Incident Investigation

Purpose / Background
Incidents are undesirable events that may result in harm to the environment, human health or safety, or property. The purpose of incident investigation is to identify causes and implement corrective actions in order to prevent future incidents from occurring. When root causes as well as more direct causes of incidents are sought, systemic shortcomings may be identified and corrected, with the goal of improving Institute-wide EHS performance, as per the MIT EHS Policy. This SOP describes procedures for investigating incidents at MIT.

1. Scope
The body of this SOP describes processes for incident investigation at MIT. Appendix B and several of the references give additional information on investigation theory as well as suggested practices for conducting an investigation.

This SOP describes procedures for investigating incidents, which should be distinguished from “findings”. Findings are undesirable situations or practices that have the potential to cause or contribute to an incident, but have not yet done so. Findings are often identified during an inspection. For example, a laboratory inspection may identify poor hazardous waste labeling practices, required training that has not been completed, or an inaccessible emergency shower. Findings are important to track and correct. Findings and related corrective actions will generally be tracked in the Inspection database, not through the Incident Reporting and Investigation systems.

Procedures for Supervisors, Principal Investigators, and others to use in reporting occupational injuries or illnesses are described in the SOP on Reporting Work-Related Injuries and Illnesses, but investigations related to these injuries or illnesses are covered by this SOP.

2. Prerequisites
No prerequisites are required.

3. Procedures
Individual aspects of the investigation program are discussed below. Many aspects have been summarized in the Incident Investigation Matrix (Appendix A).

4.1 Incident Levels
The MIT Emergency Response System defines three levels of incidents, designated as Level 1-3. For the purposes of Incident Investigation; EHS further subdivides Level 1 incidents into Level 1A and Level 1B, as follows. Each of these four Levels is shown on a separate page in the Incident Investigation Matrix (Appendix A).

Level 1A Incident: A very minor local incident that is quickly resolved with existing MIT resources and which does not require additional monitoring. This level of emergency includes injuries which are very minor and do not result in medical treatment beyond first aid or in days away from work, restricted work or job transfer (other than on the day of the injury).

Examples of incidents in this category might include:
- a minor cut or small bruise

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minor smoke contained in a lab hood, with no significant damage or disruption to work beyond the initial response
- a minor chemical spill in a secondary containment bin or on a bench top
- odor complaints which are resolved and require no further monitoring

**Level 1B Incident:** A relatively minor local incident that is quickly resolved with existing MIT resources or limited outside help. This type of emergency has little or no impact on personnel or normal operations or facilities outside the locally affected area.

Examples might include:
- an injury which results in restricted work or job transfer or less than 5 days away from work
- smoke or a small fire causing only minimal damage in a single lab room
- a minor spill on the floor
- odor complaints requiring some follow-up

**Level 2 Incident:** A critical incident emergency that disrupts a material portion of the campus community (i.e., section of a building or larger), or a serious injury resulting in 5 or more days away from work but not in-patient hospitalization. These emergencies may require assistance from or notification to external organizations. These incidents may escalate quickly, threaten to cause injury or loss of life and have serious consequences for mission-critical functions, loss of material resources and/or special liability problems for the campus.

Examples of Level 2 incidents include:
- serious injuries resulting in 5 or more days away from work
- needle sticks
- a fire or explosion causing or with the potential to cause significant damage to a single building
- a major flood
- an major spill which posed a threat of environmental release

**Level 3 Incident:** A very serious injury resulting in in-patient hospitalization or fatality, or a disaster involving the entire campus and surrounding community. Incidents resulting in in-patient hospitalization of three or more workers or any worker fatalities require MIT to notify outside agencies and must be reported to the EHS Office immediately (2-3477). A level 3 disaster would cause Institute operations to be suspended and the effects of the disaster would be wide-ranging. Resolution of the disaster would require Institute-wide cooperation and extensive coordination with external resources.

Examples might include:
- an employee fatality
- a fire involving significant damage to more than one building
- a severe hurricane or major earthquake
- a major environmental release
- a terrorist action

**4.2 Incident Types**
For the purposes of investigation, MIT EHS recognizes five incident types:
1. Work-related injuries, illnesses or fatalities involving MIT employees or students
2. Injuries, illnesses or fatalities which are not work-related

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3. Fires, explosions or property damage
4. Hazardous materials spills or releases
5. Near misses

These five incident types are each represented in one of the five columns in the Investigation Matrix.

