

This form is to be completed for all safety incidents.

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| **INCIDENT REPORT DETAILS** | | | | |
| Date of the Incident: |  | Time of Incident: | |  |
| Incident Reported By: | Name: | ☐ Employee ☐ Contractor  ☐ Civilian ☐ Sub-contractor | | |
| Project Relation: | ☐ Construction project  ☐ Maintenance work  ☐ Other/ None | Project Name: | Contract No: | Incident Report No: |
| Project Manager: | Name: | PM Email: | | |
| Location of the Incident: | Directorate: | Region: | Branch: | |
|  | Road Name: | Road Number: | SLK: | GPS Location: |
|  | ☐ DAC  ☐ HVS  ☐ MEB  ☐ TOC | ☐ Regional Office:  ☐ Laboratory: | | ☐ Depot:  ☐ Road Staff  ☐ Other:  ☐ Floor: |
| Outcome of the Incident: | ☐ Lost Time Injury  ☐ Medically Treated Injury  ☐ First Aid Injury  ☐ Near Miss  ☐ Damage | | Incident Notification:  For Serious Incidents:  Date Notified: | |
| **DESCRIPTION OF THE INCIDENT** | | | | |
| Type of incident:  (Check the appropriate boxes, can be multiple selections)  Please clarify, if needed:  Does this incident involve a member of the public? | ☐ Safety | | ☐ Health | |
| ☐ Slips/Trips/Falls  ☐ Plant and Equipment  ☐ Cranes and Lifting  ☐ Working at Height  ☐ Confined Space  ☐ Vehicles and Driving  ☐ Traffic Management  ☐ Hand Held Tools  ☐ Electrical  ☐ Excavation/Trenching  ☐ Hazardous Substances  ☐ Hot Work  ☐ Foreign Objects  ☐ Injections  ☐ Ergonomics  ☐ Other (Specify):  ☐ Yes ☐ No | | ☐ Ergonomics  ☐ Asbestos  ☐ Dust  ☐ Bites/Stings  ☐ Chemical Exposure  ☐ Noise Exposure  ☐ Alcohol and Drugs  ☐ Fatigue  ☐ Needle Stick  ☐ Vibration  ☐ Viral/Bacterial  ☐ Mental Health  ☐ Health  ☐ Other (specify):  Other:  ☐ Process Loss  ☐ Production Loss  ☐ Damage Reputation  ☐ Disruption to a Community  ☐ Exposure to Legal Liability  ☐ Security Threat | |
| Incident Description:  (Step by step account of the incident) |  | | | |
| What are the existing controls in place? |  | | | |
| **Corrective Actions** | **Action Description** | **Responsible Person and Role** | **Due Date** | **Completion Date** |
| Controls are put in place before and after the incident to rectify, contain, or remedy the situation |  |  |  |  |
| Persons Involved | Name: | Job Title: | Employee Type: | |
| (1)  (2)  (3)  (4)  (5) | (1)  (2)  (3)  (4)  (5) | (1)  (2)  (3)  (4)  (5) | |
| What was the actual consequence? | ☐ Insignificant | ☐ Minor | ☐ Moderate | ☐ Catastrophic |
| What was the potential outcome? | ☐ Low  Complete Incident report | ☐ Medium  5 Why’s or equivalent investigation | ☐ High  ICAM or equivalent investigation | ☐ Very high  ICAM or equivalent investigation |
| What is the risk rating after the controls are put in place? | ☐ Low | ☐ Medium | ☐ High | ☐ Very high |
| Is this incident required to be reported? | ☐ Yes ☐ No | | Report Made By: | |
| Reference No: | | Report Date: | |
| INJURY DETAILS (only if applicable, if the incident resulted in a personal injury): | | | | |
| How was the injury sustained? | ☐ Fall from a height  ☐ Slips and trips  ☐ Vehicle incident  ☐ Musculoskeletal  ☐ Repetitive movement with low muscle loading  ☐ Exposure to mental health factors  ☐ Exposure to vibration | | ☐ Exposure to noise  ☐ Contact with a chemical  ☐ Cuts, abrasions, and lacerations  ☐ Contact to heat and cold  ☐ Contact with electricity  ☐ Insect bites and stings  ☐ Unspecified mechanisms of injury or other | |
| Treatment given and assessed by: | Name: | | Job title: | |
| Type of treatment given: | ☐ None ☐ First Aid ☐ Medical ☐ Emergency Department | | | |
| Work-related injury | ☐ Yes ☐ No | | | |
| Bodily location of the injury:  (Please select all that apply) | ☐ Eye  ☐ Face  ☐ Ear  ☐ Neck  ☐ Head | ☐ Shoulders and arms  ☐ Hands and fingers  ☐ Back  ☐ Hips and legs  ☐ Feet | | ☐ Internal organs  ☐ Trunk  ☐ General and unspecified locations |
| Comments: |  | | | |