Example 60-Day Incident Report

Southern California Edison
Contractor Safety

60-Day Contractor Incident Report

(Not submitted for MRC)

Contractors: Fill out this form completely and update the report status and date completed fields at the bottom. Then use the buttons at the bottom of this page to save the 60-Day Contractor Incident Report and submit it to the Edison Safety Team.

Do you need help with this form?

- Example 60-Day Report
- 60-Day Report instructions tab

General Information (automatically copied from Initial Report)

***Contractor	Subcontractor (if applicable)	
ABC Company		
***Incident date	***Incident time (military time HH:MM)	60-Day Report Due-Date
1/1/2021	12:34	3/2/2021

Updates to Other Tabs

If any details have changed since the initial report, please go back and update any required details on the initial report tab and confirm any changes made using the drop-downs below:

***Initial Report	***Initial Injury/Illness	***Initial CCCI	***Initial Property Damage
Yes	Yes	N/A	Yes

***Evaluation Team Participants

Name	Company	Title
Manager #1	ABC Company	Operations Manager
Manager #2	ABC Company	Safety Manager
Supervisor #1	ABC Company	Senior Supervisor
Supervising SubStation Electrician #1	ABC Company	SubStation Electrician, Supervisor

***Involved People

Name	Title	Years of Service	Years in Position
SubStation Electrician #1	SubStation Electrician / Upgrade Supervisor	30	20
SubStation Electrician #2	SubStation Electrician	15	12
Apprentice SubStation Electrician #1	Apprentice SubStation Electrician	2	1

Summarization of Incident

***Executive summary**

Briefly describe who (use worker role, not individual's name), what, where, and how the incident happened, paraphrase cause and major corrective actions

Executive summary instructions

On January 1, 2019, a 3-Man crew was assigned the tasks of performing maintenance and circuit breaker analysis (CBA) various pieces of 16kV equipment at Baseball Substation. The crew consisted of an Apprentice Substation Electrician and two Substation Electricians, one of them acting as Upgrade Supervisor.

The crew arrived at Baseball Substation, performed a job tailboard to discuss the day's work, and proceeded to set up the various tasks they would be performing. They completed maintenance on the 1B, 2A & 2B 16kV Capacitor Switchers without incident then broke for lunch. After lunch, the crew conducted another tailboard to discuss and determine roles and responsibilities for the circuit breaker analysis. All of the switching for the circuit breaker analysis's was to be performed by pre-written procedures for circuit breaker switching.

The first circuit breaker the crew would be performing the CBA's on was the Pitchers 16kV. After receiving permission from the Switching Center, the crew performed Step Nos. 93-102 in move IX of the CBA program without incident. Step No. 103 called to open the Pitchers 16kV Transfer Bus Disconnects, which would have de-energized the Transfer Bus. The Apprentice Substation Electrician tapped the Pitchers Circuit Breaker and said "Pitchers position, Pitchers Transfer Bus Disconnects coming open, de-energizing the Transfer Bus, expecting spit". He put the hook of his disconnect pole on the A-Phase Line Disconnect, thinking he was on the A-Phase Transfer Bus Disconnect and heard the Substation Electrician acting as the Upgrade

Supervisor say “check” and proceeded to open the A-Phase Line Disconnect , causing a flash and relay operation.

There are two Apparent Causes and one Contributing Cause of this incident. Apparent Cause No. 1 was the substation design/configuration created an error likely work environment. Apparent Cause No. 2 was failure to complete a thorough switching rack tailboard by not completing power flow. Contributing Cause No. 1 was the loss of focus to a critical task due to multitasking.

The corrective actions include: 1) The development and implementation of an Advanced Distribution Management System (ADMS), 2) Perform engineering due diligence in researching available disconnect systems, 3) Perform engineering due diligence in researching designs to make adjacent disconnects visually distinct from other similarly appearing components, 4) Implement Error Prevention Training, 5) Implement of a proactive re-qualification program, and 6) Revise of Standard Operating Bulletin 0100 (SOB 0100) Section 1 and Substation Training Operators School Sections.

***Problem statement — Requirement

State the governing requirement or standard or expectation. For an example of a problem statement, please reference the sample 60-Day Report on SCE.com.

Problem statement instructions

ABC Company's worker's risk of injury should be minimized during work activities.

***Problem statement — Deviation

State the deviation from the requirement.