The MIT Police investigate crimes; EHS will assist if requested. Utility emergencies are investigated by Facilities; again, EHS will provide assistance if requested. No additional EHS investigations of these types of incidents will normally be required.

No investigation of the cause of natural disasters themselves is necessary, although other incidents caused by a natural disaster may need to be investigated. For example, an earthquake might cause chemical containers stored on open shelves to fall off the shelves and unsecured gas cylinders to fall over. Investigation might result in a program to better protect laboratories from future earthquake damage.

### 4.3 Determining the Incident Level and Type

It is primarily the responsibility of the Preferred Investigator(s) (see section on Investigation Team, below) to classify the incident as to level and type. In several cases, decisions about incident levels are based on whether the victim received medical treatment beyond first aid. First aid is defined on page 6 of the matrix.

In some cases Investigation Team members may choose to elevate a Level 1A incident to Level 1B or higher if they will be participating in the investigation and they believe that a more rigorous investigation is required. For this reason, initial communication among these individuals about the incident should include the proposed level of the incident.

For incidents where it is not clear if an EHS investigation is needed or how to classify the incident, a Deputy Director or the Director of the EHS Office shall make this decision.

### 4.4 Investigation Team

In many cases the EHS Responder(s) involved in the initial incident will initiate the investigation. The person(s) who will generally be in the best position to investigate different types of incidents are listed in the “Preferred Investigator” rows of the Incident Investigation Matrix. Others who should be notified before an investigation begins, in case they would like to take part in the investigation, are listed in the “Notify” row. If an investigation team is formed, a team leader should be chosen to coordinate the investigation. A number of EHS staff are trained and certified in Incident Investigation and are available to lead or advise investigation teams; for Level 2 and higher incidents a certified investigator from EHS should be included on the team. The Deputy Director of the Safety Program will maintain the list of certified investigators.

Certain types of incidents may require representation of specific additional investigators (for example, EHS Biosafety or Industrial Hygiene programs) on the investigation team. Page 5 of the Incident Investigation Matrix contains a list of these incident types and the additional investigators who should be involved in these investigations.

### 4.5 Timing of the Investigation

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Completing the investigation in a timely manner is important to obtaining accurate and complete information about an incident. The Incident Investigation Matrix contains a suggested time frame for initiating and completing investigations; every effort should be made to stay within this time frame except when unusual circumstances prevent doing so. For example, very complex investigations or investigations where outside consultation or testing is required might require extra time to complete. In this case an interim report may be appropriate. Steps should be taken to correct any ongoing hazardous conditions as soon as they are identified, rather than waiting for the investigation to be completed.

### 4.6 Reporting of Incidents and Initiation of Investigations

The table below summarizes the role of EHS in initiating an investigation for different types of incidents. Work-related injuries and illnesses are reported to EHS via the Supervisor’s Report system, described in detail in the SOP on Reporting Work-Related Injuries and Illnesses. The Safety Program receives and reviews these reports and monitors lost time data, and will work with Supervisors to notify the Lead Contact about Level 1B and higher incidents, and to set up an investigation team for Level 2 and 3 incidents of this type.

EHS is notified of other incidents in a number of ways. Notification may come via the EHS Emergency Response system, through a faxed Police Report from MIT Police, through the Day Call system, or by other means. When an EHS Staff member needs to initiate an investigation, that EHS Staff member may lead the investigation team or another member of the EHS staff may agree to lead the team. DLC personnel involved in the incident are also expected to participate in the investigation.

<table>
<thead>
<tr>
<th>Type of Incident</th>
<th>Notified By</th>
<th>Who Receives Notification</th>
<th>Who initiates the investigation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work-related injury</td>
<td>Supervisor’s Report System</td>
<td>EHS OSHA Record keeper, Safety Program, EHS lead contact</td>
<td>Supervisor, with offer of EHS assistance if Level 1B or higher or EHS lead contact</td>
</tr>
<tr>
<td>Emergency incident</td>
<td>EHS Response System</td>
<td>EHS Primary and/or Secondary Responders</td>
<td>EHS Secondary Responder</td>
</tr>
<tr>
<td>Crime or injury</td>
<td>Police Report faxed to Safety</td>
<td>Safety Program</td>
<td>Safety Program</td>
</tr>
<tr>
<td>Day Call</td>
<td>Phone call to EHS Office</td>
<td>Day Call Responder</td>
<td>Day Call Responder</td>
</tr>
<tr>
<td>Various</td>
<td>Coordinator, Rep, or other DLC source</td>
<td>Lead Contact or Team Member</td>
<td>Lead Contact or Team Member</td>
</tr>
</tbody>
</table>

* For Level 2 and higher incidents, an EHS staff member certified in incident investigation should be included on the investigation team.

