attached to the On-Base form:
   - Tier 1 and 2 incidents.
   - Injuries incurring lost time.
   - Recordable injuries that occur in a lab.
   - Other incidents deemed necessary by RMS.

5.5. Investigation Process (Refer to Appendix E for Tier 1 & 2 process flow chart)
5.5.1. A team approach shall be used when conducting internal incident investigations.
5.5.2. Criminal or fire incident investigations shall be managed by the jurisdiction having authority.
5.5.3. Tier 1 (Critical Incidents) and Tier 2 (Significant Incidents)
   - For fire and police incidents, the scene shall remain secured until it is approved for access by NDFD / NDPD. Only at that time will NDFD / NDPD permit key personnel entry for fact finding. Key personnel shall be identified by Campus Safety.
• The incident investigation shall be led by Campus Safety personnel or by others at the request of Campus Safety.

• All photographs used as evidence for Tier 1 incidents shall be taken by, or at the direction of, NDPD.

• Once evidence is gathered and the scene is safe, the area may be released to the department or area owner (manager, supervisor, etc.). Every effort will be made to return the area back to the owning department/unit as quickly as possible.

• The incident investigation team shall include (at a minimum) the area supervisor or the employee’s immediate supervisor/manager and Campus Safety. At least one team member shall have knowledge of the process involved. The employee(s) involved in the incident shall not be a member of the team.

• The team shall conduct the investigation to determine the incident’s root cause(s) and identify corrective actions to prevent recurrence.

• The team leader shall provide daily progress reports to the VP of Campus Safety & University Operations for Tier 1 (Critical Incidents) and other incidents as identified by the VP of Campus Safety & University Operations.

5.5.4. Tier 3 (Minor Incidents)

• It is required that the Manager or Supervisor responsible for the employee or the Manager or Supervisor responsible for the area where the incident occurred initiate/lead the incident investigation.

• The team leader shall identify team members. At least one team member shall have knowledge of the process involved. The employee(s) involved in the incident shall not be a team member.

• The team shall conduct the investigation to determine the incident’s root cause(s) and identify corrective actions to prevent recurrence.

5.5.5. Fact Finding

• The incident investigation shall be conducted as a fact-finding exercise and not as a fault-finding mission.

• The incident scene shall be visited as quickly as possible to collect and document evidence.
• The incident area shall be carefully controlled. In some cases, it may be necessary to isolate and/or barricade the area pending the investigation. Contact NDPD as necessary for scene control.

• In some cases, pictures, diagrams, and other means should be taken to record evidence.

• Interviews shall be conducted with personnel involved in the incident, including witnesses, as soon as possible. These interviews should be conducted with each person individually and be documented. If a person involved in the incident is not immediately available, he/she should be interviewed as soon as practical or be asked to write their statements and provide to the lead investigator.

• Evidence for Tier 1 incidents shall be secured by NDPD or the authority having jurisdiction. Evidence for Tier 2 and 3 incidents shall be retained at the discretion of the team leader.

5.5.6. Corrective Actions

• Specific corrective actions shall be developed to address the incident’s root causes so that similar events can be prevented.

• Each corrective action shall include the name of a person responsible for completing the item and a target date.

• Where feasible, corrective actions shall be developed using the following hierarchy of controls:
  ➢ Elimination of process or activity,
  ➢ Substitution of less hazardous materials, processes, operations or equipment,
  ➢ Engineering controls (i.e. redesign, machine guards, ventilation systems),
  ➢ Warnings and Administrative controls (i.e. signage, changes to work procedures, training, job planning, rotating and scheduling), and
  ➢ Personal protective equipment (e.g., hearing protection, gloves).

5.5.7. Written Report

• All workplace injuries shall be documented using the RMS Safety Incident Report (See Appendix A). This shall be completed by the Manager or Supervisor responsible for the employee within 48 hours of the injury or knowledge of the injury.
• Investigations shall be completed within five (5) business days of the investigation being assigned.
• Tier 1 (Critical Incidents) and Tier 2 (Significant Incidents) investigations shall be documented using the Incident Report Form (Appendix D). Campus Safety leadership may elect to use a different investigation process for certain events.
• All incident investigations shall be entered in the On-Base system using the Investigation Complete Form (Appendix B). Appendix C (Root Cause Analysis Forms) defines root cause categories and provides formats for documenting the investigation’s root cause analysis.
• For investigations requiring additional time, the departmental Safety Coordinator or the manager/supervisor responsible for completing the report shall notify the Department Head / Manager and RMS. A reason for the delay and expected completion date shall be provided.

5.6. Communication – In order to create an atmosphere of information sharing and learning, a safety alert shall be created for all Tier 1 (Critical Incidents). The safety alert shall be disseminated to affected departments by RMS and posted on the RMS web site.