Problem statement instructions

On January 1, 2019, a flash occurred at Baseball Substation during routine switching.

***Problem statement — Consequences

State the consequences (actual or potential) of the deviation.

Problem statement instructions

Actual: Approximately 13 minute interruption of service to customers on the Pitchers Circuit out of Baseball Substation. Damage to the Pitchers Line and Transfer Bus Disconnects.

Potential: Life altering or threatening injury to ABC Company workers

***Immediate actions taken

Steps taken without delay to resolve situations or conditions.

Immediate actions taken instructions

IM-1: Switching was completed and all load was restored to customers.

IM-2: Repair Pitchers 16kV Line and Transfer Bus Disconnects

***Interim actions taken

Temporary action taken to prevent or mitigate the effects of the problem, and/or minimize the probability of a repeat problem.

Interim actions taken instructions

IA-1: Conduct a telephone conference with all of ABC Company employees in order to communicate key takeaways and learnings regarding this incident to Transmission, Substation, and Operations Management and require management to disseminate the information to field personnel of the facts of the incident, including key takeaways, by the end of January 2, 2019.

IA-2: Communicate and implement the 90-day recommendations developed by ABC Company Senior Management partnering closely with ABC Safety, ABC Transmission, Substation and Operations which identified immediate actions to proactively prevent the recurrence of flash events.

***Extent of conditions

Where else could the same or similar problem or condition exist? List the actions taken to address each extent of condition scenario.

Extent of conditions instructions

The Extent of Condition was evaluated and it was determined that other employees are susceptible to injury from a possible flash while completing programmed or emergency switching at substations. The team determined that those most susceptible are Substation Operators and Maintenance and Test employees because they perform switching activities within ABC Company substations.

To address the Extent of Condition, key takeaways and learnings were shared after this incident occurred via a Conference Call on January 1, 2019 and later disseminated to field personnel with the expectation that the incident, including key takeaways, by the end of January 2, 2019.

A Learning Team model consisting of ABC Safety, ABC Training and ABC employees was leveraged to identify immediate actions until all four cause evaluations were completed to further understand what led to the events and share associated corrective actions. This information was shared on January 8, 2019 when ABC conducted a Call to Action which leaders were asked to discuss the flash event that occurred and included a proposed short-term (90-day) recommendations and critical reminders.

***Sequence of events

Describe in list or paragraph form. Use times if relevant and state if exact or estimated.

1/1/2019
08:00 - 3-Man Maintenance Crew arrived at Baseball Substation
08:10 - Apprentice Substation Electrician made contact with Switching Center to identify purpose of job and obtain confirmation
08:15 - Maintenance Crew began maintenance on three capacitor bank switchers
10:57 - Maintenance Crew completed maintenance on three capacitor bank switchers
10:58 - Apprentice Substation Electrician made contact with Switching Center and informed completion of maintenance and CBA procedures to be completed after lunch 11:00 - Maintenance Crew goes on lunch break
12:00 - Maintenance Crew returns from lunch break, conducted tailboard and began 16kV Baseball Substation CBA at Move IX - Pitchers 16kV Circuit Breaker

12:30:09 - CBA Trip Event for Pitchers 16kV CB Recorded
12:30:47 - CBA Close Event for Pitchers 16kV CB Recorded
12:32 - Apprentice Substation Electrician opens Pitchers 16kV Line Disconnects
12:32 - Flash Occurs. All three crew members were not hurt and did not receive any medical attention
~15:00 - Maintenance Crew returned to headquarters on their own

***Analysis and causes

Use at least two types of cause evaluation methodology. Document your analysis processes and summarize the identified causes in this section. Attach your documentation when submitting this report to SCE.

Analysis and causes instructions

Three primary analysis methodologies were used to determine the causes of the event: Event and Causal Factor Analysis, Barrier Analysis, and Safety Culture, Organizational and Programmatic Analysis. Information used in these analyses was obtained through a combination of employee interviews, records, and document reviews. This information was used to determine the causes and corrective actions.

Causal Factors:
Apparent Cause No. 1: Substation design/configuration created an error likely work environment.
Apparent Cause No. 2: Failed to complete a thorough switchrack tailboard by not completing power flow.
Contributing Cause No. 1: Loss of focus to a critical task due to multitasking.