### 4.7 Incident Investigation Report Approval and Distribution

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The Incident Investigation Report form given in Appendix B, or another form or format chosen by a given Department, Laboratory or Center (DLC), may be used in conjunction with this procedure. In many cases the EHS Incident Emergency Response Template (Appendix C), which is used for many day calls, may suffice for documenting investigation of an incident.

The Incident Investigation Matrix contains a suggested list of persons who should review and approve the completed Incident Investigation Report, and a list of those persons in addition to the investigation team who should receive copies of the report. Others may be included in the report distribution at the discretion of the investigation team.

A copy of each investigation report, regardless of the format, should be filed on the M drive so that it can be entered into the SAP Incident System.

4.8 Tracking Corrective Actions
When corrective actions are identified during an investigation, the investigation team should specify clearly who is responsible for implementing each corrective action and in what time frame. How completion of corrective actions will be tracked should also be determined. These issues can be included in the investigation report. If a corrective action is considered but then not implemented, the reasons for not implementing the action should also be documented in the report.

5. Roles & Responsibilities

Individuals/Witnesses:
Individuals who are involved in or witnesses to an incident shall assist in the investigation and the implementation of any corrective actions agreed upon by the investigation team.

Preferred Investigators:
Persons designated as Preferred Investigators in the Incident Investigation Matrix include supervisors, EHS Office staff, EHS Coordinators and Lead Contracts. Preferred Investigators shall perform or assist in the incident investigation as specified in the Incident Investigation Matrix. Preferred Investigators are responsible for notifying the individuals listed in the “Notify” row of the Incident Investigation Matrix. They are also responsible for implementing any agreed-upon corrective actions assigned to them by the investigation team.

“Notified” Persons
Persons listed in the “Notify” row of the Incident Investigation Matrix have the option to participate in investigations of which they are notified. If notified of a Level 1A investigation, they have the option to request that the incident be escalated to a higher level if they believe that a more thorough investigation is warranted. If “Notified Persons” choose to participate in an investigation, they are responsible for implementing any agreed-upon corrective actions assigned to them by the investigation team.

EHS Office – DLC Lead Contact:
Work-related injuries and illnesses that are reported through the on-line Supervisors Report of Injury will be automatically forwarded to the EHS office lead contact person. Upon receiving this notification of injury, the DLC lead contact shall work in conjunction with the DLC in question to ensure that any injury or illness causal factors are addressed in a timely manner. It is important to note that the information provided by the automatic e-mail to lead contacts may include sensitive information that should only be shared with others participating in any investigation or after action review.

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injury that meet the definition of a 1B incident as described in section 4.1 of this document must be investigated and documented electronically through the EHS website at the following address: https://ehs.mit.edu/site/ehsnet or by a written accident investigation report as described above in section 4.7. Copies of investigation reports must be forwarded to the OSHA recordkeeper to be included in the individual injury files.

**EHS Office – Safety Program:**
For injuries and illnesses that meet OSHA’s definition of a Privacy Concern Case, the worker’s name and any other information that might be used to identify the worker shall be deleted from any information that is forwarded.

The Safety Program shall ensure that results of investigations are provided to the Departments, Labs and Centers (DLCs). This may involve two forms of reporting – copies of the Incident Investigation Report to the DLC(s) directly involved with an investigation, and periodic incident summaries for DLCs.

The Safety Program shall provide training in the procedures for reporting and investigating incidents, and shall be responsible for coordinating a periodic audit of the effectiveness of the reporting and investigating programs.

**EHS Office – Biosafety, Radiation Protection, Environmental Management, Industrial Hygiene and Safety Programs and Lead Contacts**

The EHS Office staff shall participate as needed in incident investigations in their roles as EHS Responders, Lead Contacts and when participation of a specific program is required by the nature of the incident (see page 5 of the Incident Investigation Matrix for some examples of such incidents).

EHS Office staff shall also participate as necessary in the identification, implementation and follow up of corrective actions in their roles as members of the investigation team.

**EHS - OSHA Record keeper:**
The EHS Office OSHA Record keeper shall notify the Safety Program of Supervisor’s Reports of Occupational Injury or Illness, or other incident reports, if not received through the online system.

**6. Training**
Training and certification in Incident Investigation is offered by the EHS Office Safety Program. It is highly recommended that at least one member of each investigation team investigating level 2 or 3 incidents be certified in incident investigation.

