

**2026 NORTHEAST
SAFETY CONFERENCE**

**Workplace Safety
Incident Investigation
Workshop**



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EANE

Learning Objectives

- Why Investigate? The OSHA Mandate
- OSHA Recordkeeping & Reporting Requirements (29 CFR Part 1904)
- Types of Incidents That Require Investigation
- Assembling the Investigation Team
- The Four-Step OSHA Investigation Process
- Root Cause Analysis Methods
- Conducting Witness Interviews
- Documenting Findings & Writing the Report
- Corrective Actions & Follow-Up
- Q&A



Why Investigate? The OSHA Mandate

1

Legal Obligation

The OSH Act General Duty Clause requires employers to provide a workplace free from recognized hazards. Failure to investigate can constitute a violation.

2

Prevent Recurrence

Identifying root causes enables corrective actions that prevent the same or similar incidents from happening again.

3

Protect Workers

Investigations demonstrate organizational commitment to employee safety and well-being.

4

Reduce Liability

Through, documented investigations provide legal defensibility and reduce organizational risk exposure.

OSHA Recordkeeping & Reporting Requirements

29 CFR Part 1904

Reporting to OSHA (All Employers)

- Fatality: report within 8 hours
- In-patient hospitalization: report within 24 hours
- Amputation: report within 24 hours
- Loss of an eye: report within 24 hours

Recording on OSHA 300 Log (Employers with 10+ employees in covered industries)

- Record within 7 calendar days of learning of the incident
- Use OSHA 300, 301, and 300A forms for required recordkeeping
- Electronic submission via OSHA ITA: Jan 2–Mar 2 annually

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What Must Be Investigated?

Fatalities

Any work-related death.

Injuries & Illnesses

Any recordable work-related injury or illness.

Near Misses / Close Calls

Incidents where someone could have been hurt.

Property Damage Incidents

Failures or events that could have caused injury.

Hazardous Conditions

Unsafe conditions or practices that pose risk.

BEST PRACTICE: Investigating near misses is a cost-effective safety investment.

Assembling the Investigation Team

Effective investigations require the right people. OSHA recommends that investigations include both managers and employees, since each brings different knowledge, understanding, and perspectives. The team composition should match the severity and complexity of the incident.

Who Should Be on the Team:

- Immediate supervisor of the area where incident occurred
- Safety officer or EHS manager
- Employee representative / union rep (if applicable)
- Subject matter expert (e.g., engineer, equipment specialist)
- HR representative (for incidents involving personnel issues)
- Senior management (for serious/fatal incidents)

Key Principles for Team Effectiveness:

- Investigators must be trained in investigation principles
- No team member should investigate their own work area without oversight
- Maintain objectivity — focus on systems, not individuals
- Begin investigation immediately — memories fade quickly
- Preserve the scene before any cleanup or repairs
- Document everything from the start



The Four-Step OSHA Investigation Process

OSHA's recommended systems approach to incident investigation follows four sequential steps that help identify root causes and drive meaningful corrective action.

Step 1: Preserve & Document the Scene

Secure the area immediately and document the scene before any cleanup or repairs.

Step 2: Collect Information

Promptly gather witness accounts, records, and other relevant evidence to reconstruct what happened.

Step 3: Determine Root Causes

Use root cause analysis to identify the underlying system factors behind the incident.

Step 4: Implement Corrective Actions

Assign and track corrective actions that address each root cause and prevent recurrence.

Step 1: Preserve & Document the Scene

The first minutes after an incident are critical. Scene preservation protects physical evidence and ensures the investigation starts with accurate, unaltered information. Acting quickly — while maintaining safety — is essential.

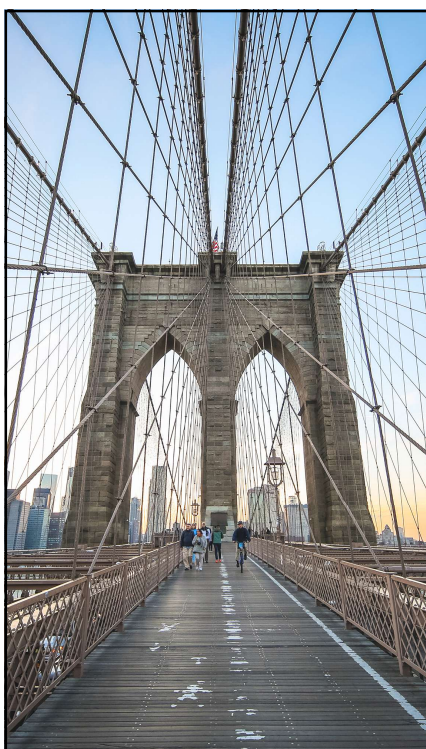
Immediate Actions (First 15–30 Minutes):

