

Incident Investigation Report

This form was designed to assist the clinic in creating preliminary and full incident investigation reports.

Employer information:

Clinic name (legal and trade):

WorkSafeBC account number:

Injured worker information:

Full name:

Position/Job title:

Incident details:

Location:

Date: DD / MM / YYYY

Time: HH : MM

Type of occurrence:

a. Death of a worker

d. Major release of hazardous substance

b. Serious injury* to a worker

e. Minor injury or no injury but had potential for causing serious injury*

c. Major structural failure or collapse; blasting accident or other dangerous incident involving explosives; fire explosion with potential for serious injury*

f. Injury requiring medical treatment beyond first aid

* Serious injuries are life-threatening or can cause permanent impairment, including major fractures, amputations, serious burns, chemical exposure, spinal cord and brain injuries, and heat or cold stress.

If a, b, c, or d, report it immediately to WorkSafeBC at 1-888-621-7233 (24/7).

Description of incident:

What happened? Summarize the sequence of events, the unsafe factors and the resulting injury, if any. Describe the environment/surrounding conditions; activities taking place in the space; availability, use, and functionality of necessary equipment.

Contributing factors:**Environment related causes:**

<input type="checkbox"/>	Variations in floor surface	<input type="checkbox"/>	Working alone or in isolation
<input type="checkbox"/>	Wet/slippery floor	<input type="checkbox"/>	Inadequate security equipment/measures
<input type="checkbox"/>	Personal protective equipment not sufficient	<input type="checkbox"/>	Limited or cluttered workspace
<input type="checkbox"/>	Noise	<input type="checkbox"/>	Lighting insufficient
<input type="checkbox"/>	Poor housekeeping	<input type="checkbox"/>	Chemical or biological hazard exposure
<input type="checkbox"/>	Other (specify):		

Organizational related causes:

<input type="checkbox"/>	Excessive workload	<input type="checkbox"/>	Inadequate job/skill training
<input type="checkbox"/>	High staff turnover	<input type="checkbox"/>	Inadequate staffing
<input type="checkbox"/>	Poor communication	<input type="checkbox"/>	Inadequate/unavailable standard operating procedures
<input type="checkbox"/>	Other (specify):		

Equipment related causes:

<input type="checkbox"/>	Inadequate signage/labeling	<input type="checkbox"/>	Defective equipment
<input type="checkbox"/>	Inadequate/unavailable equipment	<input type="checkbox"/>	Preventative maintenance/inspections inadequate
<input type="checkbox"/>	Material/equipment failure	<input type="checkbox"/>	Incorrect equipment
<input type="checkbox"/>	Other (specify):		

Human factors:

<input type="checkbox"/>	Knowledge/skill/experience lacking	<input type="checkbox"/>	Illness
<input type="checkbox"/>	Pre-existing condition/illness	<input type="checkbox"/>	Violent behaviour (verbal, physical, threats)
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Physical limitations (reach, height, etc.)
<input type="checkbox"/>	Other (specify):		

Immediate corrective actions:

Action(s) taken to prevent re-occurrence of similar incidents:	Assigned to:	Expected completion date:	Completion date:
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

Persons who carried out the preliminary investigation:

Employer representative:

Full name:		Position:	
Signature: <i>(optional)</i>		Date:	DD / MM / YYYY

Worker representative:

Full name:		Position:	
Signature: <i>(optional)</i>		Date:	DD / MM / YYYY

End of preliminary report. For the full report, also complete the sections on page 4.

Determination of causes of incident *(Required for full report):***Why did the event occur?**

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Final corrective action plan *(Required for full report):*

Additional corrective action(s) required to prevent reoccurrence of similar incidents:	Assigned to:	Expected completion date:	Completion date:
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

Persons who carried out the full investigation:**Employer representative**

Full name:		Position:	
Signature: <i>(optional)</i>		Date:	DD / MM / YYYY

Worker representative

Full name:		Position:	
Signature: <i>(optional)</i>		Date:	DD / MM / YYYY

Other (optional)

Full name:		Position:	
Signature: <i>(optional)</i>		Date:	DD / MM / YYYY