**7. Monitoring Requirements**
The Safety Program shall be responsible for coordinating a periodic audit of the effectiveness of the reporting and investigating programs.

**8. Record Management**
At MIT, all records of injuries and illnesses, all Incident Reports, and all Incident Investigation records shall be retained for at least six years as prescribed in the Records Retention Schedule in the EHS Records Retention SOP.
9. References

9.1 Standards
Code of Federal Regulations, Part 1904, Recording and Reporting Occupational Injuries and Illness
Massachusetts General Laws, Chapters 151,152
Code of Massachusetts Regulations, 452

9.2 Other SOP/ SOGs
SOP for Reporting Work-Related Injuries and Illnesses
SOP for EHS Records Retention

9.3 Supplementary Documents
Appendix A: Incident Investigation Matrix
Appendix B: MIT Incident Investigation Guidelines and Report
Appendix C: EHS Incident Emergency Response Template

9.4 Reference Materials
Oakley, Jeffrey S. Accident Investigation Techniques: Basic Theories, Analytical Methods, Applications
ASSE, Des Plaines, IL, 2003

10. Definitions

Certified Investigator – An individual who has completed Incident Investigation training through MIT EHS. This training includes a classroom component and a mentored investigation of one or more actual incidents. For level 2 and 3 incidents, it is recommended that one member of the team be certified in incident investigation.

Days Away – An injury or illness is said to result in “Days Away” if as a result of the injury or illness, the injured or ill person misses a day or more of work other than the day on which the injury occurred or the illness began.

Finding – A finding is an undesirable situation or practice, identified by inspection or other means, which has the potential to cause or contribute to an incident, but has not yet done so.

First Aid – See page 6 of the Incident Investigation Matrix for the definition of first aid used by OSHA, which is relevant to the SOP.

Incident – An incident is any undesired occurrence that results in harm to human health or safety, the environment, or property. Examples of incidents include injuries, events such as fires, explosions, floods, natural disasters, hazardous material incidents, and near misses.

Job Transfer – Job transfer occurs when the MIT supervisor assigns an injured or ill worker to another job for all or part of a day (other than the day on which the injury or illness occurred) as a result of the injury or illness.

Major Spill – A Major Spill is defined by the EHS Industrial Hygiene Program as one in which ANY of the following conditions apply: the responsible party is unknown (it’s an “orphan” spill); the material spilled is unknown; the material spilled is highly toxic; a large (or undetermined) quantity was spilled; a significant fire hazard may be present; the material has the potential to reach the environment (e.g.,
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### Appendix A: Incident Investigation Matrix

<table>
<thead>
<tr>
<th>LEVEL 1A Incidents</th>
<th>Work-Related Injury / Illness / Fatality</th>
<th>Non-Work-Related Injury /Fatality on MIT property</th>
<th>Fire/Explosion/Property Damage</th>
<th>Hazardous Materials Spill/Release</th>
<th>Near Miss</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1A-Definition</strong></td>
<td>Minor work-related injury or illness not resulting in any days away from work or restricted duty</td>
<td>Minor non-occupational injury not requiring medical treatment beyond first aid&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Minor smoke or a small quickly contained fire (for example in a fume hood) with no significant damage or disruption of work beyond initial response; no additional monitoring required</td>
<td>Minor spill; no disruption of work beyond initial response; no additional monitoring required</td>
<td>Incident with little or no potential to cause injury and potential to cause only minor property damage if repeated</td>
</tr>
</tbody>
</table>

**Preferred Investigator(s)**<sup>1, 2</sup>

- Supervisor
- PI or Other Reporter
- Supervisor or PI Other Reporter
- EHS Safety Program
- EHS Coordinator & Lead Contact
- EHS EMP and Safety Program
- EHS Coordinator & Lead Contact

**Notify**<sup>2</sup>

- EHS Coordinator, HR Workers’ Comp. and EHS Safety (all can be automatically notified via SAP when Sup’s Report is submitted)
- EHS Safety Program
- EHS Coordinator & Lead Contact
- Fire dept (if not involved and if a fire extinguisher was used)
- EHS EMP and Safety Program
- EHS Coordinator & Lead Contact

**Reporting and Investigation**

- **Report Incident**: Supervisor submits Supervisor’s Report within 1 business day of incident.
- **Report Incident**: Reporter contacts EHS within 1 business day; EHS completes Incident Report
- **Report Incident**: Sup/PI contacts EHS within 1 business day; EHS completes Incident Report
- **Report Incident**: Sup/PI contacts EHS within 1 business day; EHS completes Incident Report

**Approvals, Copies**

- Copies of Sup’s Rep go to: EHS Safety Program; limited info available to others via Brio report
- Copies to: M Drive Emergency folder & EHS Coord.
- Copies to: M Drive Emergency folder & EHS Coord.
- Copies to: M Drive Emergency folder & EHS Coord.