- Ensure injured workers receive immediate medical attention
- Secure and restrict access to the incident scene
- Notify management and safety officer immediately
- Do NOT move equipment, materials, or debris until documented
- Identify and separate witnesses before they can confer
- Begin photographing and videoing the scene from multiple angles

Documentation Checklist:

- Photographs: wide-angle, mid-range, and close-up shots
- Video walkthrough of the scene
- Sketches and measurements of the area
- Equipment positions and conditions
- Environmental conditions (lighting, weather, temperature)
- Labels and tags on equipment
- Written description of scene as found
- Witness names and contact information

Legal Note: Premature cleanup or alteration of the scene can compromise the investigation and create legal liability.



Step 2: Collecting Information

Information gathering provides the evidence needed to understand what happened and support the investigation.

Witness Interviews

Interview witnesses separately and privately as soon as possible, including the injured worker if they are able.

Physical Evidence

Collect and preserve damaged equipment, tools, PPE, and materials, and photograph everything before moving it.

Documentary Evidence

Gather training records, maintenance logs, SOPs, prior reports, work schedules, SDS, and permits.

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Step 3: Root Cause Analysis

OSHA defines a root cause as "a fundamental, underlying, system-related reason why an incident occurred that identifies one or more correctable system failures." Addressing root causes — not just symptoms — prevents recurrence.

The Three Levels of Causation:

- **Immediate Cause:** The direct cause of the incident (e.g., "worker slipped on oil spill"). This is what most people stop at — but it's only the beginning.
- **Contributing Causes:** Conditions or factors that allowed the immediate cause to exist (e.g., "no spill containment procedure in place").
- **Root Cause:** The fundamental system failure that allowed contributing causes to exist (e.g., "management had not established a preventive maintenance program for hydraulic equipment").

Common Root Cause Analysis Tools:

- **5 Whys Method:** Ask "why" repeatedly (typically 5 times) until the underlying system failure is identified. Simple, effective for most incidents.
- **Fishbone (Ishikawa) Diagram:** Visually maps causes across categories: People, Equipment, Environment, Methods, Materials, Management.
- **Fault Tree Analysis (FTA):** A top-down, deductive approach using logic diagrams to trace pathways to the incident. Best for complex, multi-factor incidents.

OSHA Insight: Most 'unsafe behaviors' trace back to a weakness in management systems or organizational programs — not individual carelessness.

The 5 Whys in Practice



Incident:

A warehouse worker suffered a back injury while lifting a heavy box.

Why #1:

Why did the worker injure their back? → They lifted a 75-lb box without mechanical assistance.

Why #2:

Why did they lift it without mechanical assistance? → The pallet jack was unavailable.

Why #3:

Why was the pallet jack unavailable? → It was broken and had not been repaired.

The 5 Whys in Practice



Why #4:

Why had it not been repaired? → There was no formal equipment maintenance request process.

Why #5:

Why was there no maintenance request process? → Management had never established a preventive maintenance program for material handling equipment.

ROOT CAUSE:

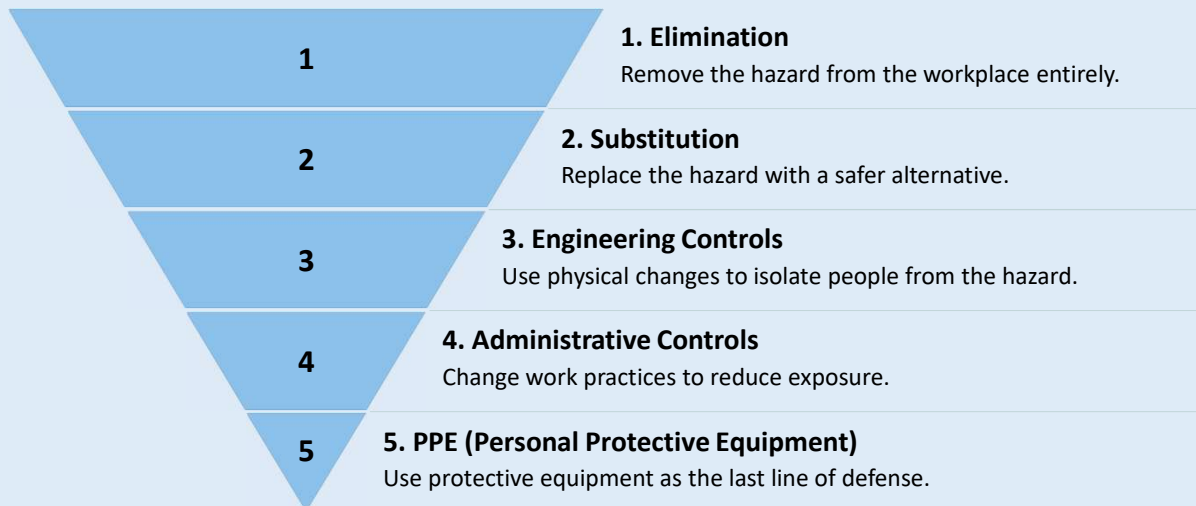
Absence of a preventive maintenance program for material handling equipment.