Event and Causal Factor Analysis:
An Event and Causal Factor Analysis (E&CFA) was used in order to determine the Undesired Actions and subsequent Apparent Causes and Contributing Cause that led to the incident.

An analysis of the Event and Causal Factor Chart found one Undesired Action which led to the development of the Apparent Cause No. 1, Apparent Cause No. 2, and Contributing Cause No. 1. The Undesired Action is as follows

* Apprentice Substation Electrician opens Pitchers 16kV Line Disconnects

The Undesired Action ultimately led to an interruption of service to customers for approximately 13 minutes on the Pitchers Circuit and damage to the Pitchers 16kV Transfer Bus Disconnects. This event had the potential to be life altering and are explained in detail below.

Basis for Apparent Cause No. 1:
The maintenance crew began the approved Switching Procedure after contacting the Switching Center to identify the purpose of the job and obtain confirmation to proceed with the approved Switching Procedure at 08:10.

After completing the maintenance on the three (3) capacitor bank switchers, the Apprentice Substation Electrician made contact with the Switching Center and informed them of the completion of the maintenance procedures and that CBA procedures were going to be completed after lunch.

After lunch, the maintenance crew assigned their individual roles. Substation Electrician #1 was to man the computer in order to obtain the reads, Substation Electrician #2 was the designated checker, and the Apprentice Substation Electrician was to complete the switching. The crew began on the 16kV Baseball Substation CBA at Move IX – Pitchers 16kV Circuit Breaker. The CBA Trip Event and the Close Event were recorded and Step Nos. 101 – 102 completed.

Step No. 103 of the approved Switching Procedure indicated “Open Pitchers 16kV Transfer Bus Disconnects”, the Apprentice Substation Electrician completed the required Switchrack Technique and performed Position, Device, Operation, Expectation (PDOE) and hooked a disconnect. The Apprentice Substation Electrician waited for the verbal check from Substation Electrician #2. Substation Electrician #2 confirmed the Apprentice Substation Electrician was on a disconnect and confirmed what the Apprentice Substation Electrician had previously called out. Substation Electrician #2 stated during interviews that he only confirmed that the Apprentice Substation Electrician was on a disconnect and did not confirm whether the disconnect was correct or incorrect. The Apprentice Substation Electrician proceeded to open the disconnect and a flash occurred.

The Apprentice Substation Electrician had hooked and opened the Pitchers 16kV Line Disconnects rather than the Pitchers 16kV Transfer Bus as the switching procedure had indicated. The 16kV Pitchers Transfer Bus and Line Disconnects are in close physical proximity to each other, are virtually identical in appearance, and are unlabeled. The method used to identify these disconnects is for the operator to conduct proper switchrack technique which solely relies on the operator who may be prone to human errors. The introduction of a checker may help in the prevention of a human error, but still relied on the checker to conduct the same switchrack technique as the operator.
Based on the information presented above, Apparent Cause No. 1 was determined that the Substation design/configuration created an error likely work environment.

Basis for Apparent Cause No. 2:
Interviews of the maintenance crew were conducted Baseball Substation. The Apprentice Substation Electrician, who was acting as the operator, and the Substation Electrician #2, who was acting as a checker, both admitted that a thorough switchrack tailboard had not been completed by either one of them as neither completed power flow prior to operation of the disconnect (by the Apprentice Substation Electrician) and prior to providing a verbal confirmation (by Substation Electrician #2).

Based on the information presented above, Apparent Cause No. 2 was determined that the Apprentice Substation Electrician and the Substation Electrician had failed to complete a thorough switchrack tailboard by not completing Power Flow.

Basis for Contributing Cause No. 1:
Substation Electrician #2 had removed his glove in order to increase dexterity in order to turn the pages of the switching program to look ahead at next steps. While looking ahead in the switching program, the Apprentice Substation Electrician was verbalizing the switchrack technique in order to perform Step No. 103 of the switching program.

As the Apprentice Substation Electrician neared the end of the switchrack technique, Substation Electrician #2 began to place his glove back on his hand. While doing so, he verified the step against the switching order and responded with verbal confirmation to the Apprentice Substation Electrician.

Substation Electrician #2 wanted to have the glove back on prior to having the Apprentice Substation Electrician performing the switching operation and had not conducted a thorough switchrack technique and admittingly did not complete power flow prior to providing verbal confirmation. Substation Electrician #2 stated during interviews that he only confirmed that the Apprentice Substation Electrician was on a disconnect and did not confirm whether the disconnect was correct or incorrect.

