**WORKPLACE INCIDENT REPORT**

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| **INVESTIGATIVE TEAM** |
| Name | Position | Role |
|  |  | *Employer Representative* |
|  |  | *Worker Representative* |
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| **INCIDENT DETAILS** |
| Date of Incident: |  |
| Time of Incident: |  |
| Location of Incident: |  |

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| **TYPE OF OCCURRENCE** |
| Type | Yes | Type | Yes |
| Death of a worker |  | Minor Injury or no injury but with potential for serious injury |  |
| Serious Injury to worker\* |  | Injury requiring medical treatment beyond first aid (Physician ER) |  |
| Major structural failure or collapse |  |  |  |
| Incident of fire or explosion with potential for serious injury |  |  |  |

\*Serious injury = Life threatening, traumatic injury, loss of consciousness, permanent change

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| **DESCRIPTION OF INCIDENT** |
| *What happened? Describe the environmental/surrounding conditions; activities taking place in the space; availability, use and functionality of necessary equipment.* |

**CONTRIBUTING FACTORS AND/OR DIRECT CAUSES:**

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| **ENVIRONMENT RELATED CAUSES** |
| □ Variations in floor surface | □ Working alone |
| □ Wet/slippery | □ Inadequate security equipment/measures |
| □ Personal Protective Equipment not sufficient | □ Limited space |
| □ Noise | □ Lighting |
| □ Other (specify):  |

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| **ORGANIZATIONAL RELATED CAUSES** |
| □ Excessive workload | □ Job/Skill training inadequate |
| □ High staff turnover | □ Staffing inadequate |
| □ Poor communication | □ Standard operating procedures not available/adequate |
| □ Other (specify):  |

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| **EQUIPMENT RELATED CAUSES** |
| □ Signage/labeling inadequate | □ Defective equipment |
| □ Proper equipment unavailable/inadequate | □ Preventative maintenance/inspections inadequate |
| □ Material/equipment failure | □ Incorrect equipment |
| □ Other (specify): |

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| **HUMAN RELATED CAUSES** |
| □ Knowledge/skill/experience lacking | □ Illness |
| □ Pre-existing condition | □ Violent behaviour |
| □ Fatigue | □ Physical limitations (reach, height, etc.) |
| □ Other (specify): |

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| **DETERMINATION OF CAUSES OF INCIDENT** |
| *Why did the event occur?*  |

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| **CORRECTIVE ACTION** |
| *How can a reoccurrence be prevented?* |

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| **CORRECTIVE ACTION PLAN** |
| Action(Description of action required to prevent reoccurrence of incident) | Assigned To:(Position of the person performing the action) | Expected Completion Date(YYYY-MM-DD) | Completion Date (YYYY-MM-DD) |
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