CORRECTIVE ACTION:

Establish a formal preventive maintenance program; implement a daily equipment inspection checklist; provide ergonomic lifting training as a secondary control.

Step 4: Implementing Corrective Actions

Corrective actions should prioritize the most effective controls by following OSHA's hierarchy of controls.



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Step 4 (Cont.): Implementing Corrective Actions

Corrective actions are the ultimate purpose of every investigation. OSHA's hierarchy of controls provides a framework for selecting the most effective interventions — prioritizing elimination of hazards over reliance on human behavior.

Effective Corrective Action Criteria (SMART):

- **Specific:** Clearly defines what will be done
- **Measurable:** Can be verified as complete
- **Assigned:** Has a named responsible person
- **Realistic:** Achievable with available resources
- **Time-bound:** Has a defined completion deadline

Tracking & Follow-Up:

- Document all corrective actions in writing
- Assign a responsible person and due date for each action
- Conduct follow-up inspections to verify implementation
- Evaluate effectiveness — did the action actually reduce the hazard?
- Share lessons learned with all affected employees and locations
- Update SOPs, training materials, and inspection checklists as needed

Writing the Investigation Report

A well-written investigation report is the permanent record of the fact-finding process. It should be objective, concise, and legally defensible.

Required Report Components:

1. Incident Summary — What happened, when, and where
2. Investigation Team — Who investigated
3. Scene Documentation — Photos, diagrams, and evidence
4. Witness Statements — Key facts from interviews
5. Root Causes — Underlying system failures
6. Corrective Actions — What will be done, by whom, and by when

Report Writing Best Practices:

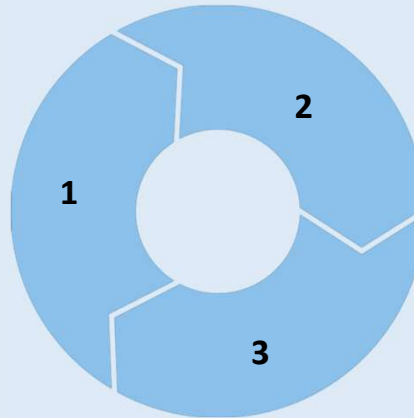
- Use plain, factual language
- Separate facts, observations, and conclusions
- Focus on system failures, not personal blame
- Attach relevant evidence
- Retain reports per your document policy

OSHA Insight: Forms 300, 300A, and 301 are separate from your internal investigation report.

Building a Culture of Safety Investigation

Non-Punitive Reporting Culture

Employees must feel safe reporting near misses and hazards without fear of discipline.



Leadership Commitment

Senior leaders must visibly champion investigations, allocate resources, and act on findings.

Systematic Follow-Through

Every investigation should end with documented corrective actions, owners, and deadlines.

OSHA recommends incident investigation as a core element of an effective safety management system.

Key OSHA Resources & References

OSHA Incident Investigation

[osha.gov/incident-investigation](https://www.osha.gov/incident-investigation) — Overview, guidance, and worker rights information

OSHA Recordkeeping (29 CFR Part 1904)

[osha.gov/recordkeeping](https://www.osha.gov/recordkeeping) — Forms 300, 300A, 301, electronic submission requirements, and exemptions

OSHA Injury Tracking Application (ITA)

[osha.gov/injuryreporting](https://www.osha.gov/injuryreporting) — Electronic submission portal for annual injury/illness data

OSHA Incident Investigation Guide for Employers (December 2015)

Four-step systems approach guide — available at [osha.gov](https://www.osha.gov)

OSHA Root Cause Analysis Fact Sheet (OSHA-3895)

Guidance on conducting root cause analysis — available at [osha.gov](https://www.osha.gov)

OSHA Recommended Practices for Safety and Health Programs

Seven core elements of an effective safety management system — available at [osha.gov](https://www.osha.gov)

Report a Fatality or Severe Injury

[osha.gov/report](https://www.osha.gov/report) — Online reporting portal | 1-800-321-OSHA (6742) — 24-hour hotline

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Questions?

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Thank You!



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