

- Serious
- Non-Serious
- Near Miss

**FACTORS TO CONSIDER**

**Management**

- Do we have:**  
 Policy Enforcement  
 Hazard Recognition  
 Accountability  
 Supervisor Training  
 Corrective Action  
 Production Priority  
 Proper Resources  
 Job Safety Training  
 Hiring Practices  
 Maintenance  
 Adequate Staffing

**Employee**

- Was the employee:**  
 Following Procedure  
 Training  
 Previous Injury  
 Mental Ability  
 Physical Capacity  
 Equipment Use  
 Short Cuts  
 PPE Worn  
 Safety Attitude

**Equipment**

- Do we have:**  
 Proper Tool Selection  
 Tool Availability  
 Maintenance  
 Visual Warnings  
 Appropriate Guards

**Environment**

- What about:**  
 Worksite Layout  
 Chemical  
 Temperature  
 Noise  
 Radiation  
 Weather  
 Terrain  
 Vibration  
 Ergonomics  
 Lighting  
 Ventilation  
 Housekeeping  
 Biological

**Additional Causal Factors:**

- Faulty Equipment
  - Non-Employee
  - Prior Injury
  - Late Reporting
  - Off-the-Job Injury
- (Explain any checked boxes on separate sheet)*

# Accident/Incident Analysis

Immediate supervisor should complete this form promptly with employee. **DO NOT INCLUDE EMPLOYEE'S NAME ON THIS FORM.**

Department: \_\_\_\_\_

Job Position/Title: \_\_\_\_\_

Where Incident Occurred: \_\_\_\_\_

Date/Time: \_\_\_\_\_

If injury, describe (Nature/Body part)  
 \_\_\_\_\_

Treatment: None First Aid Only Doctor Hospital

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

Describe Accident/Incident:  
 \_\_\_\_\_

Date corrective action taken: \_\_\_\_\_ Corrective action taken by: \_\_\_\_\_

Describe corrective action taken (attach additional pages if needed):

Identify factors which contributed to or caused accident (refer to list on left side of page):

<b>Management</b>	<b>Employee</b>
<b>Equipment</b>	<b>Environment</b>

<b>List at least one idea or best practice which might prevent a reoccurrence:</b>	<b><u>Who</u> should be responsible for doing this?</b>
--	---

Date: \_\_\_\_\_ Supervisor's Signature \_\_\_\_\_

\_\_\_\_\_  
 Supervisor's Printed Name

*(When completed, submit this form to the County Administrator through your Department Head)*

## Completing the Accident/Incident Analysis

All close calls, near-misses, incidents, and accidents should be analyzed for corrective action regardless of severity. Time and distance work against a thorough analysis as most people quickly forget important facts and key details. Distance from the incident means loss of visual information, so complete the analysis at the scene as soon as possible. This form should be completed by the immediate supervisor of the person(s) directly involved in the incident. A manager, safety committee, safety coordinator or analysis team can assist in the absence of the immediate supervisor. The form asks no questions other than a brief description of an injury, if one occurred. Questions often provide closed answers, so the key items on the analysis document are designed to encourage open dialogue and communication about facts and details. This is the primary opportunity for those involved to gather key information for preventing similar incidents in the future.

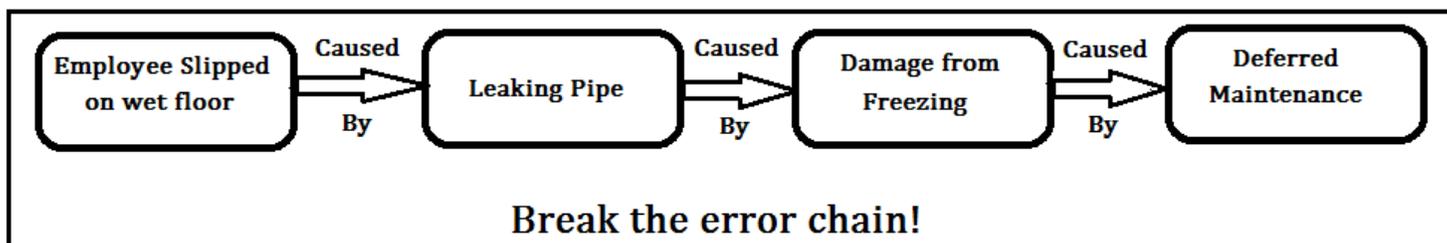
**A Successful Analysis Process:** The person(s) conducting the analysis need to look at the systems/procedures/policies within the department which may have contributed in some way to the incident. Even minor contributions should be listed. The systems to review are: Management, Employee, Equipment, and Environment (MEEE). Review system items shown in the left margin of the Accident/Incident Analysis form **in relation to the incident**. These are areas to explore within these systems, they are not questions. Once the contributing system elements are identified, write them in the Counter measures/best practices box along with any other system changes that will prevent recurrence.

**First Step - Care for the injured:** Insure appropriate medical care or first aid is provided for anyone injured.

**Second Step - Secure the scene of the accident:** Make certain that key evidence is preserved so that all pertinent facts of the accident can be determined. In the case of serious accidents, photographs of the scene are a valuable tool in determining causes, particularly if the area needs to be put back in order quickly. Note the position of equipment and materials, presence or lack of equipment safeguarding, specific materials and chemicals involved, warning signs and any other physical evidence.

**Third Step - Interview witnesses:** Witnesses to the accident or persons having knowledge valuable to the analysis should be met with individually. Emphasis should be placed on determining the facts, not on placing blame. If the injured employee(s) is/are not seriously injured, they should be interviewed while awaiting transport for medical treatment. All questions should be open-ended (who, what, when, where, how and why), to encourage a detailed account of the facts. Yes and No questions should be avoided.

**Fourth Step - Analyze data to determine causes and best practices to prevent recurrence:** Refer to your notes from the scene of the accident and witness interviews. Work backwards from the accident to trace all causes to their source. It is helpful to have multiple people involved in determining possible solutions. Each cause identified presents an opportunity for intervention to reduce the potential for future accidents



**Fifth Step - Follow up on corrective actions:** This is usually the function of the safety coordinator or safety committee. At the next safety committee meeting, any accident analysis reports should be reviewed to ensure appropriate corrective actions (Countermeasures/Best Practices) were identified. Furthermore, steps should be taken to ensure that these actions have been implemented at the site of the accident as well as in any other areas appropriate in the organization. Any accidents or incidents occurring, for which a report was not completed, should be referred to the appropriate person responsible for completion of the report.