Death in the Workplace, What's Different About Catastrophic Workers' Compensation Claims?

When the company's workers' compensation claim coordinator and the risk management consultant walked up to the plant entrance, the first person they saw was a grim-faced man wearing a county sheriff's office jacket just leaving the site of the fatality. His presence was one of the differences in catastrophic on the job injuries compared to other on the job injuries. He was there to investigate any possible criminal activity associated with the cause of the accident. Workplace fatalities are serious enough, but the involvement of law enforcement adds another layer of concern and something to consider as the accident investigation unfolds. The employee was working by himself and there was no nearby witness to the accident. Someone heard it, but no one saw it. Fortunately, there was no indication of criminal activity in this fatality so there was no criminal investigation opened.

Another difference is the emotional impact a workplace fatality has on co-workers, families and management. Workplace friends, team members, witnesses and other staff members are shocked, grieving and stunned by the suddenness of the accident. Grief counseling is usually made available to employees as part of the district's response in the immediate aftermath. The impact can also show up later as people adjust to the absence of a friend and co-worker as work gets back to normal. In areas where the availability of counselors is limited, local priests and ministers may be able to help. Many districts have EAP plans as part of their health insurance program. This is another good source of counseling. It is also possible that symptoms of post-traumatic stress syndrome can emerge in workers who witnessed the accident or were involved in attempts at first aid or rescue.

The district should also expect diminished productivity as workers deal with the trauma and adjust workflow to make up for the missing person. There is usually a significant loss of time and revenue associated with a workplace fatality. People are taken away from their normal jobs to deal with equipment repair, clean-up, the investigation and attending counseling, funerals or memorial services.

A full-scale investigation should be conducted to determine the root cause of the fatality and find ways of preventing another one. This step may be resisted by management in some cases due to the time and expense involved as well as anxiety about the possible findings. Often, we choose the easy path and look for the simple answer. It's easier to accept simple explanations such as the operator left the machine being repaired in gear when he shut off the ignition. But there may be other factors that lead to more complex answers, embarrassment or unpleasant acceptance of ultimate responsibility. The root cause may lie in inadequate training, an inexperienced person shutting off the ignition,

equipment malfunction, lack of attention to where people were in relation to the equipment, too many people around the equipment or taking short cuts to speed the repair work. All these factors could contribute. If you don't account for all of them and take measures to correct the deficiencies the same thing could happen again.

Investigations should be conducted by a team that includes outside consultants like your Fund Risk Control Consultants, possibly an attorney and someone in management who can open doors, arrange interviews and knows where the documentation is. The risk control consultant is objective and knows how to conduct an investigation. The attorney brings knowledge of the law and any exposure to liability. They also know about potential subrogation possibilities and the potential for lawsuits. They are also good advisors for requests from the press or other interested parties like family members or attorneys. The use of an attorney can also create an attorney-client privilege that could help protect the report and other internal documents from discovery in the event of lawsuits.

The investigation should start with the gathering of documents such as training records, maintenance records and manuals, workers' compensation loss history for possible prior similar claims, any disciplinary history and performance evaluations. This should be done by the district staff. While documents and witnesses are being assembled, visit the scene of the accident. Take pictures or short videos. Draw diagrams and make sure equipment involved in the accident is preserved in its current state so it can be examined for any contributing factors.

Another first step is to interview witnesses, supervisors and top management. Interviews should be conducted in private with only the witness and one or two investigators. Other employees, supervisors or managers should not be present. Assure the witness that the purpose of the interview is to find out as much as possible about the accident for the purpose of preventing another accident. There is no search for blame, only for cause. Ask the witness to describe what happened in their own words. Do not interrupt this first telling. Then ask them to tell it again and take notes and ask questions that do not contain a conclusion. For instance, ask "where was the victim when the backhoe started up?" Not "what safety rule was the victim violating when the backhoe started up?"

Supervisors should also be interviewed about what they know about the circumstances of the accident. They can also describe the job being performed and how any equipment involved works. Management is interviewed about safety policy, training and immediate actions to insure safety around the accident site. The general manager must commit to open doors, access to all documentation, acceptance and action on the final report and its recommendations.

For members of the Texas Water Conservation Risk Management Fund, fatalities are usually related to equipment and operations in the field. Fatalities in the last ten years came from mowing operations and construction activities. Near misses that very easily could have been fatalities were a trench collapse and tractor and backhoe rollovers, usually on wet canal banks and accidents in boats.

The report written in response to the fatality should describe the accident and the factors that contributed to it. The report does not speculate or cast blame. If possible, it should arrive at the root cause and contain concrete recommendations. It is an instrument for the member to learn from so future catastrophic events can be prevented. The report should go to the General Manager for review and his or her use within their organization. Risk control consultants will be ready to help the district with any recommendations made in the report.

What is the cost of a workplace fatality? There is a monetary cost for workers' compensation medical and indemnification payments. There may be repair costs and the cost to replace damaged or destroyed equipment or vehicles. In the private sector there may be OSHA fines and the cost of coming into compliance. There can be lawsuits that seek to penetrate the exclusive remedy of Workers' Compensation. There is also the impact of the claim cost on future insurance premiums. By far the most expensive part of the cost is lost productivity and the time cost of people's involvement in the accident, its investigation and recovery. In one fatality investigated several years ago the medical cost for the victim's three days in the hospital before he died was almost $100,000. The OSHA fine was $30,000 but the estimate of time cost, lost productivity, lost sales, loss of damaged product and investigating the accident reached slightly over $2,000,000.

There is no way to calculate the emotional cost to co-workers, witnesses, and management. In the example mentioned in the first paragraph of this article the root cause of the accident was determined to be a conflict in operating procedures between two different product teams. The solution that would have prevented the accident was proposed 15 months before the event. Conflict between the teams and management's failure to resolve it led directly to the death. Documentation of that meeting lead to the finding. Realization of what had happened lead to the beginning of a process to modify the machine that inflicted the fatal injury. It also led to the devastating moment when management realized their ultimate responsibility.

Recommendations

1. Any clean-up of the accident scene involving bodily fluids should be done by a company that specializes in cleaning up blood borne pathogens. Otherwise, do not disturb the accident site or repair equipment until investigators have had a chance to do their work.
2. Implement district public relations protocols. Announce to all staff that there is only one authorized spokesperson for the district. Use press inquiries to push out information about what the district does in the community. You should also state that the district is cooperating in the investigation and observing privacy regulations that prevent you from divulging information about the victim or victims.
3. Begin the investigation process as soon as possible.
4. If you record the interviews, ask the witness' permission. Take notes and ask the witness to make diagrams.
5. Take photographs and short videos of the accident scene and work processes.
6. OSHA may show up. Public entities in Texas are not under OSHA's jurisdiction. Politely refuse any request they make including access to your premises.

7. Present the findings of the accident investigation to your board and workforce.
8. Revise training and operating procedures to prevent future injuries. Remember the loss triangle presented in Fund Safety Seminars? A fatality is at the top of the pyramid but there may be dozens or hundreds of minor injuries or behaviors that could have had the same result.
9. Utilize the Risk Control resources of the Fund to help you investigate and recover from the fatality.