**INVESTIGATION REPORT**

1. **Background**

Following the missing truck LSD628YA and driver Ikechukwu Emmanual discovered on the 3rd of May 2024 after he was sent on a pick up assignment at WWC and phamatex on 2nd of May 2024, an internal investigation was instituted to support the various investigation efforts and also establish root causes and preventive measures that would forestall a repeat of similar incidence.

Upon the receipt of this information and directive, the HRM in conjunction with Mr Ehis nominated by Mr Patrick the south west regional leader formed the investigative panel introduced to the LTL team on Friday 10th May 2024.

1. **Objectives of the Investigation**
2. To investigate the processes leading to the incidence.

2. To get detailed information and possible evidence regarding the roles various staff played leading to the incidence.

3. To emphasize the importance of maintaining ethical standards and adherence to company policies and procedures.

4. To initiate queries to staff as a form of formal documentation of accounts of staff involved in the shipment process.

5. To request process changes, recommendations and solution steps that will improve operations and avert risk in LTL/SW operation.

1. **Mode of investigation**

The mode of investigation into the processes leading to the missing LSD628YA truck and driver, involved a thorough and impartial process to ensure fairness and accuracy. Here are the steps taken:

1. Gather Evidence: We scrutinize all available pieces of evidence, including truck tracker report, waybill reports, staff file, email correspondences , testimonies of staff, and other relevant information related to the incidence.

2. Interview Witnesses: Visited WIHU and invited implants in customer location as individuals who could provide information about the activities leading to the missing truck and driver.

3. Documentation: The entire investigation process, including interviews, findings, and evidence collected was documented with witnesses.

**Observations, Root cause and Investigation Comments**

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| **S/N** | **Observations** | **Root cause** | **Investigation Comments** |
| 1. | O  Late Knowledge of missing truck. | No follow up on shipment by LTL staff. | No defined collaborative communication flow between Implant, LTL officer, DC.  As truck was only discovered missing next day when it was needed for another customer shipment |
| 2. | No effective Driver management. | Driver supervisor do not check driver daily work load, driver periodic location and reporting. | Driver direct supervisor did not know driver activity on may 2nd 2024 only knew anything according to him on 3rd May 2024 by 10am a time that contradicts those of the LTL officer who only called around 2pm on 3rd May 2024. |
| 3 | Poor staff Ownership spirit and commitment to END to END operational standards. | Lack of operational SOP and trainings. | Responses of all queries issued to (1) LTL head Charity, (2) Driver direct supervisor Wale, (3) LTL officer who gave driver the task Ugo and the two implant where customer picked up the shipment before his disappearance shows this ROOT CAUSE. |
| 4 | POOR change management | No effective communication and poorly defined strategy. | The dissolution of fleet unit and the creation of professional market operation without a well-defined strategy of how FT and LTL will combine seamlessly and communicated to all staff involved gave room to gaps that made driver management complex. |
| 5 | Poor Leadership and capacity in some staff interviewed. | Flawed process in making them managers and officers without testing them to see if they have capacity to handle the role. | Charity who was formerly a T3 coordinator was made LTL manager without training or test to see if she can handle such responsibilities, Ugo also was made LTL officer from support staff to Mr Dien (former south west leader) with no form of training and test or background knowledge on standards, processes etc. |

**4.0Summary of Findings**

**Evidence from this investigation shows that:**

1. The LTL team lacks sufficient experience to effectively manage operations involving LTL shipments. This has led to consistent poor termination of the end-to-end process due to a lack of ownership mentality within the team.

ii. There is a lack of standard processes in the daily operations of the LTL team and Implants, resulting in inadequate monitoring of driver departure and arrival times, as well as a lack of knowledge regarding the next arrival site of shipments.

iii. A significant communication gap exists between the LTL team and Implants, particularly regarding pre-alert notifications, which are not consistently practiced. This lack of communication increases the likelihood of discrepancies.

iv. The investigation revealed a lackluster attitude among drivers due to poor monitoring of their activities and inadequate reconciliation between parties involved due to insufficient manpower in the monitoring team.

v. There are concerns regarding the background and knowledge of pharmaceutical products among drivers, which may have contributed to attempts to divert goods for personal gain.

vi. There is a lack of synchronization between the tracker and the LTL team, allowing drivers to engage in unofficial travels unrelated to their assigned duties.

**5.0 Conclusion**

The culture of allowing experienced staff to leave on resignation without an attempt to keep and recycle talents within the system is not a good idea for a growing company aiming to seal a spot as one of the most reliable logistics company with a global reputation.

The practice of deploying employees across departments or hiring new staff without providing adequate training creates opportunities for lapses and errors.

Certain segments of operations lack defined standard operating procedures (SOPs) and outlined steps to achieve operational excellence.

Negligence, and Poor attention to details by the implants and lack of ownership mentailty by all parties involved.

**6.0 Recommendation.**

To address these issues effectively,

* I recommend implementing comprehensive training programs for the LTL team, Establishing clear SOPs and guidelines for each aspect of operations with valuable inputs from the heads of operations, especially Quality Control, is essential to standardize processes and minimize the risk of errors or misconduct. This will improve communication protocols between teams, enhancing monitoring of driver activities, and ensuring proper synchronization between tracking systems and operational teams.
* Adequate capacity must be ensured at all times in strategic positions such as the monitoring team. There should be a working schedule that accomodates day/night shift to cater for drivers on delivery operations during late hours.
* Additionally, measures should be taken to address any potential security risks associated with driver behavior, by reviwing and re-validating the documentation process involving the biodata, work history, family background, guarantorship for all drivers.