

# Mascott Equipment Company

## INCIDENT/ACCIDENT ANALYSIS

Location Name / Address \_\_\_\_\_

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

Date and time of incident: \_\_\_\_\_ Date and time reported: \_\_\_\_\_  
mm/dd/yy hh:mm am/pm mm/dd/yy hh:mm am/pm

Witnesses ? And what were Witnesses doing at time of incident / accident ?

Describe incident completely. What was Employee doing at time of incident / accident ?

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

<b>System factors</b>	<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><b>M</b></u> anagement systems	<u><b>E</b></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 Proper Supervision provided Disciplinary action recommended ?	<b>System factors</b>
	<b>Equipment</b>  <i>Consider:</i> Proper tool selection Tool availability Maintenance Visual warnings Guarding	<u><b>E</b></u> quipment systems	<u><b>E</b></u> nvironment systems	<b>Environment</b>  <i>Consider:</i> Plant layout Chemicals used Temperature Noise Radiation Weather Terrain Vibration Ergonomics Lighting Ventilation Housekeeping Biological	

<b>Counter measures/Best practices:</b> How do we correct areas identified in the MEEE areas above, who will make changes, and when will the changes be completed?	Who will implement?	By when?	Date done.
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Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_ **Copy to:** Safety committee, management, owner or president

## Conducting an incident/accident analysis

All accidents, incidents, close calls, and near-misses should be analyzed for corrective action regardless of severity. If practical, the analysis should be completed promptly and at the scene of the incident. Time and distance from the incident work against a thorough analysis because most people quickly forget important facts and key visual details.

The Incident/Accident Analysis form should first be completed by the immediate supervisor of those directly involved in the incident. Managers, safety committee members, the safety coordinator, or an analysis team can assist in the absence of the immediate supervisor. However, at a minimum, the supervisor should review the analysis for more fact finding and corrections.

The purpose of the Incident/Accident Analysis form is to prompt the people doing the analysis to ask open-ended questions about the various components that may have contributed to the incident. The analysis explores the four organizational systems: **Management, Employee, Equipment, and Environment (MEEE)**. The prompts alongside each box are designed to encourage open dialogue and communication about facts and details.

### Analysis process

The people conducting the analysis needs to look at the systems, procedures, and policies within the business that are not working and that may have contributed in some way to the incident. Even minor contributions should be listed. Only record those items found that are not working. The intent of the analysis is to discover **system failures**, so they can be corrected in order to prevent future incidents and accidents.

### The analysis

There are four steps to this analysis: fact gathering, system analysis, countermeasures, and monitoring. You may need more space than provided on the form, so record on another paper if needed.

#### Step 1: Fact gathering

Move through each section and record facts that contributed to the incident. There is no specific order on the form. You may find yourself going back and forth between MEEE elements, and you may even have items that overlap more than one MEEE element because these systems work together at some level. Ask open-ended questions such as: How did this happen? Tell me what you and others were doing? What tools were you using? How were the conditions around you? Record findings in the boxes.

#### Step 2: System analysis

This is a series of “why” questions for each of the facts recorded during Step 1. The key to the system analysis is in asking “why” questions. It will take you to core system and cultural issues within the organization. Keep asking “why” to determine what caused or allowed this condition or practice to occur until you get to the core of the problem. Record your findings in the boxes.

#### Step 3: Countermeasures

Once the system analysis is complete, it is time to develop solutions or countermeasures. Each item that has been identified in the spaces should have a corrective action that will be taken. You may find that some items in one or more of the MEEE boxes are similar or the same, so one solution could be possible for all of those. You should then identify who you think is responsible to fix this item or implement this solution. Also determine the time frame in which you think it should be done. Take your best effort at filling in the spaces, knowing that this information will be reviewed and can be updated or revised as needed.

#### Step 4: Monitoring

Many times great solutions are developed and implemented only to have things revert back to former practices. This is because no one followed-up on these new processes to make sure they were used effectively. All employees are responsible to follow safe work practices, but it is essential for management and the safety committee to ensure that the countermeasures identified in this analysis are actually used.

This is only an Incident/Accident Analysis form. You will need to complete the workers' compensation claim form (801) if the injury required medical treatment beyond first aid. There are also other Oregon record keeping requirements for recording and reporting work-related fatalities, injuries, and illnesses. Please visit <http://www.orosha.org/subjects/recordkeeping.html> for additional information on these requirements.