Good and bad examples of reporting accidents to OARS site at UW EH&S

Example of good, introspective report with concrete changes that will be made in the lab to prevent it in the future.

![Incident Details]

Myself and another student were working in the fume hood in B33. The other student left an uncapped needle attached to a Schlenk line unattended and I poked the side of my hand with the needle. After the needle stick, I removed my gloves and inspected the area but couldn’t tell if the needle punctured my skin or not. Before returning to work, I ran water over my hand for 10 minutes to flush the area. I confirmed that the needle was clean when the other student returned to the fume hood.

![Supervisor's Comments]

ROOT CAUSES:
(Please look at all the factors that may have contributed to the accident. Such factors may include equipment, environment, policies, procedures, and personnel.)
This accident occurred as a result of one student leaving a needle uncapped and attached to a Schlenk line in a common space fume hood.

Recommendations/Preventive Measures:
We have reminded all group members of the importance of following EH&S recommendations with respect to needle handling, including keeping them capped when not in active use, how to safely re-cap (if their reuse is absolutely required), as well as proper needle disposal processes. We will update our Schlenk line SOP to include this information.

Examples of poor, vague reasons that an accident occurred and how it will be prevented in the future.

“No preventative measures necessary – just an accident”
“Not sure what could have been done to prevent this.”
“Again, this was an isolated incident, so no real recommendations are required.”
“It is hard to make people change their behavior.”
“Be more careful, use more care.”
“I (Supervisor) did not observe the incident.”
“Be more aware and don’t rush.”
“Employee did not know.”
“No change in procedures recommended.”
“Be more aware of your surroundings.”
“In the future, we will investigate more thoroughly.”
“No sure what could have been done to prevent this.”
“Inattention.”
“Purely an accident.”
“None or unknown.”
“Pay closer attention.”
“Try to stay focused.”
“Possible age related.”
“Rushing, in a hurry.”