



Section 4

Incident Reporting and Investigations



Occupational Health &
Safety Manual 2020

Incident Reporting and Investigations

Overview

An **Incident** is the unplanned or uncontrolled transfer of energy from one object to another that results in or has the potential of resulting in loss. A **Near Miss** is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Since there are usually more “near misses” than incidents result in injuries, investigation of near misses provides vital information for improving health and safety at the workplace and preventing more serious incidents.

Since the term “accident” suggests events are out of our control, but are only out of our control because we have failed to introduce proper training, procedures and other hazard controls. “Incident” is a more appropriate term to use.

There are several legal requirements when an incident occurs:

1. The *Alberta Occupational Health and Safety Act* requires that an employer to investigate all serious injuries and to report specific occurrences to Alberta Workplace Health and Safety. They are:
 - An injury or accident that results in a worker being admitted to a hospital for more than 2 days,
 - An unplanned or uncontrolled explosion, fire or flood that causes a serious injury or that has the potential of causing a serious injury,
 - The collapse or upset of a crane, derrick or hoist, or
 - The collapse or failure of any component of a building or structure necessary for the structural integrity of the building or structure.
 - An injury or accident that results in death.
2. The *First Aid Regulation* requires that all injuries treated at the work site be recorded in a First Aid Record and the record be kept in a secure area for three years.
3. The Worker’s Compensation Act requires certain forms be filled out by the employer and the employee when the employee is injured at work. *Note: Staff covered under WCB is; support, maintenance, custodial, contract, teachers working in shop programs and administrators (principals) if they are injured during non-teaching duties.*

All incidents are to be reported as soon as possible. Reports are to be kept on file at the individual schools and a copy forwarded to the OHS Coordinator at Central Services. The proper reporting and subsequent investigation of all incidents is an important aspect in ensuring the ongoing health and safety of everyone.

Incident investigations are done to:

- Discover the causes of incidents that will allow measures to be put in place to prevent recurrences of similar incidents.
- Ensure that previously uncontrolled hazards related to an incident or injury does not remain a risk in the future.
- Determine if training or changes in personal protective equipment, procedures, etc. are required to make the work process safer or healthier.
- Gather facts for the purpose of prevention and not to assign blame.

An investigation should determine:

- **Who** was involved or injured?
- **Where** did the incident happen?
- **When** did the incident occur?
- **Why** was the unsafe act or condition allowed?
- **How** can a similar incident be prevented?

Things to consider when conducting an incident investigation:

- Unsafe or defective equipment
- Unsafe environmental conditions
- Poor housekeeping
- Poor instruction
- Physical hazards
- Unsafe work practices
- Unusual or unfamiliar work conditions
- Personal factors

REVIEW:

Safe Work Guidelines for Reporting Work Related Incidents

Safe Work Guidelines for Incident Investigation

Incident Investigation Power-point Presentation

Safe Work Guidelines for Reporting Workplace Hazards or Unsafe Conditions

East
Central
Catholic
Schools



Next pages are the Incident report forms:

INCIDENT INVESTIGATION REPORT

Identification	File number	Date of Incident:	Injury <input type="checkbox"/>	Vehicle accident <input type="checkbox"/>
	Near Miss /Hazard ID:	Time of Incident:	Near miss <input type="checkbox"/>	Property damage <input type="checkbox"/>
			Hazard ID <input type="checkbox"/>	Equipment damage <input type="checkbox"/>
	Date of report:	Location of Incident:	Witnesses and contact info:	
	Investigator:			
	WCB notified: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		Alberta OHS notified:	
	Person contacted:		Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	WCB Case Number:		Person Contacted:	
			OHS Case Number:	
	Next of Kin Notified Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		Contact information:	
Person contacted:				
Central Office and OHS Coordinator Notified of Incident Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		Person contacted:		
Injury or Illness		Primary Incident	Secondary Incident	
Part of body:		Object damaged:	Object damaged:	
Nature of injury or illness:		Nature of damage:	Nature of damage:	
Occupation:		Object/Substance inflicting harm:	Object/Substance inflicting harm:	
Person In control of activity at time of occurrence		Occupation of person in control of activity at time of occurrence	Contact Information of person in control of activity at time of occurrence	
Risk	Probability of Reoccurrence (Within 3 years)		Loss Severity Potential	
	High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/>		Major <input type="checkbox"/> Serious <input type="checkbox"/> Minor <input type="checkbox"/>	
Definitions: Major: Fatality, Loss time, or catastrophic failure or loss of equipment or building Serious: Requires trip to hospital or clinic, but no loss time. Equipment is not usable, but can be repaired. Minor: Did not require outside medical attention. Equipment was damaged, but still can be used.				

