Safety Documentation

SAFETY INCIDENT INVESTIGATION PROCESS

1 PURPOSE

The Safety Incident Investigation Process (SIIP):

- Provides process for investigation of safety incidents to support consistency
- Outlines investigation requirements based on verified actual or potential severity of incidents (Minor, Significant, Major, or Critical as per the **SaskPower Incident Reference Chart for Employee, Contractor & Public Safety Incidents (IRC)**)
- Supports organizational learning to prevent incidents from occurring or recurring
- Provides context for collaborative investigation of incidents which affect multiple business divisions
- Focuses on facts and continuous improvement, not fault finding
- Ensures investigations identify Primary Root Cause(s) and Contributing Cause(s)
- Provides guidance on obtaining legal direction in anticipation of litigation or regulatory action

2 DEFINITIONS

The following definitions apply to this document:

Contributing Cause(s) - Cause that influences or allows the effect / incident by increasing likelihood of Condition(s) /Action(s) / Inaction(s) / Event(s) occurring or being present. Includes causes that have the potential to affect severity of the consequences. Eliminating a Contributing Cause will not directly prevent an event and/or incident from occurring.

Corrective Action - Actions to eliminate the cause of a detected nonconformity or any other undesirable situation.

Dangerous Occurrence - Is as defined in Part 2-3 of ***The Occupational Health and Safety Regulations,2020.***

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

Good Catch – An unsafe condition or action that was corrected or stopped prior to an injury or damage occurring.

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.

Near Miss Incident - An occurrence that could have, but did not, result in unintended harm or damage.

Privileged and Confidential - A document 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.

Primary Root Cause(s) - Condition(s) / Action(s) / Inaction(s) / Event(s) that produces an immediate effect resulting in an incident or potential for an incident; eliminating Primary Root Cause(s) will eliminate the effect and/or incident.

Verification of Effectiveness - A process to determine whether and to what degree a change or action has achieved the intended results.

3 APPLICATION

The SIIP applies to safety incidents and Good Catches that occur involving:

- SaskPower personnel, assets, properties, and/or
- Contractors or individuals working on SaskPower's behalf, and or
- Members of the public involving SaskPower personnel, assets, properties

4 ROLES

4.1 INCIDENT OWNER:

- Own the incident that occurred in the assigned area of responsibility
- Act as the primary contact for the investigation and development of corrective actions
- Responsible to track costs associated to an incident
- Assign staff to the Corrective Action Team (if required)
- Review draft 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 preventive actions upon completion of the investigation
- Maintain confidentiality of records including the investigation report, if required
- Present results of the investigation to the Executive and others if required

4.2 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
- Conduct interviews
- Work with the Incident Owner to set the investigation team and coordinate the investigation team, when appropriate
- Coordinate OHC involvement in the investigation if required
- Act as the primary contact for the investigation
- Identify Root Cause(s) 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, other applicable stakeholders and Corrective Action Team, if applicable.
- Notify Employee Relations (ER) of any incident involving SaskPower employees where human factors may be a cause. For incidents with a Lead Investigator assigned by Safety follow the ***Investigation Process Flowchart When Investigated by Safety***. For Incidents where a lead Investigator is not assigned by Safety the Incident Owner assumes the responsibility to contact ER.

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.

4.3 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/preventive actions

Directors shall:

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

4.4 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

4.5 OCCUPATIONAL HEALTH COMMITTEES (OHC) SHALL:

- Be involved in relevant incidents, as required
- Participate in investigations, when requested by SaskPower or as required by ***The Occupational Health and Safety Regulations, 2020***
- Be notified of and have access to incident reports as required by ***The Occupational Health and Safety Regulations, 2020***

4.6 EMPLOYEES SHALL:

- Report all incidents and Good Catches to their immediate Supervisor as soon as possible (This meets the Safety Absolutes and Safety Constants)
- Complete incident witness form when requested
- Cooperate during the incident investigation process, including participating in interviews as requested

4.7 CORRECTIVE ACTION TEAM:

- Is formed for Major and Critical actual or potential severity incidents or Good Catches at the direction of the Incident Owner with support from Safety to develop appropriate corrective and/or preventive actions in response to the recommendations outlined in the investigation report
- Shall develop the verification of effectiveness criteria for each corrective action (if needed)
- Should include Safety Business Partner, Human Resources Business Partner, and Subject Matter Experts. May include Specialist, Monitoring and Compliance and Environmental Specialist supporting the group

4.8 CONTRACTORS SHALL:

- Report all incidents to the designated SaskPower contact and to regulators, as required
- Investigate their incidents and provide a copy of the investigation report to SaskPower
- Ensure corrective or preventive actions have been implemented and provide updates on corrective actions when requested
- Ensure corrective or preventive actions have been appropriately prioritized and completed as scheduled

