

Paperwork Reduction Act Notice

Persons are not required to respond to this collection of information unless it displays a valid OMB control number. The Occupational Safety and Health Administration (OSHA) requires that State On-Site Consultation program Consultants use the Incident Investigation Reporting Template to report findings and recommendations when incidents (e.g., fatalities, catastrophes, severe injury reports) occur at SHARP or Pre-SHARP sites.

Consultants will use the reporting template to determine the root causes of workplace incidents, the effectiveness of the implemented safety and health program, as well as report findings and recommendations for assuring a safe and healthful workplace.

In accordance with 29 CFR 1908.6(h)(1) and (2), Consultants must preserve the confidentiality of information obtained as a result of a consultative visit, including information that contains or might reveal a trade secret of the employer.

OSHA estimates that it will take an average of 6 hours for a Consultation program to conduct an on-site investigation and report findings and recommendations using the template.

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Office of Small Business Assistance, Occupational Safety and Health Administration, Room N-3660, 200 Constitution Avenue, NW, Washington, DC 20210.

Appendix M

Incident Investigation Reporting Template (SHARP and Pre-SHARP Establishments)

Note: When required in this Instruction to complete Appendix M, only the List of Hazards is required (when applicable) and any other documentation deemed necessary by the CPM.

SECTION 1

Incident Investigation Date: Visit Number: Request Number:
User ID: RID: Region: State:
Date of Incidence: OSHA Inspection Date:
OSHA Inspection # (if applicable):

Select One:

Fatality Catastrophe Imminent Danger Formal Complaint
Referral - Severe Injuries only

SECTION 2

Establishment Name:
Establishment Address:
OIS Site ID #: NAICS: Union Name (if applicable):
Select One Program: SHARP Pre-SHARP SHARP Pilot

Current Program Status: Duration in Program:
 Last Renewal Date of Program: Last Evaluation Date of Program:
 Number of Employees at the establishment:
 Number of Contractors at the establishment:
 Number of Temporary and/or Seasonal Employees at the establishment:

SECTION 3 (Please complete this section with information pertaining to the incident only)

Total Number of Fatalities: Total Number Injured: Total Number Ill:
 Number of Employees: Fatalities Injured Ill
 Number of Contractors: Fatalities Injured Ill
 Number of Temporary and/or Seasonal Employees: Fatalities Injured Ill
 Were Employees Performing the Activities Related to the Incident? Yes No
 Were Contractors Performing the Activities Related to the Incident? Yes No
 Were Temporary or Seasonal Employees Performing the Activities Related to the Incident?
 Yes No

SECTION 4

Description of Incident:
Instructions: Please provide a description of the incident (i.e., what happened, where, when, how).

On-Site Consultation program's Findings (Root Causes):
 [See OSHA's [Incident \(Accident\) Investigations: A Guide for Employers](#), December 2015]
Instructions:
 In this section, the Consultation program will specify its investigation findings (i.e., root causes – Why did the incident happen?) and the safety and health program deficiencies identified. For example, if a hazard assessment was not conducted and resources were not provided to purchase an appropriate guard – this is a hazard identification and control deficiency with a potential management leadership failure (to provide adequate funding). Multiple deficiencies can occur concurrently.

On-Site Consultation program's Recommendations for Corrective Actions:

Instructions:

The Consultation program will recommend specific corrective actions that the employer participating in SHARP or Pre-SHARP must implement to address the deficiencies identified during the investigation. It is important to assure a safe and healthful work environment that is the corner stone of SHARP. For example, train supervisors on how to conduct hazard assessments (to find and fix hazards) and management should assure an adequate budget for implementing safety and health measures. The recommendations may be included in the employer's Action Plan (as appropriate).

The safety and health of all employees at the establishment is paramount. The integrity of SHARP, the Consultation program, and OSHA is vital.

Additional Information (if any): For example, include any additional input from the employer in this section.

Investigation Reporting Guidance

Incident Example: OSHA Incident #[1039807.015](#)

To access this incident, visit OSHA.gov, select Data & Statistics, then select Inspection Information.

Incident Description

An employee was operating a custom bending press break machine. He was bending a small metal part, which kept slipping out of place. The employee tried to hold it in place with his finger while operating the press with his foot to bend the metal. The metal slipped and the press came down on his left index finger instead of the metal part, smashing and amputating it, just proximal to the fingernail bed.

OSHA issued a citation to the employer with an initial penalty amount of \$4,900 which was reduced to \$2,940 for not complying with 29 CFR 1910.212(a)(3)(ii).

[1910.212\(a\)\(3\)\(ii\)](#)

The point of operation of machines whose operation exposes an employee to injury, shall be guarded. The guarding device shall be in conformity with any appropriate standards, therefore, or, in the absence of applicable specific standards, shall be so designed and constructed as to prevent the operator from having any part of his body in the danger zone during the operating cycle.

Consultation program's Findings (Root Causes): (See OSHA's [Incident \(Accident\) Investigations: A Guide for Employers](#), December 2015.)

Below are some questions that the consultant or CPM may ask to identify safety and health program deficiencies assuming this incident ([#1039807.015](#)) occurred at a SHARP establishment:

Why was the point of operation of the press not guarded? Is this how the press has been operated in the workplace? When was the press installed in the workplace? Was it installed prior to the SHARP approval or afterwards? If it was in the workplace at the time of the SHARP approval, was it assessed during the approval process (i.e., hazard assessment)? If yes, what was the assessment finding? Did the employer have a guard for the point of operation at the time of SHARP assessment? If yes, what happened

afterwards? Subsequent to the SHARP approval, was the press used without the guard (i.e., workplace modus operandi)?

If the press was installed after SHARP approval, did the employer notify the Consultation program – as required for changes in the workplace that might introduce new hazards? If there was no guard for the press - why was a guard not purchased? Are there adequate resources to meet the safety and health needs of the workplace? Was a hazard assessment conducted for the press? If not, why was a hazard assessment not conducted? Was the supervisor aware of the regulatory requirement to guard the press? If not, why? If yes, why did the supervisor not ensure compliance with the standard?

What did employees say about using the press (the consultant must interview employees who use the press or work in the area and have observed the press in use)? Were employees aware of the hazard? If yes, what action did they take to address it (e.g., express their concern to their supervisor, submit a work order request for a guard)? If employees took any action, what was the outcome? If employees did not take any action – why not? Did employees recognize the hazard? Was the employee involved in the incident trained to use the press? Have other employees who work with the press received training? Who provided the training? If the training was provided in-house, was the trainer found to be proficient? Was training effectiveness verified by the supervisor (e.g., observed employees using with the press)? Did employees who use the press experience near-misses prior to this incident? What was the proper procedure (i.e., if there was an established procedure) for employees to perform the task?

Consultation Program's Recommendations for Corrective Actions

Recommendations will be made to address findings or root causes. For example, if there was a finding that the employee was never trained about the point of operation hazard and how to operate the equipment properly – then establishing processes to ensure that all employees receive the proper training before starting work for this operation and all other operations at the SHARP establishment would be a recommendation. The recommendation must also include verifying training effectiveness and retraining employees when necessary.