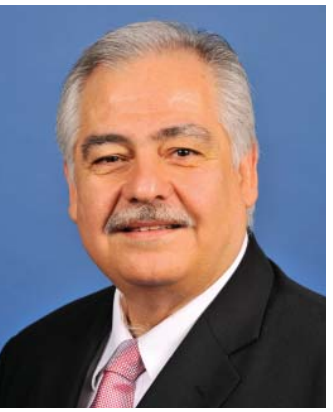
Accident investigation



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When an accident or an injury occurs, we can use the circumstances of the event to learn from it and to pass on what we have learned to others. This is the purpose of an accident investigation.

In my November 2011 column, I addressed the accident investigation process, and a citation from that column bears repeating.

The *Employee and Labor Relations Manual (ELM)* contains a section dedicated to this principle at §821.3, Accident Analysis. The section explains that the purpose and responsibility is as follows:

> ...Accident analysis is vital for identifying the hazardous conditions, contributing factors, and root causes of accidents...Installation heads/managers must use the results of accident analyses to address the causes of accidents, develop specific actions (countermeasures), and enter them into an accident reduction plan (ARP)...The ARP serves as management's primary tool for reducing OSHA injury and illness (OSHA II) and motor vehicle accident (MVA) rates...

"Once we know how an accident occurred, then and only then can we learn from it and teach others how to prevent a similar accident."

In addition to the above excerpt of the *ELM*, there are numerous rules listed identifying the responsibilities that fall on management's shoulders. Review those regulations if you feel that the accident reduction plan fails to hit the mark in your office.

Section 817.12 of the *ELM* provides that:

> Executives and managers at the plant level and above must be provided an orientation that discusses their responsibility for...Accident investigation and reporting.

Section 821.131 of the *ELM* provides that:

> Managers and supervisors of the employee or operation are responsible for investigating all accidents and occupational injuries and illnesses quickly and accurately to determine root causes.

The above passages do not tell management to find a way to pin responsibility on the employee; rather, they instruct them to find the true cause of an accident. In our postal world, managers frequently form an opinion first, then seek facts to prove what they believe. This technique is not an accident investigation and does nothing to reveal the cause of an accident. This reaction discourages our membership from reporting accidents and, just as important, it denies us the opportunity to learn from unfortunate events.

Many times through the years, I have looked at the website of the National Transportation Safety Board (ntsb.gov) and reviewed reports that the agency has prepared following major accidents. At the very bottom-left of its pages, you will find a section titled Resources. Click on the "Database" link and then "Highway." This will open up a listing of accidents by description, the date of the accident and other relevant information. On the right, you will find a PDF linking you to the report of that accident.

I reviewed one report involving a multi-vehicle accident that resulted in two fatalities. The description of the accident shows that the investigators simply acquired all the facts that they could, including but not limited to photos, diagrams, charts, statements of witnesses, skid marks, identification of damage to vehicles, etc.

In its report of Aug. 5, 2010, of this multi-vehicle accident that resulted in two fatalities, the NTSB determined that the probable cause of the collision was distraction, likely due to a text-messaging conversation being conducted by the pickup driver (Vehicle 2), which resulted in his failure to notice and react to a tractor (Vehicle 1) that had slowed or stopped in a work zone. This report further explains how the drivers of the other vehicles were distracted further by the actions of those not involved in the initial collision.

A motorcoach (Vehicle 3) had pulled over to the shoulder of the road to avoid hitting Vehicles 1 and 2, and the driver of Vehicle 4 focused his attention not on the accident scene ahead, but instead on Vehicle 3, which was stopped on the shoulder. Driver 4 swerved to avoid the parked vehicle and ran into Vehicle 2. The NTSB report describes each of the events in the chain, showing how each event contributed to the accident as it unfolded.

The example set by the NTSB is a useful tool for us to use in determining the root cause of an accident. Once we know how an accident occurred, then and only then can we learn from it and teach others how to prevent a similar accident.

Find out what really happened and keep an eye on each other.