

# Incident/Accident Analysis



Company name: \_\_\_\_\_

Employee: \_\_\_\_\_ Department: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Date and time of incident: \_\_\_\_\_ Date and time reported: \_\_\_\_\_ Incident location: \_\_\_\_\_  
mm/dd/yy hh:mm mm/dd/yy hh:mm

Witnesses: \_\_\_\_\_

Describe incident completely.

## Identify system problems that contributed to the incident/accident:

System factors

System factors

<b>Management</b>  <i>Consider:</i> Policy enforcement Hazard recognition Accountability Supervisor training Corrective action Production priority Proper resources Job safety training Hiring practices Maintenance Adequate staffing Safety observations	<u>M</u> anagement systems	<u>E</u> mployee systems	<b>Employee</b>  <i>Consider:</i> Procedures followed Shortcuts taken Appropriately trained Experience with the task Physically able to do the work PPE used Stressful conditions Safety attitude
<b>Equipment</b>  <i>Consider:</i> Proper tool selection Tool availability Maintenance Visual warnings Guarding	<u>E</u> quipment systems	<u>E</u> nvironment systems	<b>Environment</b>  <i>Consider:</i> Plant layout Chemicals used Temperature Noise Radiation Weather Terrain Vibration Ergonomics Lighting Ventilation Housekeeping Biological

<i>Consider:</i> Elimination/substitution Engineering controls Administrative controls Personal protective equipment (PPE)	Corrective actions/best practices:	Who will implement?	By when?	Date done?
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Person(s) conducting analysis: \_\_\_\_\_ Date: \_\_\_\_\_ **Copy to:** Safety committee, management, owner or president

## Conducting an incident/accident analysis

All workplace accidents, incidents, close calls, and near-misses should be promptly analyzed and corrected, regardless of severity.

This incident/accident analysis form should be completed by the immediate supervisor, with assistance from managers, safety committee members, safety coordinator, or analysis team as needed.

The form explores four organizational systems: management, employee, equipment, and environment (MEEE). Prompts alongside each box are designed to encourage open dialogue and communication about any factors, however minor, that may have contributed to the incident. The intent is to discover system failures so they can be corrected, and future incidents and accidents can be prevented.

There are four steps to this analysis. (You may need additional pages to record your findings.)

### Step 1: Fact gathering

For each of the four systems (MEEE), record any facts that contributed to the incident. (Some items may fall into more than one category.) Ask open-ended questions such as: How did this happen? Tell me what you and others were doing? What tools were you using? What were the conditions around you?

### Step 2: System analysis

For each of the facts you record, try to determine what caused or allowed this condition or practice to occur. Asking “why” will help you get to the core of the problem. Record your findings.

### Step 3: Corrective action

For each cause you’ve identified, develop solutions or corrective actions. (The solution could be the same for more than one fact.) Determine who is responsible for fixing the problem or implementing the solution, and when it should be done. This information can be updated or revised as needed. The following are descriptions of ways to control hazards:

**Elimination/substitution**—Remove or replace the hazard. While this is the most effective at reducing hazards, it also tends to be the most difficult to implement in an existing process.

**Engineering controls**—Isolate people from the hazard. Engineering controls (such as equipment guards or shields) are highly effective because they are designed to remove the hazard at the source, before coming in contact with the worker.

**Administrative controls/PPE**—Change the way people work, including adding personal protective equipment. Administrative controls and PPE are frequently used with existing processes where hazards are not particularly well controlled. They are helpful but have been proven to be less effective than thoughtful design or engineering measures.

### Step 4: Monitoring

Management and the safety committee should follow up to make sure corrective actions were taken and countermeasures were used effectively.

If an injury requires medical treatment beyond first aid, you must complete the workers’ compensation claim form (801). Legal requirements for recording and reporting work-related fatalities, injuries, and illnesses also may apply. Please visit [osha.oregon.gov/Pages/topics/recordkeeping-and-reporting.aspx](https://www.osha-oregon.gov/Pages/topics/recordkeeping-and-reporting.aspx) for additional information.