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1 Some incidents will require additional investigators – see page 5
2 Any of these stakeholders or others may request to elevate to level 1B, requiring investigation.
3 See page 6 for the definition of first aid
<table>
<thead>
<tr>
<th>LEVEL 1B Incidents</th>
<th>Work-Related Injury / Illness / Fatality</th>
<th>Non-Work-Related Injury / Fatality on MIT property</th>
<th>Fire/Explosion/Property Damage</th>
<th>Hazardous Materials Spill/Release</th>
<th>Near Miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1B-Definition</td>
<td>Work-related injury or illness resulting in days away from work or restricted duty, but not resulting in 5 or more days away from work</td>
<td>Non-occupational injury not resulting in medical treatment beyond first aid; but additional monitoring or restriction of activities recommended by health care professional</td>
<td>Significant smoke or a small fire (for example in a lab quickly extinguished); minor property damage only within a single room</td>
<td>Minor spill requiring some additional monitoring or resulting in disruption of work beyond initial response</td>
<td>Incident with potential to cause minor injury and/or significant property damage if repeated</td>
</tr>
<tr>
<td>Preferred Investigator(s)</td>
<td>Supervisor</td>
<td>PI (if applicable) or Other Reporter</td>
<td>Supervisor or PI or Other Reporter</td>
<td>Supervisor or PI or Other Reporter</td>
<td>EHS Safety Program</td>
</tr>
<tr>
<td>Notify (option to take part in investigation)</td>
<td>EHS Coordinator, HR Workers’ Comp. and EHS Safety (all can be automatically notified when Sup’s Report is submitted); Lead Contact (must be manually notified)</td>
<td>EHS Coordinator &amp; Lead Contact</td>
<td>EHS Coord. &amp; Lead contact Office of Ins. &amp; Risk Mngt Fire dept (if not involved and if a fire extinguisher was used.)</td>
<td>EHS Coordinator &amp; Lead Contact</td>
<td>EHS Coordinator &amp; Lead Contact</td>
</tr>
<tr>
<td>Reporting and Investigation</td>
<td>Report Incident: Sup submits Sup’s Report within 1 business day Complete Investigation: Sup or Team submits Investigation Report -- estimated timeframe to complete: 5-10 business days</td>
<td>Report Incident: Reporter contacts EHS within 1 business day; EHS completes Incident Report Complete Investigation: Team submits Investigation Report -- estimated timeframe to complete: 5-10 business days</td>
<td>Report Incident: Sup/PI contacts EHS within 1 business day; EHS completes Incident Report Complete Investigation: Team submits Investigation Report -- estimated timeframe to complete: 5-10 business days</td>
<td>Report Incident: Sup/PI contacts EHS within 1 business day; EHS completes Incident Report Complete Investigation: Team submits Investigation Report -- estimated timeframe to complete: 5-10 business days</td>
<td>Report Incident: Sup/PI contacts EHS within 1 business day; EHS completes Incident Report Complete Investigation: Team submits Investigation Report -- estimated timeframe to complete: 5-10 business days</td>
</tr>
<tr>
<td>Approvals, Copies of Investigation Report</td>
<td>Copies of Investigation Report to: M Drive Emergency folder; EHS Coord., OSHA recordkeeper, WC office</td>
<td>Copies of Incident and Investigation Reports to: M Drive Emergency folder; EHS Coord</td>
<td>Approval by: EHS Safety Program Deputy Director; Copies to: M Drive Emergency folder and EHS Coord.</td>
<td>Approval by: EHS EMP Staff; Copies to: M Drive Emergency folder &amp; EHS Coord</td>
<td>Approval by: EHS Safety Program Staff; Copies to: M Drive Emergency folder &amp; EHS Coord</td>
</tr>
</tbody>
</table>

