



This Safety Instruction supports Sections [103: OSU Safety Program](#) and [203: Accident Investigation](#) of the [OSU Safety \(SAF\) Manual](#).

BACKGROUND

OR-OSHA requires OSU to record and report specific work-related injuries and illnesses, fatalities, and various work restrictions. This information, summarized on the OSHA Form 300A, is posted at the Office of Human Resources (OHR) from February 1 to April 30 or available upon request, and serves to raise employee awareness of workplace hazards.

Moreover, several operational units including Risk Management, EH&S, OHR, and the University Health and Safety Committee use this information to assist in:

- Recognizing trends in health and safety issues;
- Identifying opportunities to improve health and safety programs; and
- Reducing the magnitude, duration and costs incurred by the affected employees and the University.

DEFINITIONS

Incident: A situation with the potential to cause serious harm to a person. Generally, the outcome results in first aid treatment.

Accident: A situation that results in medical attention (treatment beyond first aid) and/or lost time (missed work).

Supervisor: A supervisor may be a dean, department head, director, manager, administrator or any other faculty or staff person who is in charge of one or more employees.

RESPONSIBILITIES

Employee: Immediately report all work-related incidents and accidents to your supervisor and participate in the investigation process, as needed.

Supervisor: Report incidents and accidents as directed by the OSU Office of Human Resources [Worker's Compensation Resources](#) website. **In the event of lost time, an [Accident Investigation Report](#) shall be initiated by the employee's immediate supervisor within 48 hours of the accident.** If the immediate supervisor is absent, another manager from the same operational unit may provide assistance. It is incumbent upon the employee's immediate supervisor to ensure that the corrective measures are completed, documented, and communicated to all affected employees, and incorporated into the appropriate policy, procedure, or safety program in order to prevent future occurrences.

ACCIDENT INVESTIGATIONS

An accident investigation systematically identifies event details and causal factors to determine corrective measures.

As only 2% of all workplace incidents are thought to be unpreventable*, **the primary purpose of an investigation is to prevent future occurrences, not to place blame.**

*OR-OSHA 1207-05

Beyond the primary purpose, the information obtained through the investigation should be used to update and revise the investigator's inventory of hazards, and/or the relevant safety program(s) for hazard prevention and control. For example, a [Job Hazard Analysis](#) may be generated or revised and employees (re)trained to the extent that it fully reflects the recommendations made in the investigation report. Further, implications from the root cause(s) of the accident should be analyzed for their potential impact on other operations and procedures.

Contact EHS:

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ACCIDENT / INCIDENT CAUSAL FACTORS

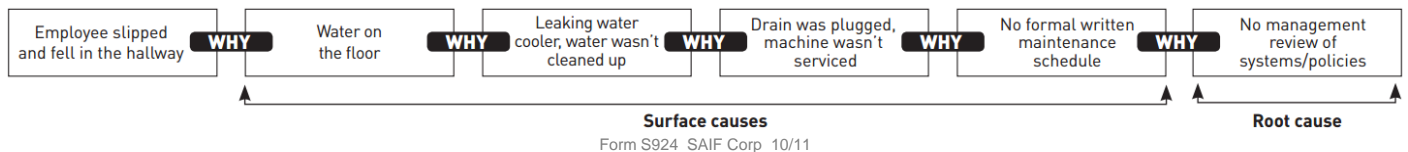
There are two major components that contribute to the cause of an accident / incident; surface cause and the root cause.

The **surface cause** is the condition or act that directly caused the incident. An example of a surface cause is a small spill of oil on the floor that someone slipped on.

The **root cause** is the system failure that allowed the surface cause to occur. For example, a root cause may be a lack of preventive maintenance that resulted in the fork truck leaking oil on the floor. A thorough investigation will reveal the root cause of the incident. Corrective measures that address the root cause have the greatest potential to prevent accident / incident recurrence.

BASIC STEPS FOR CONDUCTING AN INVESTIGATION

- **Secure the scene.**
 - This is the beginning of your analysis. Your primary goal is to secure the scene as soon as possible in order to prevent further injuries, ensure the well-being of the affected employee, and to protect any critical physical clues from being spoiled.
- **Collect the facts.**
 - Focus on finding the facts about the event. Remember to gather valid information without drawing conclusions or assigning blame. Document your observations. Take photos and check video surveillance if available. Interview employees and witnesses. Review relevant records, such as maintenance, training, policies, procedures, etc.
- **Develop the sequence of events.**
 - Review and accurately arrange the gathered information to determine the order of events. Constructing an accurate timeline may be critical to an effective analysis. Document what happened before, during and after the event. Arrange this information to accurately determine the order of events.
- **Determine potential causal factors.**
 - Every accident / incident is caused by a set of contributing factors. These factors represent the surface or root causes that led to the event. The goal is to identify these by analyzing how or why each consecutive event happened. Use the following diagram as an example.



Surface causes: unsafe behaviors and hazardous conditions; **Root cause:** underlying problems with policies and/or procedures.

- **Recommend or implement corrective measures.**
 - Your recommendations should be relevant and concise.
 - Identify, either independently or as part of a collaborative effort, and describe:
 - The recommended corrective measure(s),
 - who will be responsible for implementation, and
 - the anticipated completion date.
 - Follow up to ensure that:
 - The corrective measures are implemented within the appropriate time frame, and
 - incorporated into the appropriate policy, procedure, or safety program in order to prevent future occurrences.
- **Communicate the outcomes of the investigation.**
 - Train your employees on what changes will be / have been implemented.
 - Share your experience with peers so they, too, may enjoy a safer and more productive work environment.

ADDITIONAL RESOURCES

OR-OSHA

- [OSHA 300 Recordkeeping](#)
- [Accident Investigation](#)
- [Online Courses / Current Workshops](#)
- Workbook: [Accident Investigation](#)

SAIF

- [Accident / Incident Analysis website](#)
- [ACTION form: step-by-step approach to accident analysis](#)
- [Incident form: systems-based approach to accident analysis](#)