5.7. Contractors, Minors, Volunteers, Visitors, and Visiting Researchers
  5.7.1. Contractors – Contractors shall be instructed to report all incidents to their ND project manager or contact. The ND project manager shall perform notifications as outlined in this procedure and consult with University of Notre Dame legal counsel on Tier 1 events prior to taking action. If counsel supports, the ND project manager or contact shall ensure all Tier 1 events are investigated by the contractor company and the incident report is provided to RMS.
  5.7.2. Minors, Volunteers, Visitors, and Visiting Researchers – The ND individual responsible for the minor, volunteer, visiting researcher, or visitor shall ensure that medical treatment is sought if needed. Reporting and investigations shall follow as directed in this procedure.

6. Training
  6.1. Supervisors shall be trained initially and every two years thereafter on how to conduct and document incident investigations. Supervisor training is available through complyND (RMS-Conducting Incident Investigations).
6.2. Employees shall receive annual training on the provisions of this procedure. Training shall minimally include seeking medical treatment and reporting requirements. Training is available on complyND (RMS-Incident Reporting and Access to Medical Records).

7. Audit and Program Review

7.1. RMS shall perform a documented annual program evaluation.

7.2. The annual evaluation shall include a review of the following:
   ● This procedure to determine if it is complete and current.
   ● Appropriate incident reports and injury logs to determine if reports were completed for all required cases.
   ● Incident Investigation Reports to ensure their accuracy, including: (a) root-cause identification, (b) identification and completion of corrective actions.
   ● Training records to determine if all required training was appropriately conducted and attended.

7.3. All actions that are necessary to improve the process shall be documented and acted upon.

8. Records required by this procedure shall be retained per the University's records retention schedule. This includes:

8.1. Incident Investigations (including evidence)

8.2. Audit and program review documentation.
## Revision History

<table>
<thead>
<tr>
<th>History</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Procedure published</td>
<td>January 2017</td>
</tr>
<tr>
<td>Procedure revised</td>
<td>April 2020</td>
</tr>
<tr>
<td>• Modified injury tiers (3.9 – 3.11)</td>
<td></td>
</tr>
<tr>
<td>• Formalized RMS responsibility for notifying departments of recordable injuries (4.3.3)</td>
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<tr>
<td>• Specified that near-miss incidents may require investigation (5.1)</td>
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<tr>
<td>• Clarified incident investigation documentation (5.4)</td>
<td></td>
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<tr>
<td>• Updated incident investigation team composition (5.5.3, 5.5.4)</td>
<td></td>
</tr>
<tr>
<td>• Updated links to current On-Base forms</td>
<td></td>
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<tr>
<td>Procedure revised</td>
<td>August 2020</td>
</tr>
<tr>
<td>• Added discharge or a fire suppression system or extinguisher to Tier 2 incidents (3.10.1).</td>
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# Appendix A
## Safety Incident Reporting Form

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<tr>
<th>Field</th>
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<tbody>
<tr>
<td>Supervisor Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Reportee Name</td>
<td>Last Name</td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Date of Incident</td>
<td></td>
</tr>
<tr>
<td>Time of Incident</td>
<td></td>
</tr>
<tr>
<td>Location of Incident</td>
<td></td>
</tr>
<tr>
<td>Description of Incident</td>
<td></td>
</tr>
<tr>
<td>Description of Injuries</td>
<td></td>
</tr>
<tr>
<td>Description of Actions</td>
<td></td>
</tr>
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</table>

**Link to Form:** [Safety Incident Reporting Form](#)
# Appendix B

## Investigation Complete Form for Safety, Environment, Good Catch

**Investigation Complete Form**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation ID</td>
<td>Enter the unique ID for the incident.</td>
</tr>
<tr>
<td>Investigation Title</td>
<td>Provide a description of the event.</td>
</tr>
<tr>
<td>Investigation Date</td>
<td>Enter the date of the incident.</td>
</tr>
<tr>
<td>Investigation Location</td>
<td>Specify the location of the incident.</td>
</tr>
<tr>
<td>Investigation Photos</td>
<td>Attach any relevant photos.</td>
</tr>
<tr>
<td>Investigation Videos</td>
<td>Include any relevant videos.</td>
</tr>
<tr>
<td>Investigation Notes</td>
<td>Include any additional notes or comments.</td>
</tr>
<tr>
<td>Investigation Findings</td>
<td>Summarize the findings of the investigation.</td>
</tr>
<tr>
<td>Investigation Conclusions</td>
<td>Make recommendations for future actions.</td>
</tr>
<tr>
<td>Investigation Summary</td>
<td>Provide a summary of the investigation.</td>
</tr>
<tr>
<td>Investigation Analysis</td>
<td>Conduct a thorough analysis of the incident.</td>
</tr>
<tr>
<td>Investigation Follow-Up</td>
<td>Plan the follow-up actions.</td>
</tr>
<tr>
<td>Investigation Template</td>
<td>Select the appropriate template for the investigation.</td>
</tr>
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**Management System Root Cause Category**

- **Risk Management and Safety**
  - Communications
  - Training and Education
  - Consequences
  - Initiatives
  - Management of Change
  - Controls

**Links to Useful Templates**

- Safety Templates
- Why Tree Templates
- Management System Root Cause Documentation

**Link to Form:** [Investigation Complete Form for Safety, Environment, Good Catch](#)

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Approval Date: January 2017  
Revision Date: August 2020  
Incident Reporting, Notification, & Review Procedure SAFE016  
Owner: Director, RMS  
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Appendix C
Root Cause Analysis Forms

Management System Root Cause Worksheet

The management system deficiencies below should be used to help identify and categorize the causes from a “Why Tree”. Compare the root causes to the “Explanation” column, if the statement is true, identify that “Category” in the Management System Root Causes section of the Incident Investigation of the On-Base form.

