

MAJOR INCIDENT REPORT
(To be filled out by Management & Safety Committee)

School:		Address:		Date of Report:	
Exact Location of Incident:			Date of Occurrence:		Time of Occurrence: <input type="checkbox"/> AM <input type="checkbox"/> PM
Report Prepared by:			Title:		Phone Number:
Injured (name):			Employment Status: Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Relief <input type="checkbox"/>		Hours worked: Week <input type="checkbox"/> Day <input type="checkbox"/>
Birth date:		Date Hired: District		Start Date: School	
Nature of Injury:					
Body Part:			Source of Injury:		
Job Classification:			Activity at Time of Incident:		
Name of Doctor:			Doctor's Address and/or Phone Number:		
Property Damage/Identification:			Other Incident/Damage (Identification):		
Model/Serial Number:					
Damage Results:					
Name of Supervisor With the Most Control of Job Task:		Title:		Phone Number:	
Type of Incident: <input type="checkbox"/> Caught in <input type="checkbox"/> Caught Between <input type="checkbox"/> Struck By <input type="checkbox"/> Fall same level <input type="checkbox"/> Exposure to <input type="checkbox"/> Caught on <input type="checkbox"/> Struck Against <input type="checkbox"/> Strain/stress <input type="checkbox"/> Fall to lower <input type="checkbox"/> Contact with					
Describe How Incident Occurred: <i>Activity, Authority, Job Procedure, Post-Contact Actions.</i>					
Sketch Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No					
PROTECTIVE EQUIPMENT USE:					
Function		Required	Available	Used	Needed
Head Protection:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Protection:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Protection:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Protection:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body Restraint:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Protection:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gloves:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire/Heat Protection:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remarks:					

Root Cause Analysis – Questions to Ask

These questions provide samples of issues to cover when investigating an incident. There is some overlap between these categories, which reflects the situation in real life. For most of these questions an important follow-up question is "if not, why not?" and/or "what caused this to occur?"

CODE: "C" Contributed "N" Not a Factor "P" Present but not significant

	C	N	P		C	N	P
Supervisory:				Psychological:			
Safety Policies and Rules established	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Human Design Factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety Policies and Rules communicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perceptual Distortion/Illusion/limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety Policies and Rules followed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responsibilities defined and understood by management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training Program in place and effective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Misinterpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sufficient time allowed for task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preoccupation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hazard/Risk Analysis performed prior to job/actions taken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Written procedures available and enforced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Complacency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervision effective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protective Equipment provided/used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate management structure in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental limitations: intelligence/aptitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervisors trained and qualified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Reaction time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communications:	C	N	P				
No Instructions/Feedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physiological:	C	N	P
Misinterpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disrupted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue: mental/physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noise Interference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toxic Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language Barrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used Only One Mode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Capabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental:	C	N	P	Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weather conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Too hot, too cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Illness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hazardous materials present (gases, dusts, fumes etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Equipment	C	N	P
Human factors (e.g. workplace conflict, influences)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Equipment properly maintained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical impacts such as posture/forces etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Necessary tools and equipment available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acceleration, Deceleration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safety devices in place and working properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden changes to conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worker training on tools/equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Was the machinery/equipment poorly designed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				a) physical aspects (fit, reach, see)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				b) non-physical aspects (cognitive, sensory motor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Immediate Causes: *What substandard acts and conditions contributed directly to this incident?*

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What Personal Factors Were Basic Causes of This Incident? Explain.

- Lack of Knowledge/Skill Improper Motivation Physical or Mental Problems Inadequate Planning Willful Deviation Other

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What Job Factors Were Basic Causes of This Incident? Explain.

- Inadequate Work Practice Inadequate Design Inadequate Maintenance Inadequate Purchasing Standard Abuse or Misuse Inadequate inspection Other

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What are the Reasons for the Activity Causing the Accident? Explain.

Other Inadequate Safety Program Inadequate Safety Program Standards Inadequate Compliance with Safety Standards

ACTION PLAN

Loss Severity Potential:

Major Serious Minor

Probability of Recurrence:

Frequent Occasional Seldom

What Has or Should be Done to Prevent Similar Loss:

Empty space for writing the action plan.