1 Some incidents will require additional investigators – see page 5
3 See page 6 for the definition of first aid
<table>
<thead>
<tr>
<th><strong>LEVEL 2 Incidents</strong></th>
<th><strong>Work-Related Injury / Illness / Fatality</strong></th>
<th><strong>Non-Work-Related Injury / Fatality on MIT property</strong></th>
<th><strong>Fire/Explosion/Property Damage</strong></th>
<th><strong>Hazardous Materials Spill/Release</strong></th>
<th><strong>Near Miss</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level-Definition</strong></td>
<td>Work-related injury or illness resulting in 5 or more days away from work; all contaminated needles and other contaminated sharps injuries</td>
<td>Non-occupational injury resulting in medical treatment beyond first aid[^3] (but not in-patient hospitalization); all needles sticks</td>
<td>Fire, explosion or other incident involving significant damage to a single building</td>
<td>Major spill which posed possibility of environmental release (but no actual release occurred)</td>
<td>Incident with potential to cause serious injury and/or severe property damage if repeated</td>
</tr>
<tr>
<td><strong>Preferred Investigator(s) [^1]</strong></td>
<td>Supervisor EHS Coordinator and/or Lead Contact</td>
<td>PI (if applicable) or Other Reporter EHS Coordinator and/or Lead Contact</td>
<td>Supervisor or PI or Other Reporter EHS Safety Program (notifies EPO) EHS Coordinator and/or Lead Contact</td>
<td>Supervisor or PI or Other Reporter EHS EMP (notifies EPO) EHS Coordinator and/or Lead Contact</td>
<td>Supervisor or PI or Other Reporter EHS Safety Program</td>
</tr>
<tr>
<td><strong>Notify (option to take part in investigation)</strong></td>
<td>Other DLC EHS Team Members HR Workers’ Compensation</td>
<td>Other DLC EHS Team Members Office of Insurance &amp; Risk Mgmt</td>
<td>Office of Insurance &amp; Risk Mgmt</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting and Investigation</strong></td>
<td>Report Incident: Sup submits Sup’s Report within 1 business day Complete Investigation: Team submits Investigation Report -- estimated timeframe to complete: 5-10 business days</td>
<td>Report Incident: Reporter contacts EHS within 1 business day; EHS completes Incident Report Complete Investigation: Team submits Investigation Report -- estimated timeframe to complete: 10 business days</td>
<td>Report Incident: Sup/PI contacts EHS within 1 business day; EHS completes Incident Report Complete Investigation: Team submits Investigation Report -- estimated timeframe to complete: 10 business days</td>
<td>Report Incident: Sup/PI contacts EHS within 1 business day; EHS completes Incident Report Complete Investigation: Team submits Investigation Report -- estimated timeframe to complete: 10 business days</td>
<td></td>
</tr>
<tr>
<td><strong>Approvals, Copies</strong></td>
<td>Approval by: EHS Safety Program Dep. Director Copies of Investigation Report to: M Drive Emergency folder; EHS Coord, OSHA recordkeeper, WC office</td>
<td>Approval by: EHS Safety Program Deputy Director Copies to: M Drive Emergency folder; EHS Coord</td>
<td>Approval by: EHS Safety Program Deputy Director Copies to: M Drive Emergency folder; Dep. Dirs.</td>
<td>Approval by: EHS EMP Deputy Director Copies to: M Drive Emergency folder; Dep. Dirs.</td>
<td>Approval by: EHS Safety Program Deputy Director Copies to: M Drive Emergency folder; EHS Coord</td>
</tr>
</tbody>
</table>

[^1]: Some incidents will require additional investigators – see page 5  
[^3]: See page 6 for the definition of first aid
<table>
<thead>
<tr>
<th>Level 3 Incidents</th>
<th>Work-Related Injury / Illness / Fatality</th>
<th>Non-Work-Related Injury /Fatality on MIT property</th>
<th>Fire/Explosion/Property Damage</th>
<th>Hazardous Materials Spill/Release</th>
<th>Near Miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3-Definition</td>
<td>Very serious work-related injury or illness resulting in in-patient hospitalization; employee fatality</td>
<td>Non-occupational injury resulting in in-patient hospitalization; non-employee fatality</td>
<td>Fire, explosion or other incident involving significant damage to more than one building</td>
<td>Major spill with actual environmental release</td>
<td>Incident with potential to cause fatality and/or very severe property damage if repeated</td>
</tr>
<tr>
<td>Preferred Investigator(s)</td>
<td>Supervisor EHS Safety Program (must be notified immediately); notifies EPO/other programs EHS Coordinator &amp; Lead Contact</td>
<td>PI (if applicable) or Other Reporter EHS Safety Program (notifies EPO) EHS Coordinator &amp; Lead Contact</td>
<td>Supervisor or PI or Other Reporter EHS Safety Program (notifies EPO) EHS Coordinator &amp; Lead Contact</td>
<td>Supervisor or PI or Other Reporter EHS EMP (notifies EPO) EHS Coordinator &amp; Lead Contact</td>
<td>Supervisor or PI or Other Reporter EHS Safety Program (notifies EPO) EHS Coordinator &amp; Lead Contact</td>
</tr>
<tr>
<td>Approvals, Copies</td>
<td>Approval by: Dir EHS Copies to of Investigation Report to: M Drive Emergency folder; Dep Dirs, OSHA recordkeeper, WC office</td>
<td>Approval by: Dir EHS Copies to: M Drive Emergency folder; Dep Dirs</td>
<td>Approval by: Dir EHS Copies to: M Drive Emergency folder; Dep Dirs</td>
<td>Approval by: Dir EHS Copies to: M Drive Emergency folder; Dep Dirs</td>
<td>Approval by: Dir EHS Copies to: M Drive Emergency folder; Dep Dirs</td>
</tr>
</tbody>
</table>