Based on the information presented above, Contributing Cause No. 1 was determined that the Substation Electrician had a loss of focus to a critical task due to multitasking.

Barrier Analysis
The effectiveness of existing barriers was considered. Barriers that failed and the cause of those failures were identified.

The barriers that were determined to be ineffective, weak, or missing were:

1. Procedure Use/Adherence: Switchrack Technique – A thorough switchrack technique had not been completed prior to the verbal confirmation and subsequent operation of the disconnect.

2. Procedure Use/Adherence: Switchrack Technique – ABC Substation Training and the Switching Center Management Team expectations of the Substation Electricians were to complete proper switchrack techniques whenever one leaves their position or becomes distracted for any reason.

3. Substation Design - The 16kV Pitchers Transfer Bus and Line Disconnects are in close physical proximity to each other, are virtually identical in appearance, and are unlabeled.

4. There may be physical barriers (i.e. manual padlocks, RIFD, Smart Interlocking Devices) that can be explored to prevent the unwanted operation of equipment as a result of human error.

All ineffective, missing, and weak barriers are addressed by the corrective actions listed in the Corrective Action Section below.
Other barriers considered and determined to be effective and did not contribute to this event or were not applicable to this event were:

1.Knowledge/Training – The Apprentice Substation Electrican and Substation Electrician had all necessary knowledge and training needed to complete the job at hand.
2.Supervisory Oversight – Safety Observations provided valuable feedback to field personnel on management's expectations on how to successfully complete a job.
3.Personal Protective Equipment (PPE) – Apprentice Substation Electrician and Substation Electrician had all required PPE.
4.Resource Management – The appropriate level of resources were available.
5.Written Switching Procedure – The written switching procedure used during this incident was written correctly.
6.Change Management – There were no upset conditions.
7.Equipment Performance Programs – All substation inspection programs were followed, however none would have had any bearing on the outcome of this incident.
8.Personal Protective Equipment (PPE) – All employees had the required PPE for the task at hand.

Organizational Programmatic Analysis
An Organizational and Programmatic Analysis Tool was used in order to verify organizational and programmatic deficiencies related to this incident.

• Did the individuals demonstrate risk-informed/conservative decision making?
Substation Electrician #2 had removed his glove in order to increase dexterity in order to turn the pages of the Switching Program to look ahead at next steps. As the Apprentice Substation Electrician neared the end of the Switchrack Technique, Substation Electrician #2 began to place his glove back on his hand. Substation Electrician #2 wanted to have the glove back on prior to having the Apprentice Substation Electrician perform the switching operation and had not conducted a thorough switchrack technique by not completing power flow prior to providing verbal confirmation.
• Was engineering/planning/financial or scheduling adequate in preventing actual or possible injuries?
The 16kV Pitchers Transfer Bus and Line Disconnects are in close physical proximity to each other, are virtually identical in appearance, and are unlabeled. The method used to identify these disconnects is for the operator to conduct proper Switchrack Technique which solely relies on the operator who may be prone to human errors. The introduction of a checker may help in the prevention of a human error, but still relied on the checker to conduct the same Switchrack Technique as the operator. Substation Design/Configuration created an error likely work environment.
• Was the depth of training/qualification adequate for the person(s) and the task?
The Apprentice Substation Electrician, who was acting as the operator, and the Substation Electrician #2, who was acting as a checker, both admitted that a thorough Switchrack Tailboard had not been completed by either one of them as neither completed power flow prior to operation of the disconnect (by the Apprentice Substation Electrician) and prior to providing a verbal confirmation (by Substation Electrician #2).

All deficiencies listed above are addressed by the corrective actions listed in the Corrective Action Section below.

*****Operational experience**

Evaluate if there have been other similar incidents in the past 3 years while on a project for SCE and what the corrective actions were. State here if there have beer similar incidents, the corrective actions, completion date, and if they were successful or not.

There has been one ABC crew involved in flash incidents that were similar to this event which resulted in Cause Evaluations completed.

ABC submitted a benchmarking request to inquire about additional Operating Experience outside of ABC. As of the date of this report, no responses have been received.

