

Incident & Near-Miss Investigation

Professional downloadable safety training

TRAINING OUTCOME

Secure the scene and gather reliable facts quickly

AUDIENCE

Supervisors, EHS, team leads

TIME

35-45 min

REFERENCE

OSHA recommended practice / root-cause guidance

USE NOTE

Best-practice training for investigation quality. Recordkeeping/reporting obligations and company investigation procedures must also be followed.

Start with the hazard. Build the safe decision.

Use this slide to connect the topic to what employees actually see, touch, drive or do.

Purpose: prevent recurrence

An investigation is not a blame exercise.

First actions

Care for injured people and control ongoing hazards.

Gather facts

Interview separately and promptly using open questions.

ASK THE ROOM

01

Where could this go wrong here?

02

What control keeps us safe?

03

What should make us stop?

What employees should be able to do

Keep the session practical: recognize the hazard, choose the control, know when to stop.

01

Secure the scene and gather reliable facts quickly

02

Build a timeline using people, equipment, environment and process evidence

03

Identify underlying/root causes rather than stopping at “employee error”

04

Develop corrective actions that reduce exposure and verify effectiveness

Purpose: prevent recurrence

Start with what the employee is exposed to.

- An investigation is not a blame exercise.
- Near misses and hazard reports deserve the same learning mindset.
- Focus on how the system allowed the event, not only the last action.

FIELD DECISION

01

Where could this fail?

02

What control do we use?

03

What makes us stop?

First actions

Tie every point to a visible action or decision.

- Care for injured people and control ongoing hazards.
- Preserve evidence when safe and appropriate.
- Meet regulatory/internal reporting deadlines.

FIELD DECISION

01

What changes the risk?

02

What must the employee do?

03

Who needs to know?

Gather facts

Tie every point to a visible action or decision.

- Interview separately and promptly using open questions.
- Document equipment condition, scene layout, photos, records, procedures and training.
- Separate facts from assumptions.

FIELD DECISION

01

Where could this fail?

02

What control do we use?

03

What makes us stop?

Build the timeline

Tie every point to a visible action or decision.

- Sequence what happened before, during and after the event.
- Look for changing conditions, decisions, handoffs and failed defenses.
- Compare work-as-done with work-as-imagined.

FIELD DECISION

01

What changes the risk?

02

What must the employee do?

03

Who needs to know?

Root causes and contributors

Tie every point to a visible action or decision.

- Ask why conditions existed: design, maintenance, staffing, planning, supervision, training, procedure, procurement or change management.
- Human error is a starting point for questions, not a final root cause.

FIELD DECISION

01

Where could this fail?

02

What control do we use?

03

What makes us stop?

Corrective actions and follow-up

Tie every point to a visible action or decision.

- Prefer elimination/engineering controls when feasible over reminders alone.
- Assign owner/date and define how effectiveness will be checked.
- Share learning without exposing unnecessary personal information.

FIELD DECISION

01

What changes the risk?

02

What must the employee do?

03

Who needs to know?

These are the moments to slow down and regain control.

01

Investigation concludes “employee was careless” with no deeper analysis

02

Evidence is discarded before documentation

03

Corrective action is only “retrain employee”

04

No owner, due date or effectiveness check is assigned

What would you do next?

Give the group 30-60 seconds before revealing the recommended response.

A worker bypassed a guard to clear a jam. The investigation says “failure to follow procedure.” What questions should come next?

RECOMMENDED RESPONSE

Why was bypassing possible/normal? Was the jam frequent? Was safe access practical? Were production pressures, equipment design, maintenance, supervision or training contributors? Identify systemic causes and stronger controls.

DISCUSS

01

What is the hazard?

02

What control is missing?

03

What is the safest next action?

04

What is our site rule?

This is where generic training becomes your program.

Replace examples with your actual equipment, procedures, hazards and expectations.



Company notification/reporting requirements



Who leads and who participates in investigations



Evidence/photo/interview forms and record retention



Corrective-action approval, tracking and effectiveness review

BEFORE WORK

01

Show the actual procedure

02

Show the actual
equipment/task

03

Confirm questions are
answered

04

Complete required evaluation

Can the employee apply it?

Written knowledge matters. Safe performance in the real workplace matters more.

☐ Secures scene and controls hazards

☐ Separates facts/assumptions

☐ Uses open interview questions

☐ Builds event timeline

☐ Identifies multiple contributing causes

☐ Writes higher-order corrective actions

☐ Assigns owner/due date

☐ Defines effectiveness verification

Use the included evaluation form when hands-on demonstration or workplace verification is appropriate or required.

Knowledge check 1-5

Use the printable test in the course package for employee responses.

1 The primary purpose of incident investigation is to:

2 A good investigation should include:

3 “Employee error” should usually be:

4 Evidence should be:

5 Interviews are stronger when they use:

Knowledge check 6-10

Use the printable test in the course package for employee responses.

6

A timeline helps investigators:

7

Stronger corrective actions usually:

8

Each corrective action should have:

9

Near misses should be:

10

Retraining is always enough as the sole corrective action.

Know the hazard. Use the control. Stop when it is not right.

- 01 Secure the scene and gather reliable facts quickly
- 02 Investigation concludes “employee was careless” with no deeper analysis
- 03 Company notification/reporting requirements

NEXT STEPS

- 01 Answer questions
- 02 Complete site-specific training
- 03 Complete required hands-on evaluation
- 04 Document attendance/completion

Use this package as a strong training foundation.

Always align the material to current requirements, manufacturer instructions and your own procedures.

Primary reference

OSHA recommended practice / root-cause guidance

Training use note

Best-practice training for investigation quality. Recordkeeping/reporting obligations and company investigation procedures must also be followed.

BEFORE YOU DELIVER

- ✓ Confirm current OSHA/state-plan requirements
- ✓ Insert your procedures and equipment information
- ✓ Use qualified/competent trainers where required
- ✓ Complete practical/workplace evaluation where required
- ✓ Keep training and authorization records

<https://www.osha.gov/incident-investigation>