4.9 SAFETY DEPARTMENT SHALL:

- Own the Incident Investigation Process
- Provide administrative and technical support for the application of the Incident Investigation Process
- 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
- Share information from incident investigations
- Participate in the monitoring of the identified corrective or preventive actions and verification of effectiveness
- Maintain confidentiality of records including the Final Investigation Report, if required
- Consult Law to obtain legal advice in contemplation of litigation and/or regulatory action
- Ensure that serious injuries, fatalities, and dangerous occurrences are reported to the Ministry of Labour Relations and Workplace Safety

4.10 LAW SHALL:

- Declare incidents Privileged and Confidential in Contemplation of Litigation when deemed necessary
- Provide legal advice in contemplation of litigation and/or regulatory action
- Provide legal advice to ensure compliance with laws and regulations
- Review information requested by regulators prior to providing
- Review communications prior to release for privileged and confidential investigations

4.11 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

4.12 EMPLOYEE RELATIONS SHALL:

- Support the investigation when human factors are identified
- Conduct a separate investigation when human behaviour issues are identified in a safety investigation

5 METHOD

5.1 INVESTIGATION REQUIREMENTS

Investigations are dependent on actual or potential severity of the incident or Good Catch. Incidents and Good Catches with a high potential for serious injury or fatality (SIFP) shall have their severity determined according to the potential, not just the actual outcome of the occurrence.

- **Minor** – Requires an investigation by the Manager (or designate) of the employee involved in the incident. The Manager (or designate) acts as both Lead Investigator and Incident Owner. The investigation must identify the hazard that contributed to the incident. It is beneficial to identify at least one Root Cause and Action Plan but is not mandatory.

- **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 investigation must identify the hazard that contributed to the incident. It is mandatory to identify at least one Root Cause and Action Plan as part of the investigation.

Minor and Significant investigations shall use the ‘5 Why’ methodology to determine the Primary Root Cause(s) and Contributing 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. Safety will 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 Safety. A summary of the events leading to the incident, investigation information, Primary Root Cause(s) and Contributing Cause(s) and recommendations must be part of the investigation.

- **Critical** – The Incident Owner is assigned and must be at a Director or higher level. A Lead Investigator is assigned from Safety. A summary of the events leading to the incident, investigation information, Primary Root Cause(s) and Contributing Cause(s) and recommendations must be part of the investigation.

Contractors are responsible to complete investigations of their incidents and submit to their Contract Administrator for review and approval. SaskPower may simultaneously investigate contractor incidents.

5.2 INCIDENT MANAGEMENT

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

1. Initial Response
2. Report the Incident
3. Investigation of the incident

5.2.1 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 evoked).
4. Prevent further loss by determining and implementing an interim measure to mitigate the risk of recurrence if required. Ensure injured people receive medical attention if required.

5. Do not disturb the incident scene more than is necessary to make the scene safe, treat injuries, stop and contain spills or to secure the facility or area. The Secure the Scene checklist may be used as a tool.
6. Verbally notify the responsible Manager of the incident.

5.2.2 INCIDENT REPORTING

*NOTE: Incidents must be entered into the **Safety Management System Software** as per the timelines in the **IRC**.*

5.2.2.1 SASKPOWER EMPLOYEES

Employees involved in an incident or Good Catch must inform their immediate supervisor as soon as possible and before the end of their scheduled shift. This fulfills the Safety Absolute and Safety Constant of reporting all incidents and Good Catches. The immediate supervisor at whatever level of the organization is required to notify and escalate incidents reported to them.

Notification/Escalation requirements will be determined by the actual or potential severity of the incident or Good Catch.

5.2.2.2 CONTRACTORS

Contractors performing work for SaskPower shall report all safety incidents to the Contract Administrator as soon as they are able. The Contract Administrator will determine the required level of notification/escalation based on the actual or potential severity of the incident.

Notification/Escalation requirements will be determined by the actual or potential severity of the incident or Good Catch.

Contract Administrators are responsible to ensure contractor incidents under their direction are documented using the assigned ***Safety Management SsytemSoftware***

5.2.2.3 INCIDENTS AND GOOD CATCHES INVOLVING MEMBERS OF THE PUBLIC

Incidents and Good Catches involving members of the public including contractors not working for SaskPower will be reported by the SaskPower employee who discovered the incident to their immediate supervisor.

Notification/Escalation requirements will be determined by the actual or potential severity of the incident or Good Catch.

Printed copies may not be current, refer to SafetyNet for the controlled version. Printed on: 2023-08-22.

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5.2.3 INVESTIGATION - ASSIGN ROLES

If the incident or Good Catch 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.

Typically, Incident Owner is the individual with the most to gain from the recommendations and is empowered to approve and execute the corrective or preventive 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 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.