INCIDENT INVESTIGATION REPORT

Descriptions	Describe what happened (Be as detailed as possible. Attach pages and photos if necessary) What happened? What were you doing when incident occurred? How long were you on shift? What was the weather conditions like? Have you performed this job before? Was this part of your normal duties? Is there a procedure for this job? Was the work area cluttered?
	Cause Analysis 1. Immediate Causes: What acts/practices and conditions caused or could have caused the event? Refer to checklists 1A. and 1B on page 3 for suggestions (Attach additional pages if necessary)
	Cause Analysis 2. Root causes: What specific personnel or job/system factors caused or could have caused event? Refer to checklist 2A, 2B,2C on page 3 for suggestions (Attach additional pages if necessary)
	Action Plan Remedial Actions: What has and/or should be done to control the causes listed (Attach additional pages if necessary)
The above report accurately describes the event / situation _____ <div style="text-align: right;">Reporter's Signature</div>	

INCIDENT INVESTIGATION REPORT

1 Immediate Causes: Operating equipment without authority Failure to warn Failure to secure Operating at improper speed Failure to follow procedures Removing or making safety devices inoperable Using defective equipment Using equipment improperly Failure to use Personal Protective Equipment properly Improper loading Improper lifting Improper position for task Servicing equipment in operation Horse play Under influence of alcohol and/or drugs Inadequate Guards or Barriers Inadequate or improper protective equipment Defective tools, equipment or materials Congestive or restrictive action Inadequate warning system Fire and /or explosion hazard Poor house keeping Hazardous environmental conditions: Gases, dust, smoke, fumes and vapors Noise exposures High or low temperature exposures Inadequate or excess illumination Inadequate ventilation Radiation exposures		2 Personal factors Inadequate capability Lack of knowledge Lack of skill Stress Improper motivation In line of fire Mind not on task 2B. Job/System factors Inadequate leadership/supervision Inadequate engineering Inadequate purchasing Inadequate maintenance Inadequate tool/equipment Inadequate work standards Wear and tear 2C Contact with Electricity Heat Cold Radiation Caustics/acids Noise Toxic or noxious substances Object or equipment	
Actions to Prevent Recurrence			
Item	Person Responsible	Date to be Completed By:	Actual Date Completed
1			
2			
3			
4			
Investigator Name _____ Signature _____ Date _____		Secondary Investigator (If applicable) Name _____ Signature _____ Date _____	
School Administrator Name _____ Signature _____ Date _____		Senior Administrator or Director Name _____ Signature _____ Date _____	

Work Related Incident Record

An incident is an unplanned or unwanted event that causes harm or has the potential to cause harm. All district employees and volunteers are required to complete this form when injured or ill or experiencing pain as a result of carrying out work duties or to report an incident with the potential to cause serious injury/illness. For more information refer to district OHS Safe Work Guideline – Reporting Work Related Incidents. If hospitalization is required, please notify a district OHS Coordinator at 780-842-8912 as soon as possible. Provide a copy of this completed record to the injured employee and file a copy at the worksite in a confidential location for at least 3 years.

Person's Full Name :		School or Worksite :		Home Phone:	Room or Location of Incident:
Date of incident (D/M/Y):		Time: AM or PM	Date reported to Supervisor (D/M/Y) :		Time: AM or PM
Who did you report the incident to?			If you did not report on same date of incident why not?		
Is this incident related to work duties? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does this incident involve a work related injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Staff Group:		Body Part Injured:		Type of Injury:	
<input type="checkbox"/> Custodial <input type="checkbox"/> Exempt <input type="checkbox"/> Maintenance <input type="checkbox"/> Support <input type="checkbox"/> Teacher <input type="checkbox"/> Other		<input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Teeth <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Ribs <input type="checkbox"/> Trunk <input type="checkbox"/> Fingers <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Toes <input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Leg <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Other		<input type="checkbox"/> Chemical or Biological Exposure <input type="checkbox"/> Burn <input type="checkbox"/> Concussion <input type="checkbox"/> Cut <input type="checkbox"/> Bruise <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Puncture <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Scrape <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Other	
Description of incident, injury or illness and how it occurred.					
This section to be completed by the employee and their supervisor.					
Was first aid given? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of First Aider:			
Qualifications of First Aider:		<input type="checkbox"/> Emergency First Aid <input type="checkbox"/> Standard First Aid <input type="checkbox"/> Nurse <input type="checkbox"/> Other			
Describe first aid provided :					
Has the employee seen a doctor or other health care professional?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Is injury likely to result in time away from work or require medical treatment beyond the day of the injury?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes and the employee is covered by WCB, has the <i>WCB Employer's and Worker's Report of Injury</i> been completed and faxed to Employee Health Services? If not, please complete and fax along with this record form to Central Services within 24 hours of the incident (Fax: 780-842-3255).					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If there is time lost from work beyond the day of the incident, what was the first day off work? (D/M/Y)					
Has a copy of this <i>Record</i> been faxed to Central Services? If not please fax within 24 hours of the incident (Fax # 780-842-3255).					<input type="checkbox"/> Yes <input type="checkbox"/> No
What was the cause of the incident, injury or illness?					
What can be to done to prevent a similar incident in the future?					
Did this incident result in hospitalization, a serious injury/illness or have the potential to result in serious injury/illness? If yes, conduct an incident investigation using the <i>Incident Investigation Report Form</i> .					<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee's Name (Print):		Signature:		Date (D/M/Y):	
Supervisor's Name (Print):		Signature:		Date (D/M/Y):	