1 Some incidents will require additional investigators – see page 5
**Incidents Requiring Participation of Certain Investigators on the Investigation Team**

<table>
<thead>
<tr>
<th>Incident Involves</th>
<th>Additional Investigators – also notify</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exposure to hazardous biological agents, including human blood, cells or tissues.</td>
<td>Biosafety Program (BSP) Team Member</td>
</tr>
<tr>
<td>• All injuries from contaminated sharps including contam needlesticks</td>
<td></td>
</tr>
<tr>
<td>• Animal bites or scratches</td>
<td></td>
</tr>
<tr>
<td>• Radioactive materials incident</td>
<td>Radiation Protection Program Team Member</td>
</tr>
<tr>
<td>• Laser or other non-ionizing radiation incident</td>
<td></td>
</tr>
<tr>
<td>• Exposure to radiation from radiation-producing machines (accelerator, X-ray machine)</td>
<td></td>
</tr>
<tr>
<td>• Exposure to radiation or other radiation-related incident at nuclear reactor</td>
<td></td>
</tr>
<tr>
<td>• Exposure to hazardous chemicals</td>
<td>Industrial Hygiene Program (IHP) Team Member</td>
</tr>
<tr>
<td>• Noise exposures, thermal stress (hot or cold environment), asbestos</td>
<td></td>
</tr>
<tr>
<td>• Ergonomic / Repetitive strain injuries</td>
<td></td>
</tr>
<tr>
<td>• Occupational illnesses (skins diseases, respiratory conditions, poisoning…)</td>
<td>IHP and BSP Team Members</td>
</tr>
<tr>
<td>• Hazardous materials spill or release</td>
<td>IHP and Environmental Management Program Team Members</td>
</tr>
</tbody>
</table>
What is « medical treatment beyond first aid »?
Per the OSHA Recordkeeping Standard, the following are considered « first aid »:

- Visits to a physician or other licensed health care professional solely for observation or counseling;
- The conduct of diagnostic procedures, such as x-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes (e.g., eye drops to dilate pupils); or
- Using a non-prescription medication at nonprescription strength (for medications available in both prescription and non-prescription form, a recommendation by a physician or other licensed health care professional to use a non-prescription medication at prescription strength is considered medical treatment for recordkeeping purposes);
- Administering tetanus immunizations (other immunizations, such as Hepatitis B vaccine or rabies vaccine, are considered medical treatment);
- Cleaning, flushing or soaking wounds on the surface of the skin;
- Using wound coverings such as bandages, Band-Aids™, gauze pads, etc.; or using butterfly bandages or Steri-Strips™ (other wound closing devices such as sutures, staples, etc., are considered medical treatment);
- Using hot or cold therapy;
- Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc. (devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment for recordkeeping purposes);
- Using temporary immobilization devices while transporting an accident victim (e.g., splints, slings, neck collars, back boards, etc.).
- Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister;
- Using eye patches;
- Removing foreign bodies from the eye using only irrigation or a cotton swab;
- Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means;
- Using finger guards;
- Using massages (physical therapy or chiropractic treatment are considered medical treatment for recordkeeping purposes); or
- Drinking fluids for relief of heat stress.

Are any other procedures included in first aid? No, this is a complete list of all treatments considered first aid for Part 1904 purposes.
Appendix B: Incident Investigation Guidelines and Form

Guidelines for conducting an incident investigation and an optional Incident Investigation form are given below. DLCs choosing to use their own forms should develop similar guidelines.