1. On January 1, 2017, while performing switching operations to restore the Point Guard 12kV circuit to normal alignment following routine maintenance, a ABC Test Technician (TT No. 2) suffered an injury to TT No. 2's eyes and circuit equipment was damaged. The injury and equipment damage was caused by an arc flash which occurred when the Point Guard 12kV Line disconnect, which was under load at the time, was inadvertently opened by the other Test Technician (TT No. 1) performing the switching operation. TT No. 1 had intended to open the Transfer Bus disconnect. TT No. 2 began experiencing discomfort in TT No. 2's eyes later that evening and was subsequently treated and placed on work restrictions the next day.

The team reviewed an Apparent Cause Evaluation completed for this incident and determined the causes were applicable to this incident. However, the associated corrective actions were ineffective in preventing the incident that occurred at Baseball Substation.

Apparent Cause No. 1: TT No. 1 failed to recognize that TT No. 1 had invalidated the previously completed Position, Device, Operation, Expected response (PDOE) steps performed in preparation to operate the Transfer Bus disconnect.

oCorrective Action - Discuss this event including sequence of events, causes and their basis, extent of condition determination, and the corrective actions at a combined conference call for personnel. Include the expectation that this event will be discussed with those personnel that perform routine switching operations at their next scheduled Safety Meeting and that attendance rosters for those Safety Meetings.

Although this action addresses the need to re-PDOE, it was ineffective because it was a one-time communication and it did implement the formal requirement of re-PDOE.

Contributing Cause No. 1: Equipment Design/Configuration.

oCorrective Action - Revise Engineering Construction Standard (ECS) No. 513604 "Ultimate 12kV/16kV Switch Rack Construction Standard" to incorporate design changes for future substations to reduce the likelihood of switching errors when operating disconnects. These changes may include increasing physical separation between adjacent disconnects, changes to make adjacent disconnects visually distinct from other similarly appearing components in the proximity, labelling, or a combination thereof. These actions would apply to disconnects with different functions
e.g. Line Disconnects vs Transfer Bus Disconnects.

This action did not apply to this incident because it only applies to new substation construction and design and not existing substation re-builds such as the substation where this incident occurred.

Contributing Cause No. 2: TT No. 1 and TT No. 2 did not consistently employ good communication practices.

o Corrective Action - Discuss this event including sequence of events, causes and their basis, extent of condition determination, and the corrective actions at a combined conference call for personnel. Include the expectation that this event will be discussed with those personnel that perform routine switching operations at their next scheduled Safety Meeting and that attendance rosters for those Safety Meetings.

Although this action addresses the need to employ good communications practices amongst personnel, it was ineffective because it was a one-time communication and it did not implement a formal requirement for communication on feedback for reviewing switching programs or how to proceed when you encounter an unexpected outcome.

***Lesson learned**

State the reasoning behind each lesson learned and the actions being taken to address the lesson learned

Lessons learned instructions

Although the corrective actions will reduce the likelihood of reoccurrence of the same or similar incident, there is no way to guarantee the complete elimination of a flash. Therefore, the Team looked at ways to reduce the consequences associated with a flash during switching by reducing the duration of a flash with the following actions: 1) Evaluate remote or automated high voltage disconnecting switches and 2) Evaluate the implementation of temporary relay protection settings where switching is performed.

***Corrective Actions

Cause Type and Cause Description: The cause type should come directly from the findings of the two types of analysis done for this investigation.
Corrective Actions: Should mitigate the cause, address the extent of condition(s), and be Specific, Measurable, Achievable, Realistic, Timely, and Sustainable (SMARTS).