If OHC participation is required in the investigation as per ***The Occupational Health and Safety Regulations, 2020***, The Lead Investigator will ensure applicable OHC members are made aware and participate as needed.

5.2.3.1 INVESTIGATION - CONFLICT OF INTEREST

For Major and Critical investigations where there is a potential conflict of interest, 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 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 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 who 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: 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.

5.2.4 INVESTIGATION - GATHER EVIDENCE

During an investigation, the investigator shall gather evidence to assist in determining Primary Root Cause(s) and Contributing Cause(s) 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 Aspect 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:

- Completed Incident Statement Forms
- Law enforcement or regulatory involvement (if applicable)
- Position of injured (e.g., worker, public)
- Position of equipment (e.g., hoists, vehicles, levers, controls)
- Position of materials (e.g., chemicals, loads, spill)

- Preventive 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 shall be documented using an ***Evidence and Chain of Custody Form*** *(available on SafetyNet)*. 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 Lead 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 the ***Evidence and Chain of Custody Form***.

5.2.5 INVESTIGATION - 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 the Primary Root Cause(s) and Contributing Cause(s) of the incident.

5.2.6 INVESTIGATION – ORGANIZE/EVALUATE EVIDENCE

Following the gathering of preliminary evidence; review, evaluate and organize the information to provide initial insight into the incident. The information can be categorized using the following categories:

- People: names of people involved or who may be able to provide more evidence, witnesses, subject matter experts
- Position: locations of equipment, controls, pictures, maps etc.
- Parts: Defective/failed materials, components, PPE, signs, labels, structures, desks, walkways, etc. Other physical evidence
- Paper: Manuals/instructions, Policies/standards, SOPs, Regulations, Job Plans, HARA, Previous incident reports

This information will be:

- Further assessed during the cause analysis to determine if it is a Primary Root Cause or Contributing Cause.
- Analyzed to determine what other evidence may be required

In most investigations, further evidence gathering, organizing and evaluation will be required prior to Root Cause analysis.

5.2.7 INVESTIGATION - INTERVIEWS

Interviews may be required to verify information, clarify facts or 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.

Audio recording may be used for capturing interview information following the notification and approval of the person being interviewed. Audio records must be kept in a secure location with controlled access.

5.2.8 INVESTIGATION - COMPLETE ROOT CAUSE ANALYSIS

For trending purposes all incidents require sub-classification when reported. This means identifying hazards. These trending sub-classifications are not intended to replace Root Cause(s) that are developed during an investigation.

It is important to find the Primary Root Cause(s) and the Contributing Cause(s) (see definitions) of the event and not focus on the superficial issues.

For Minor and Significant investigations, the ‘5 Why’ methodology will be used to determine Primary Root Cause(s) and Contributing Cause(s) . The methodology uses an interrogative technique to explore the cause-and-effect relationships underlying a particular problem.

For 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 Primary 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 Primary Root Cause(s) and Contributing Cause(s) in Major and Critical incident investigations.

In Critical incident 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 INVESTIGATION - DEVELOP RECOMMENDATIONS

Recommendations must address each identified Root Cause.

Recommendations should be written with the context that they will be used to develop corrective and preventive Action Plans. 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.

5.2.10 INVESTIGATION - REPORTING

Investigation reports for Minor and Significant incidents are completed by managing the incident within the ***Safety Management System Software*.** These investigations are due within 21 business days.

Major and Critical investigations require a formal documented report. The draft investigation report is due within 45 business days unless an extension is granted by the Incident Owner and the Manager, Safety Compliance & Investigations.

The formal written report for Major and Critical incidents will be completed with the use of the ***Safety Investigation Critical and Major Report Template*** or the ***Safety Investigation Executive Summary Report Template***. The template contains:

- Summary of the incident (including who, what, where, when)
- Investigation details
- Cause Analysis
- Identification of Primary Root Cause(s) and Contributing Cause(s)
- Recommendations to prevent a similar incident
- Appendices as required
- With the approval of the Incident Owner and Safety some incidents or Good Catches with an actual or potential severity of Major may use the information in the ***Safety Management System Software*** as the investigation report

Major and Critical investigation draft reports will be reviewed by both the Lead Investigator's Manager and the Director of Safety. Following the Safety review the draft

report will be reviewed with the Incident Owner and other identified stakeholders for feedback and comments.

Final approval of the investigation report including recommendations is required prior to action planning. The final approval of the investigation report is provided by the Incident Owner and identified stakeholders.

The final approved report becomes the property of the incident owner unless directed otherwise by Legal.

5.2.11 INVESTIGATION - CORRECTIVE 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 investigations, a meeting will be held to formally review the Primary Root Cause(s), Contributing Cause(s) and recommendations with the Incident Owner, Lead Investigator and the Corrective Action Team (if required). After the review, the Corrective Action Team will 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, Measurable, Achievable, Realistic and Time bound) wording to ensure the proposed action addresses the recommendation.

