Workplace Safety North | Ontario Mine Rescue

Template: Incident Investigation Report

<table>
<tr><td colspan="6">PART 1 EMPLOYEE SECTION: Contact Information and Description of Event</td></tr>
<tr><td colspan="2">COMPANY NAME</td><td colspan="2">DEPARTMENT</td><td colspan="2">DATE OF EVENT</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="2">LOCATION OF EVENT</td><td colspan="2">TIME OF EVENT</td><td colspan="2">REPORT DATE</td></tr>
<tr><td colspan="2" rowspan="2"></td><td rowspan="2"></td><td>AM</td><td colspan="2" rowspan="2"></td></tr>
<tr><td>PM</td></tr>
<tr><td colspan="6">IF NOT REPORTED PROMPTLY, STATE THE REASON</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="2">WORKERS SUPERVISOR</td><td colspan="2">INJURED NAME (first, last)</td><td colspan="2">TITLE</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="6">CHECK OFF ALL STATEMENTS THAT BEST DESCRIBE THE INCIDENT</td></tr>
<tr><td>☐Physical Injury</td><td>☐First Aid Injury</td><td>☐Medical Aid Injury</td><td>☐Lost Time Injury</td><td colspan="2">☐Fatality</td></tr>
<tr><td>☐Critical Injury</td><td>☐Occupational Illness</td><td>☐Psychological Stress</td><td>☐Near Miss</td><td colspan="2">☐Discrimination</td></tr>
<tr><td>☐Bullying</td><td>☐Working Alone/ Isolation</td><td>☐Workplace Incivility</td><td>☐Verbal Abuse</td><td colspan="2">☐Threat</td></tr>
<tr><td>☐Motor Vehicle Incident</td><td>☐Property Damage</td><td>☐Fire/Explosion</td><td>☐Chemical Spill</td><td colspan="2"></td></tr>
<tr><td colspan="2">☐Other, please explain</td><td colspan="4"></td></tr>
<tr><td colspan="2">WAS THE INCIDENT</td><td colspan="2">☐SUDDEN EVENT/ OCCURRENCE</td><td colspan="2">☐GRADUALLY OCCURRING OVER TIME</td></tr>
<tr><td colspan="6">DESCRIBE WHAT HAPPENED IN DETAIL (Include who was involved, what happened including any details involving machinery/equipment, when it occurred, where it occurred, what the injury/illness was and why) *Note, that if the employee cannot fill this section in, it becomes the responsibility of the supervisor</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">WHAT FACTORS CONTRIBUTED TO THE EVENT (relevant background/underlying/root causes)</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">HOW COULD IT HAVE BEEN AVOIDED/PREVENTED?</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td>WAS FIRST AID / MHFA ADMINISTERED?</td><td>☐YES</td><td>☐NO</td><td>If yes, by whom?</td><td colspan="2"></td></tr>
<tr><td>WAS MEDICAL TREATMENT ADMINISTERED?</td><td>☐YES</td><td>☐NO</td><td>INDICATE HEALTH CARE PROVIDER</td><td colspan="2"></td></tr>
<tr><td colspan="6">MENTAL HEALTH PULSE CHECK – R U OK? (Please indicate where your mental health and wellbeing is currently because of this incident)</td></tr>
<tr><td>☐HEALTHY</td><td>☐REACTING</td><td colspan="2">☐INJURED</td><td colspan="2">☐ILL</td></tr>
<tr><td colspan="6">POST INTERACTION ACTIONS OR SUPPORTS REQUIRED (please include any supports or actions you did or would benefit from to ensure your mental health is supported post incident)
WSN EAP 1.866.644.0326 OR 1.866.361.4853 (French)</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">WITNESS NAME(S) AND CONTACT INFORMATION, IF ANY</td></tr>
</table>

SIGNATURE OF INJURED PARTY/COMPLAINANT	**DATE**
IF THIS FORM WAS COMPLETE BY SOMEONE OTHER THAN THE INJURED/AFFECTED PARTY, COMPLETE THE FOLLOWING	
FORM COMPLETED BY (first, last)	**SIGNATURE**
PHONE NUMBER	**DATE**

MENTAL HEALTH CONTINUUM MODEL – MENTAL HEALTH COMMISSION OF CANADA

Signs and Indicators

HEALTHY	REACTING	INJURED	ILL
• Normal mood fluctuations • Calm/confident • Good sense of humour • Takes things in stride • Can concentrate/focus • Consistent performance • Normal sleep patterns • Energetic, physically well, stable weight • Physically and socially active • Performing well • Limited alcohol consumption, no binge drinking • Limited/no addictive behaviours • No trouble/impact due to substance use	• Nervousness, irritability • Sadness, overwhelmed • Displaced sarcasm • Distracted, loss of focus • Intrusive thoughts • Trouble sleeping, low energy • Changes in eating patterns, some weight gain/loss • Decreased social activity • Procrastination • Regular to frequent alcohol consumption, limited binge drinking • Some to regular addictive behaviours • Limited to some trouble/impact due to substance use	• Anxiety, anger, pervasive sadness, hopelessness • Negative attitude • Recurrent intrusive thoughts/ images • Difficulty concentrating • Restless, disturbed sleep • Increased fatigue, aches and pain • Fluctuations in weight • Avoidance, tardiness, decreased performance • Frequent alcohol consumption, binge drinking • Struggle to control addictive behaviours • Increase trouble/impact due to substance use	• Excessive anxiety, panic attacks, easily enraged, aggressive • Depressed mood, numb • Non compliant • Cannot concentrate, loss of cognitive ability • Suicidal thoughts/intent • Cannot fall asleep/stay asleep • Constant fatigue, i l lness • Extreme weight fluctuations • Withdrawal, absenteeism • Can't perform duties • Regular to frequent binge drinking • Addiction • Significant trouble/impact due to substance use