Multiple Root Causes and Categories are Acceptable and Likely

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<th>Category</th>
<th>Explanation</th>
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<tr>
<td>Responsibility and Accountability</td>
<td>Responsibility was not properly assigned or personnel were not held accountable to their responsibilities.</td>
</tr>
<tr>
<td>Planning and Risk Assessment</td>
<td>Planning or a risk assessment was not conducted or inadequate. The assessment did not include applicable life cycle phases or process verification.</td>
</tr>
<tr>
<td>Resources</td>
<td>The resources (personnel, equipment, time, etc.) were not adequate.</td>
</tr>
<tr>
<td>Design Review and Management of Change</td>
<td>The current design was not analyzed for risk therefore it used incorrect specifications &amp; was built so that it was inadequate for the intended service. A change occurred without proper review or analysis to implement effective controls.</td>
</tr>
<tr>
<td>Controls</td>
<td>The risk reduction controls (including elimination, engineering controls, warnings, administrative, or PPE) were not proper for the task either due to not being properly identified or specified.</td>
</tr>
<tr>
<td>Equipment &amp; Materials Procurement</td>
<td>The equipment, parts, or materials procured created a hazard or were not as analyzed for risk, were defective, or did not meet the specifications.</td>
</tr>
<tr>
<td>Contractors</td>
<td>The contractor safety program was not established or was inadequate to identify, evaluate, and control health and safety risks from contractor activities or to the contractors from the organization’s activities.</td>
</tr>
<tr>
<td>Emergency Preparedness</td>
<td>A process was not developed or was inadequate to identify, prevent, prepare for, and/or respond to emergencies.</td>
</tr>
<tr>
<td>Training</td>
<td>Training was not available, timely (initially or refresher) or not adequate or verified to be effective to achieve requirements.</td>
</tr>
<tr>
<td>Communication</td>
<td>Communication was ineffective due to no communication; late communication, no shift change process or process not used.</td>
</tr>
<tr>
<td>Incident, Assessments &amp; Preventative Maintenance</td>
<td>Inspections &amp; PM were not in accordance with procedures, manufacturer’s or experience-based recommendations or governing standards &amp; were not adequate for the conditions. Exposure assessments or occupational health assessments were not conducted as required or did not identify the risks.</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Documents and Records</td>
<td>The required documents (procedures) were not developed or maintained.</td>
</tr>
<tr>
<td>Incident Investigations</td>
<td>The incident investigation process is not in place or did not investigate or analyze previous similar events.</td>
</tr>
<tr>
<td>Corrective and Preventative Actions</td>
<td>The corrective and preventative action process was not implemented or did not address non-conformances, hazards, or new hazards to an acceptable risk level. The process did not ensure effectiveness of corrective and preventative actions.</td>
</tr>
<tr>
<td>Human Actions</td>
<td>Personnel actions, activities, and decisions were not in accordance with procedures, training, or standards. Examples: Taking shortcuts, Deliberate violation of procedure, Horseplay.</td>
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</table>
Why Tree Form
5 Why Form

Define the Problem

1. Why is That?

2. Why is That?

3. Why is That?

4. Why is That?

5. Why is That?
Appendix D
Incident Report Form

Incident Investigation Report
University of Notre Dame

Location:
Department:
Manager or Supervisor:
Date/Time of Incident:
Date Incident Discovered:
Type of Incident:
Date Investigation Began:
People Interviewed:
Team Members:
Description of Event:

Time Line of Events:

<table>
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<tr>
<th>Date</th>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
</table>

Findings / Information:

Root Causes:

Corrective and Preventive Actions:

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<th>Action</th>
<th>Responsible Person</th>
<th>Target Date</th>
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Approvals:

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<th>Name</th>
<th>Signature</th>
<th>Date</th>
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Appendix E
Tier 1 & Tier 2 Incident Investigation Process Flow Chart

1. Tier 1 and Tier 2 Incident Investigation
2. Campus Safety identifies investigation team leader
3. Conduct investigation, gather evidence and interview personnel. RMS leaves existence. Team leader identifies interviewer.
5. Identify corrective action, responsible person and targeted date.
6. Develop written report.
8. Team Leader routes final report for approvals using the On-Ramp system.
9. Team Leader develops Safety Alert and sends to appropriate groups at UND.
10. RMS tracks action items to closure. Reminders emails sent through On-Ramp system.