Corrective actions instructions

Cause Type	Cause Description	Corrective Action	Owner (Name & Title)	Due Date	Completed?
Apparent Cause	Substation Design/Configuration created an error likely work environment.	CA-1: Development and implementation of the Advanced Distribution Management System (ADMS). The ADMS will be able to simulate switching programs based on power flow validation and real time conditions at the substation. The program will be able to provide real time reporting of switching steps being executed, supports mobile devices, supports simulation of the future state of new or revised equipment and can be updated in real time. The team has reviewed in great detail over seven thousand ABC requirements involving ADMS, and again reviewed each of these requirements with a down selected preferred vendor to ensure the business capabilities of the proposed product meets ABC's needs. This Corrective Action will be considered complete when the following Business Actions are completed and ADMS is implemented.	Al Luminum, Grid Ops Director	12/31/2021	No
Apparent Cause	Substation Design/Configuration created an error likely work environment.	CA-2: Perform engineering due diligence in researching available disconnect systems (i.e. manual pad locks, RFID, Smart Interlocking Devices) in order to prevent the unwanted operation of equipment as a result of human error. This corrective action will be considered complete when the following business actions are completed.	Anna Prentice, Engineering Director	3/1/2021	Yes
Apparent Cause	Substation Design/Configuration created an error likely work environment.	CA-3: Perform engineering due diligence in researching designs to make adjacent disconnects visually distinct from other similarly appearing components in the proximity, labelling, or a combination thereof. These actions would apply to disconnects with different functions e.g. Line Disconnects vs Transfer Bus Disconnects, Inner Bus vs Outer Bus. This corrective action will be considered complete when the following business actions are completed.	Anna Prentice, Engineering Director	3/1/2021	Yes
Apparent Cause	Failed to complete a thorough Switch Rack Tailboard by not completing Power Flow.	CA-4: Implement Error Prevention Training to Substation Maintenance and Test Managers, Supervisors, Substation Electricians and Test Technicians in order to help identify critical tasks and mitigation of distractions. This Corrective Action will be considered complete when the following Business Actions are completed and the identified group of employees begin training.	Bill Ding, Substation Director	2/1/2021	Yes

Apparent Cause	Failed to complete a thorough Switch Rack Tailboard by not completing Power Flow.	CA-5: Implement a proactive re-qualification program for Substation Operators, System Operators, Substation Electricians and Test Technicians. The purpose of the program is to assess and evaluate proper switching techniques are being performed and understanding of all applicable policy and procedures. This Corrective Action will be considered complete when the following Business Actions are completed and a proactive re-qualification program for Substation Operators, System Operators, Substation Electricians and Test Technicians is established.	Bill Ding, Substation Director	2/1/2021	Yes
Contributing Cause	Loss of focus to a critical task due to multitasking.	CA-6: Revise Standard Operating Bulletin Section 1 and Substation Training Operators School Section 5.1 to require changes to switching programs that occur in the field be approved by an Substation Operator Supervisor or designee, and require re-tailboard if switching is interrupted for any reason. This Corrective Action will be considered complete when SOB Section 1 and the Substation Training Operators School Section 5.1 are revised.	Al Luminum, Grid Ops Director	3/1/2021	Yes
Other	Ways to reduce the consequences associated with a flash during switching by reducing the duration of a flash	Evaluate remote or automated high voltage disconnecting switches used in substations.	Anna Prentice, Engineering Director	3/1/2021	Yes
Other	Ways to reduce the consequences associated with a flash during switching by reducing the duration of a flash	Evaluate implementation of temporary relay protection settings for any substation equipment when and where switching is performed to reduce arc flash incident energy.	Anna Prentice, Engineering Director	3/1/2021	Yes

Final Steps (Contractor)

***60-Day report status (select one)**

Complete

***Completed/updated date**

3/1/2021

***Please confirm that you will attach the latest version of the following documents when you submit your 60-day report:**

- Two forms of cause analysis documentation
- Photographs (if they exist)
- Tailboards (if they exist)
- Witness statements (if they exist)

Yes

***If no, why not? (Explanation required if "No")**

Use these buttons to save the report (if not yet ready to submit to SCE) or save and submit the report.

Clicking the "Contractor: Save and Submit 60-Day Report" button will save this spreadsheet and generate a draft email with this spreadsheet attached to it. Please add any additional attachments you may have to the draft email and then send it to submit this incident report to SCE.

Contractor:
Save 60-Day Report

Contractor:
Save and Submit 60-Day Report

Final Steps (Edison Representative)

Review this entire 60-Day Incident Report. Work directly with the Contractor to resolve any issues. After you have addressed any outstanding issues, fill out the fields below, then use the buttons to save and e-mail the 60-Day Report.

The 60-Day Update Report (this spreadsheet) must be uploaded as an attachment in EHSync to the associated incident as soon as possible, but within one (1) business day of receiving from the Contractor. Use File > Save As to make a PDF version of this form for uploading to EHSync.

For Injury Illness, Close Calls, and Hazardous Material Release Incidents, remember to enter this incident into EHSync and upload the required document(s) within one (1) business day of receiving the report from the Contractor.