PART 2 SUPERVISOR SECTION: General information and Preventive Measures		
SUPERVISORS NAME (first, last)	**TITLE**	**REPORT DATE**
IF NOT REPORTED PROMPTLY, STATE THE REASON		
INTERVIEW THE WORKERS INVOLVED: Confirm statements that best describe the incident and contributing factors including how it could have been avoided (if possible). Use this section to include any additional findings or opportunities for improvement based on your investigation.		
MENTAL HEALTH PULSE CHECK – R U OK Employee? (Please review and confirm with employee regarding where their mental health and wellbeing is currently because of this incident)		

☐**HEALTHY**	☐**REACTING**	☐**INJURED**	☐**ILL**
POST INTERACTION ACTIONS OR SUPPORTS REQUIRED (please include any supports or actions you recommended to the employee to ensure their mental health is supported post incident) **WSN EAP 1.866.644.0326 OR 1.866.361.4853 (French)**			
BASIC AND IMMEDIATE CAUSES: WHAT ACTIONS, CONDITIONS, PERSONAL OR JOB FACTORS CAUSED OR COULD HAVE CAUSED THIS EVENT?			

EXAMPLES OF FACTORS CAN INCLUDE					
Under the Influence	**Inappropriate workplace behavior**	**Lack of knowledge/ training**	**Lack of skill**	**Stress**	**Distraction**
Fatigue	**Improper motivation**	**Lack of job satisfaction**	**Lack of engagement**	**Personal Factors**	**Inadequate communication**

Work Overload	Insufficient Leadership/supervision	Inadequate Work Standards	Inadequate Policies and/or procedures	Abuse and misuse	Unclear/ Inadequate expectations
Inadequate support	Using defective equipment	Lack of responsibility	Ineffective conflict management	Lack of control over work	Unclear/ inadequate priorities and goals
Lack of resources	Organizational change	Inadequate Tools/ Equipment	Inadequate Maintenance	Operating equipment without authority	Poor housekeeping

WHAT WERE THE CONDITIONS, ACTIONS, OR FACTORS? (list below)	**WHAT WERE THE CONTRIBUTING CONDITIONS, ACTIONS OR FACTORS THAT WERE THE ENABLERS? Root Cause (list below)**

REMEDIAL/CORRECTIVE ACTIONS: What has or should be done to control the causes listed and prevent reoccurrence or reduce further harm?	**RESPONSIBILITY**	**BY WHEN**

RISK ASSESSMENT – WAS THIS TYPE OF INCIDENT CAPTURED ON THE RISK REGISTRY	☐**YES**	☐**NO**

CHECK OFF ALL STATEMENTS THAT BEST DESCRIBE THE INCIDENT OUTCOME (FOLLOW UP)				
☐**Non-Disabling Injury/Occ. Illness**	☐**Disabling Injuries/Occ. Illness**	☐**Fatality**	☐**Critical Injury**	☐**Lost Time**
☐**Medical Aid**	☐**First Aid**	☐**Mental Health First Aid**	☐**Modified Duty**	☐**EAP**
☐**Refused medical treatment**	☐**Other, please explain**			

WAS THERE AN ABSENCE FROM WORK FOLLOWING THE EVENT?	☐**YES**	☐**NO**

DO YOU ANTICIPATE THAT AN ACCOMODATION AND/OR FLEXIBLE WORKPLACE ARRANGEMENT WILL BE REQUIRED? (If yes, please complete the functional abilities form/modified work form)		
☐**YES**	☐**NO**	☐**MAYBE**

MENTAL HEALTH PULSE CHECK – R U OK Supervisor? (As a supervisor investigating an incident, sometimes your mental health can be affected based on circumstance. Please take a moment to self-check where your mental health and wellbeing is currently based on investigating this incident)			
☐**HEALTHY**	☐**REACTING**	☐**INJURED**	☐**ILL**

POST INTERACTION ACTIONS OR SUPPORTS REQUIRED (please include any supports or you have taken to support your mental health post incident, or any additional supports you may need or benefit from) **WSN EAP 1.866.644.0326 OR 1.866.361.4853 (French)**

SIGNATURE OF SUPERVISOR	**DATE**

THIS SECTION IS DESIGNED FOR REVIEWERS OF THE INVESTIGATION REPORT TO INCLUDE ADDITIONAL OPPORTUNITIES FOR IMPROVEMENT OR RECOMMENDATIONS AFTER INITIAL REVIEW

REVIEWER'S NAME (first, last)	
REVIEWER'S TITLE	
REVIEWER'S SIGNATURE	
REVIEWER'S DATE	
THIS SECTION IS DESIGNED FOR MANAGEMENT REVIEW TO INCLUDE ADDITIONAL OPPORTUNITIES FOR IMPROVEMENT OR RECOMMENDATIONS	
REVIEWED BY MANAGEMENT MEMBER	**DATE**

Report to WSIB (as applicable):

☐ WSIB Form 6 – Worker's Report of Injury/Disease
☐ WSIB Form 7 – Employer's Report of Injury/Illness
☐ WSIB Form 8 – Health Professional's Report