Signature of Investigator:

Committee Member's Name:

Committee Member's Signature:

Date:

Reviewed by:

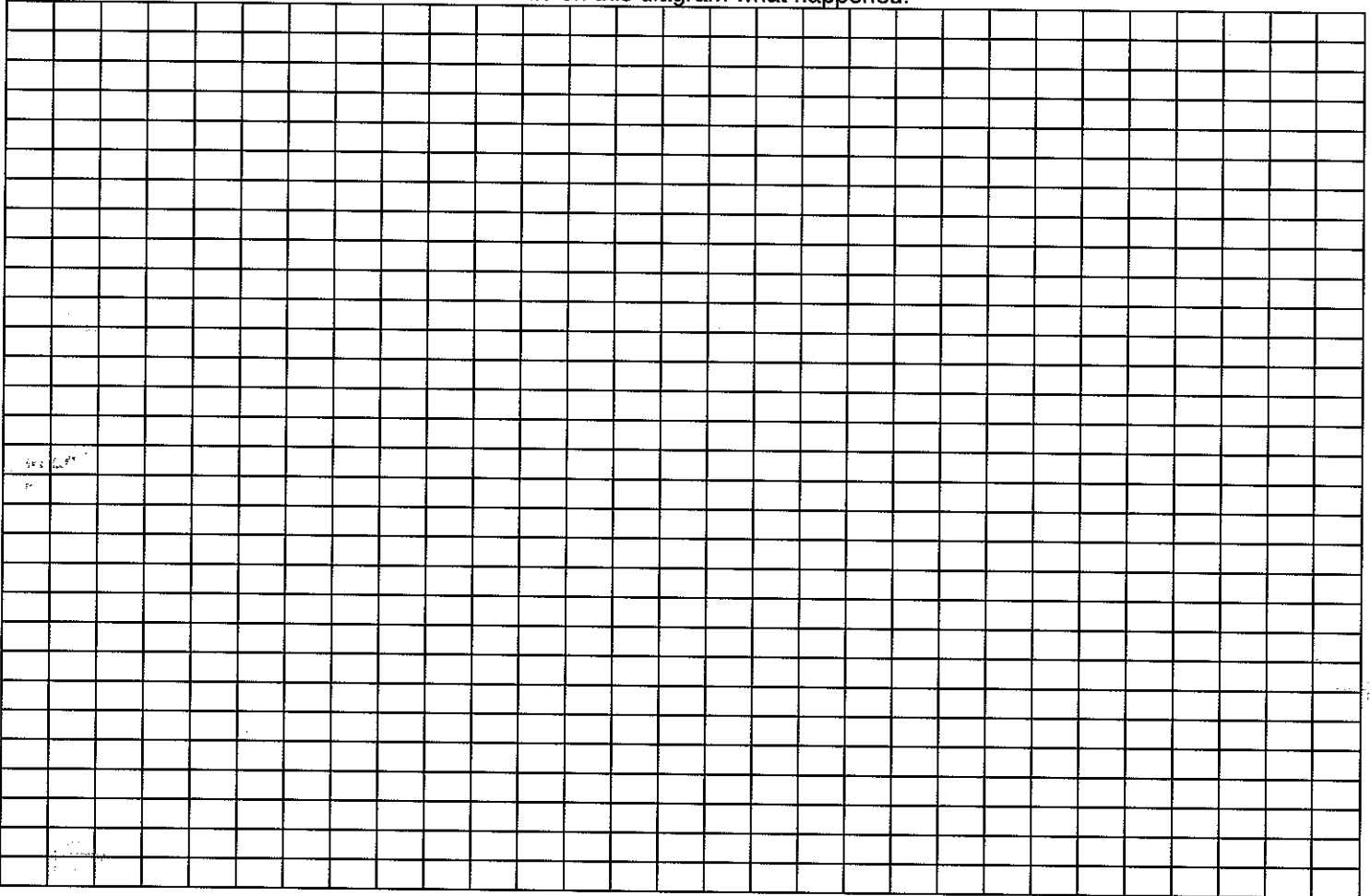
Title:

Date:

INCIDENT SKETCH MAP

Claim Number					Show North by Arrow ○ Scale
On Street or Road Building					
At Intersection					
In Location					
Hour	Month	Day	20	Reported by	

Indicate on this diagram what happened:



SKETCHING CHECKLIST

By eliminating irrelevant details and adding measurements, you can often sketch a scene more clearly than you can photograph it. The following points will make sketching for Incident maps easy without sacrificing accuracy:

1. Use squared paper. Let each square represent a fixed distance such as a foot and write the scale at the top of the sketch.
2. Use a strip of squared paper to measure diagonals on the sketch.
3. Locate each important object with a rough outline.
4. Label large objects inside their outline. Label small objects outside their outline with an arrow to the object; the arrow should just touch the object.
5. For maps with a lot of detail, use a sketch log. Use double letters to identify reference points and single letters to identify items of evidence.
6. Indicate distances of movable objects from at least two fixed points. Logs for detailed maps have columns for measurement data.
7. Include a north arrow in each sketch.
8. Mark camera positions by a letter inside a circle. Later the appropriate letter should be used on each print.
9. Identify the sketches with a label, data box or on the back just as you would a photograph

