



**Health & Safety Management System Form:  
Handout #1 - Incident Investigation**

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**Monitor:**  
Director, Health, Safety & Environment

Form #:  
10.2

**Section A – Incident Details**

Incident date:		Incident location:	
Reported by:		Position:	
Incident title:			
Incident summary:			
Incident type:	<input type="checkbox"/> Near Miss <input type="checkbox"/> Illness <input type="checkbox"/> Environmental	<input type="checkbox"/> First Aid Injury <input type="checkbox"/> Medical Treatment Injury <input type="checkbox"/> Lost Time Injury	<input type="checkbox"/> Property Damage <input type="checkbox"/> Production Loss <input type="checkbox"/> Dangerous Occurrence
Incident rank:	<input type="checkbox"/> Low (potential First Aid Injury, minor property or environmental damage)	<input type="checkbox"/> Medium (potential Medical Treatment Injury, medium property or environmental damage)	<input type="checkbox"/> High (potential Serious Injury or Fatality, major property or environmental damage)

**Section B – Investigation Team**

Name	Position	JOHSC
	(Team Lead)	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section C – Interviews**

Witness Name	Position	Date Interviewed	Attached
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No



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**Section D – Supporting Evidence**

Item	Available	Attached	Item	Available	Attached
	(mark Y if yes, leave blank if no)			(mark Y if yes, leave blank if no)	
Safety orientation:			Site orientation:		
Tailboard meetings:			Project safety plan:		
Photographs:			Diagram of incident:		
Audio recording:			Video recording:		
Safe Work Practices:			Safe Job Procedures:		
Training records:			Maintenance records:		
Work Protection:			Worksite visits:		
Contract documents:			RFP/tender:		
Daily meetings:			Safety meetings:		
Emergency plan:			Logbook entries:		
H&S Program:			Contractor qualification:		

**Section E – Sequence of Events**

1	
2	
3	
4	
5	
6	
7	

**Section F – Observations**

1	
2	
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**Section G – Direct Causes**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Animals or insects | <input type="checkbox"/> Fall from <3m      | <input type="checkbox"/> Outage            | <input type="checkbox"/> Temperature extreme |
| <input type="checkbox"/> Caught in, between | <input type="checkbox"/> Fall from >3m      | <input type="checkbox"/> Overexertion      | <input type="checkbox"/> Vehicle             |
| <input type="checkbox"/> Chemical contact   | <input type="checkbox"/> Fall at same level | <input type="checkbox"/> Repetitive strain | <input type="checkbox"/> Violence            |
| <input type="checkbox"/> Communications     | <input type="checkbox"/> Fire               | <input type="checkbox"/> Slip, trip, fall  | <input type="checkbox"/> Work Protection     |
| <input type="checkbox"/> Electrical energy  | <input type="checkbox"/> Maintenance        | <input type="checkbox"/> Struck against    | <input type="checkbox"/> Other               |
| <input type="checkbox"/> Environmental      | <input type="checkbox"/> Noise or vibration | <input type="checkbox"/> Struck by         |  |

**Description of Direct Causes**

1	
2	
3	
4	
5	
6	

**Section H – Indirect Causes**

**Substandard Practices**

**Substandard Conditions**

- |  |  |
|--|--|
| <input type="checkbox"/> Not operating with authority<br><input type="checkbox"/> Not using serviceable equipment<br><input type="checkbox"/> Not using equipment properly<br><input type="checkbox"/> Not using PPE where required<br><input type="checkbox"/> Not correct lifting<br><input type="checkbox"/> Alcohol & drugs<br><input type="checkbox"/> Horseplay<br><input type="checkbox"/> No secure equipment or warnings<br><input type="checkbox"/> Other procedural non-conformance | <input type="checkbox"/> Not effective guards & devices<br><input type="checkbox"/> Not serviceable tools & equipment<br><input type="checkbox"/> Not adequate warning systems<br><input type="checkbox"/> Poor housekeeping<br><input type="checkbox"/> Polluted environment<br><input type="checkbox"/> No noise management<br><input type="checkbox"/> No hazardous substances management<br><input type="checkbox"/> Poor illumination & ventilation<br><input type="checkbox"/> Other |
|--|--|

**Description of Indirect Causes**

1	
2	
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4	
5	
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**Section I – Root Causes**

Personal Factors	Job Factors	Supervisory Performance	Management Policy
<input type="checkbox"/> Lack of skill or knowledge <input type="checkbox"/> Improper motivation <input type="checkbox"/> Physical or mental conditions <input type="checkbox"/> Literacy or ability <input type="checkbox"/> Other	<input type="checkbox"/> Physical environment <input type="checkbox"/> Substandard equipment <input type="checkbox"/> Abnormal usage <input type="checkbox"/> Wear & tear <input type="checkbox"/> Design/maintenance <input type="checkbox"/> Purchasing standards <input type="checkbox"/> Change introduced <input type="checkbox"/> Other	<input type="checkbox"/> Inadequate instruction <input type="checkbox"/> Inadequate Job Safety Analysis <input type="checkbox"/> Rules not enforced <input type="checkbox"/> Hazards not controlled <input type="checkbox"/> Devices not provided <input type="checkbox"/> Other	<input type="checkbox"/> Safety Management System Element failure <input type="checkbox"/> Inadequate Safe Work Practices or Safe Job Procedures <input type="checkbox"/> Inadequate supervision provided <input type="checkbox"/> Training programs not provided or inadequate <input type="checkbox"/> Other

**Description of Root Causes**

1	
2	
3	
4	
5	
6	

**Section J – Corrective Actions**

*Hierarchy of Controls: 1) Elimination 2) Substitution 3) Engineering 4) Administration 5) PPE*

Action (include CMMS # where applicable)	Responsible Party	Due Date	* Date Completed
1			
2			
3			
4			
5			
6			
7			
8			

\* Inform HSE Director of corrective action completion dates.

\*\* Inform Asset Manager immediately of any equipment failure.



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**Section K – Investigation Team Signoff**

Date started:	Date completed:
Name: Signature:	Name: Signature:

**Section L – Director Review (accept or deny recommended corrective actions)**

Name:	Position:	Review date:
Comments:		

**Section M – Health & Safety Department Review**

Name:	Position:	Review date:
Comments:		

**Section N – JOHSC Review**

Co-chair name:	Co-chair name:	Review date:
Comments:		