The Corrective Action Team may outline what the completion of the corrective action will look like and how that will be measured by developing a verification of effectiveness criteria. This will be used to evaluate if the corrective action was effective or if more work is required. The verification need not be assigned to the same person assigned the corrective action. Some examples of verification of effectiveness are *performing three work observations on the work task a month after the corrective action is completed; or checking that staff are using the new form 90% or more of the time in a sample set of those forms two months after implementation.*

In the event that the Incident Owner has insufficient resources to address the corrective 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 preventive action. They may modify the wording of the corrective action to account for Operational issues or indicate that the recommendation is already addressed by an existing corrective action or that another corrective action will address multiple recommendations.

Corrective Actions will be tracked to completion in the ***Safety Management System Software*** which is designed to:

- Identify and notify individuals accountable for corrective or preventive 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.

5.2.12 INVESTIGATION - COMMUNICATION OF RESULTS

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.

Investigation information and lessons learned will be communicated using a variety of tools dependent on the incident and determined by Safety, the Incident Owner and identified stakeholders. The tools may include Safety Alert Bulletin, Safety Incident Bulletin

5.2.12.1 SAFETY ALERT BULLETIN

This bulletin is used when there is a requirement to communicate information in regard to an incident that requires.

- stoppage of a work practice,
- stop use of a particular piece of equipment,
- provide clarity in regard to serious incidents.

5.2.12.2 SAFETY INCIDENT BULLETIN

This bulletin is used to share information;

- identified during an investigation that is relevant and timely
- at the conclusion of an incident investigation to share relevant information and lessons learned

The Incident Owner or workgroup involved in the incident may wish to share information from Minor or Significant incident investigations using their own process. These communications will be supported and approved by Safety prior to releasing.

For privileged and confidential investigations, the Lead Investigator shall ensure the required review by the Law department occurs for all communications prior to publishing or distributing..

5.2.13 INVESTIGATION - PRIVILEGED AND CONFIDENTIAL

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

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.

5.2.13.1 NOTIFICATION

- Copy Law on notifications of Major and Critical incidents to the Director of Environment & Sustainability 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.

5.2.13.2 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 will include “privileged and confidential” in the subject line.

- 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.

5.2.13.3 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.

5.2.13.4 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), 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 actions 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 at the discretion of the Incident Owner.

5.2.14 INVESTIGATIONS - SPECIAL

External investigation resources may be used for investigations when deemed necessary.

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.

5.2.15 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.

6 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 that cover all the skills required for an investigation. Training opportunities should focus on developing the following skills:

- Writing
- Interviewing techniques
- Root Cause analysis
- Project Management
- Team Leadership
- Management System Software

7 RESOURCES

For more information regarding the Incident Investigation Process, contact the Manager, Safety Compliance & Investigations

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

Logic Tree (https://en.wikipedia.org/wiki/Issue_tree)

7.1 INTERNAL RESOURCES

Related Policies:	SaskPower Code of Conduct Policy
Related Standards:	SaskPower Incident Investigation Standard
References and Additional Information:	SaskPower Safety Incident Reference Chart SaskPower Incident Statement Form SaskPower Conflict of Interest Form SaskPower Secure the Scene Checklist SaskPower Corrective Action Table Template SaskPower Safety Formal Investigation Report Template SaskPower Evidence and Chain of Custody Form Investigation Process Flowchart When Investigated by Safety

7.2 EXTERNAL RESOURCES

Related Legislation:	*The Occupational Health and Safety Regulations, 2020*

Ownership

Division:	People, Safety, Indigenous and Corporate Relations
Department:	Safety
Review Frequency:	3 years
Approved by:	Health & Safety Council
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Document History

Revised by	Revision Purpose/Comments	Date
A. Reimer/M. Ereth	Continuous Improvement Updates from Investigations	May 10, 2023
A. Reimer	Continuous Improvement	November 24, 2021
R. Perras, T. Wirth	Scheduled Review Cycle Separated from Environment Title changed to Safety Incident Investigation Process	June 17, 2020
Safety Dept	Scheduled Review Cycle Integrated with Environment Title changed to Incident Reporting and Investigation Process	October 16, 2015
Safety Dept	Continuous Improvement	November 18, 2013
Safety Dept	Continuous Improvement	March 14, 2013
Safety Dept	Continuous Improvement	January 18, 2013
Safety Dept	Continuous Improvement	June 21, 2012
Safety Dept	Scheduled Review Cycle	June 29, 2011
Safety Dept	Continuous Improvement	September 25, 2008
Safety Dept	Scheduled Review Cycle Original Title - Incident Management Process	April 11, 2008