

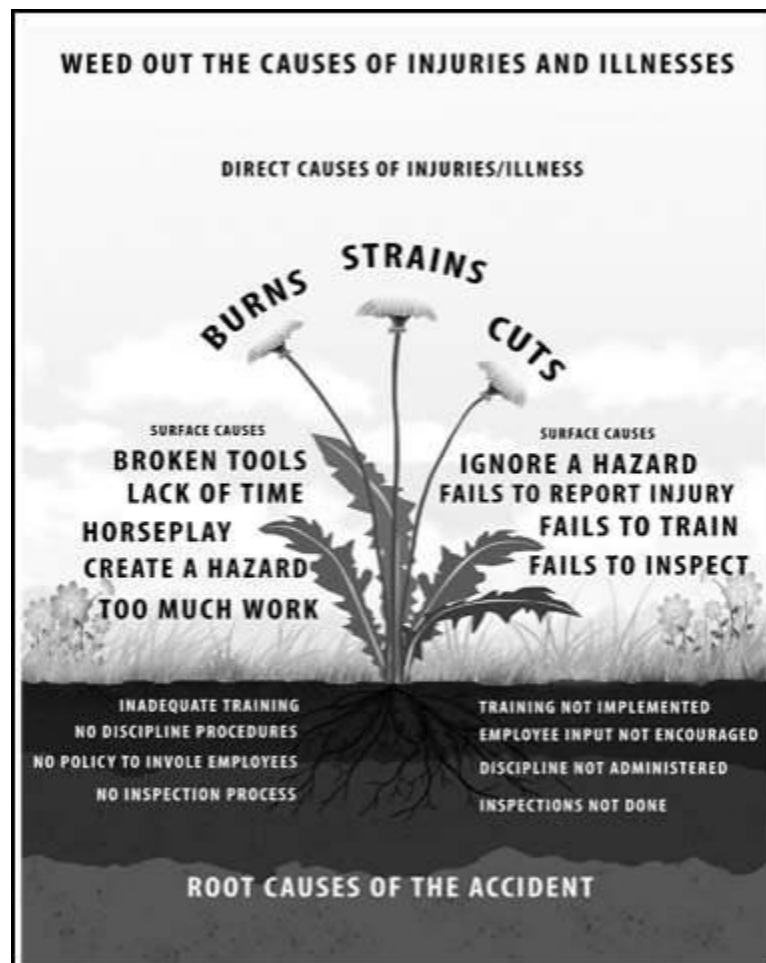
Accident / Incident Investigation Plan – Appendix B: How to Conduct an Accident Investigation

1. **Establish an investigation team:** Include employees who have been trained to conduct an effective investigation. A typical team might include:
 - An employee from the work area where the accident or near-miss occurred;
 - A PCC supervisor, department manager, or dean from a work area not involved in the event;
 - A maintenance supervisor or an employee who understands equipment or processes associated with the accident or near-miss;
 - A PCC safety committee representative.
2. **Gather information:** Record facts about the employee accident or near-miss that occurred. Interview witnesses and others involved in a location such as an office, meeting room, or a place that is quiet, comfortable, and nonthreatening. This should include the following information:
 - Date and time the accident or near-miss was noticed or occurred;
 - Location of the accident or near-miss (Campus or Center, Building, Room/Area);
 - Witness(es) to the event (Name, Location, Phone #, job title, department).

Tips: Use sketches of the area, take photographs and videos to convey the scene and narrative. Use campus and/or building maps to describe locations and other details of the area where the event occurred.
3. **Analyze the facts:** Identify the causes and contributing factors of the employee accident or near-miss. Determine how the accident or near-miss could have been prevented. Describe the accident or near-miss by asking the following:
 - *What* happened?
 - *Who* is involved?
 - *When* did it happen?
 - *Where* did it happen?
 - *Why* did it happen?
 - *How* did it happen?

Tips: Try to avoid yes or no questions and prepare what will be asked ahead of time. Let the individual being interviewed speak freely and ask clarifying questions when needed.

Perform a root cause analysis by determining all factors of the accident or near-miss, including unsafe conditions, actions, or systemic weaknesses in order to reach the fundamental root causes and prevent future recurrences.



4. **Report the findings:** Prepare a written report that describes who was involved, where the event occurred, when it happened, and what caused it. Recommend, specifically, corrective actions that can be implemented to prevent the accident or near-miss from happening again.
5. **Act on the recommendations:** Have department management review the report and determine what will be done to prevent future recurrences. Include suggestions to prevent the accident or near-miss or correct the hazard that is present.
6. **Follow up:** Ensures that appropriate corrective action was taken to prevent future recurrences. Identify who is responsible for each corrective action and the anticipated timeline to implement the change. Establish a time for a follow-up meeting for a status update on the corrective action.