The Executive Summary from this 60-Day Report (first section under "Summarization of Incident") is entered into the EHSync Executive Summary data field.
If the summary provided by the contractor is too long, shorten it in EHSync to include at least the findings and corrective actions.

***I have approved this 60-Day incident report
Select one

***Edison Representative name

***Date of review

Edison Representative comments (optional: note any exceptions)

Edison Rep:
Save 60-Day Report

Edison Rep:
Save and Submit 60-Day Report

Example Safety Culture Organizational and Programmatic Analysis

		Yes/ No	If No, Explain	Action(s) to Address
Safety Culture				
SC1	Did the individuals on the crew including field supervision demonstrate a questioning attitude?			
SC2	Was clear and accurate task direction given?			
SC3	Was task and cues to perform understood by the performer?			
SC4	Was there adequate participation in work planning?			
SC5	Was the response to undesired actions or conditions adequate?			
SC6	Did the team demonstrate mutual respect for each other?			
SC7	Did the team demonstrate alignment of vision/strategy?			
SC8	Did the team demonstrate a commitment to safety?			
SC9	Did the individuals demonstrate risk-informed/conservative decision making?			
SC10	Was the work environment free from retribution?			
SC11	Was the organization able to recruit, select, retain and develop the right people for the job?			
SC12	Did the team use available industry experience to influence their actions?			
Organizational				
O1	Did leaders exhibit behaviors that demonstrate a healthy safety culture prior			

		Yes/ No	If No, Explain	Action(s) to Address
	to the incident? Some examples are the relationship to the firsthand individuals, articulated vision, a safety versus production attitude			
O2	Was Leadership effective in monitoring, intervening or coaching individuals in topics related to the incident?			
O3	Were the appropriate people assigned to the tasks?			
O4	Were the work practices used accepted by leadership? Note: if the work practice was identified as contributing to the incident, and also accepted by leadership, the evaluator should consider this as a causal factor.			
O5	Were all of the tools and equipment to safely perform the job accessible at the time of the incident?			
O6	Was the organizational structure, span of control or levels in the organization appropriate to complete the task/job safely? (example: the FS has 7 crews and cannot make field visits for all of them)			
O7	Was communication across organizational units adequate to complete the task/job safely?			
Programmatic				
P1	Were industry or company standards adequate in preventing actual or possible injuries?			
P2	Were the program goals, vision or roles and responsibilities aligned and			

		Yes/ No	If No, Explain	Action(s) to Address
	understood to influence a safe work environment? (Example: project puts emphasis on timely completion over all other aspects)			
P3	Was the level of program control/governance/oversight adequate in preventing actual or possible injuries?			
P4	Was engineering/planning/financial or scheduling adequate in preventing actual or possible injuries?			
P5	Was the depth of training/qualification adequate for the person(s) and the task?			
P6	Did penalties or rewards affect or influence the safety behavior? (If a 'yes' answer negatively affected the incident, explain)			
P7	Is there adequate accountability over the program? (Example: Lack of ownership over the Long Beach Network led to equipment failures)			
P8	Are resources/staffing adequate to accomplish the program goals as related to the incident?			
P9	Were requirements or metrics in the program aligned to the job to influence a safe outcome?			
P10	Is there adequate buy-in/commitment from leaders to accomplish the work?			
P11	Was the current program rolled out in a way that would create a successful program?			

Example Barrier Analysis

Consequences	Barrier That May Have Precluded the Event	Assessment (supporting or refuting analysis)
An employee suffered a laceration to the thumb on his left hand.	Knowledge / Training	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Tailboards	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Procedure Use and Adherence	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Work Methods / Work Control	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Equipment / Tools Testing and Inspection / Design	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Situational Awareness / Staying Out of the Bight	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Supervisory Oversight	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Corrective Action Program / Prior Corrective Actions	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Use of Operating Experience	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Change Management	**Effective:** **Weak:** **Ineffective:** **Missing:**

Consequences	Barrier That May Have Precluded the Event	Assessment (supporting or refuting analysis)
	Personal Protective Equipment	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Use of Physical or Visual Barriers	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Accident Prevention Program / Manual	**Effective:** **Weak:** **Ineffective:** **Missing:**
	Human Performance Tools	**Effective:** **Weak:** **Ineffective:** **Missing:**