Step 1: The Initial Facts
The first job of the investigator(s) is to gather the initial facts about an incident. Sections 1.0 through 5.0 of the Incident Investigation form will guide the investigators through this portion of the investigation. The EHS Incident Emergency Response Template (Appendix C) may be helpful for taking notes.

As soon as possible, one or more of the investigators should go to the scene and check the conditions. In doing so, investigators should be conscious of safety considerations and be careful not to put themselves in danger. Clearance to enter the incident scene should be obtained from emergency responders; entry should never be attempted if there is any question as to whether conditions are safe, and proper protective equipment should be worn. Possible hazards of an incident scene might include structural issues; utility issues; electrical hazards; standing water; hazardous atmospheres; chemical, biological and radiological hazards; and hazards caused by the recovery process itself (construction or hazardous waste removal for example).

Witnesses should be interviewed as soon as possible. Depending on the nature of the incident, witnesses might be asked about the normal state of operations and/or procedures, the pre-incident state of the scene, discovery of the incident, the course of the incident, and efforts made at controlling the incident. In some cases the investigator(s) may wish to take measurements, samples or photos, make drawings, or re-enact the incident to verify the scenario. If other entities, such as the fire department, are also conducting investigations, the investigator(s) should be in communication with these entities to share information.

Fact-finding, not fault finding is the key to successful investigations. In approaching and interviewing individuals involved in an incident, the investigator(s) should emphasize that the goal of discovering causes is to prevent future incidents, not to place blame for the current incident.

Step 2: Direct Causes
Once the initial facts about an incident are clear, the direct or immediate cause or causes should be determined. There will very often be more than one direct cause that contributes to an incident. The investigator(s) should review the actions of any people involved in the incident and the conditions under which the incident occurred, and identify behaviors or conditions that directly contributed to the incident. For example, in an incident where an individual in the Facilities Department is seriously injured when the head of the hammer he is using separates from the wooden handle and hits him in the eye, the direct cause of his injury might include failure to inspect the hammer before use and failure to wear safety glasses.

It is important to focus on identifying actions or conditions and not making judgments regarding fault. Some possible contributing causes are listed in Section 6.0 of the Incident Investigation form.
**Step 3: Root Causes**

Next, with an understanding of behaviors and conditions that could have been better, the investigator(s) should start to make some judgments regarding the root causes of the incident. What underlying factors lead to the unsatisfactory actions and conditions that have been identified as direct causes?

Section 7.0 of the Incident Investigation form lists a number of possible root causes of unsatisfactory behaviors, and some examples or guidance related to each root cause. Did the injured person not know the rules or operating procedures? Did the injured person lack the ability and skills to follow the procedure? Or was it a situation where the person knew the rules and had the ability to follow them, but didn't do so due to some other factor(s)?

Similarly, root causes of unsatisfactory conditions should be determined. Were the conditions inappropriate because design needed to be better, or should maintenance have been improved? Experts should be consulted regarding safety standards if necessary.

In the case of the hammer injury described in Step 2, above, root causes might include failure to implement or train workers in a program requiring inspection of tools before use and failure to perform a hazard assessment of the hammering task (which would have indicated that safety glasses should be worn).

**Step 4: Corrective Actions**

For each root cause identified, the investigator(s) should recommend corrective actions that need to be taken. Those corrective actions may involve behavior changes by the injured person, the supervisor, or others. Corrective actions can include development of better procedures, better enforcement of the procedural requirements, or changes in the conditions by better design or maintenance. Corrective actions recommended for the hammer injury might include implementation of a department-wide tool inspection program and a plan to perform hazard assessments for hammering and similar tasks.

Involving those who will need to implement the corrective actions in the discussion at this point is important, as alternatives may need to be considered and issues of cost and timing will need to be addressed. The agreed-upon corrective actions, the responsible persons and the target dates for completion should be documented on the Incident Investigation form in Section 8.0.

**Step 5: Follow Up**

Ensuring that corrective actions are implemented is important in reducing and eliminating injuries. The investigator(s) should follow up on the implementation of the corrective actions. The right-hand column in Section 8.0 of the Incident Investigation form should be used to document the date of actual implementation of corrective actions; this column can be updated after the initial Incident Investigation report has been completed.
## 1.0 Incident Information

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>Time of Incident</th>
<th>Incident Location (building, room number, street, etc.)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of Incident</th>
<th>Occ. Injury</th>
<th>Non-Occ. Injury</th>
<th>Fire/Explosion</th>
<th>Haz. Mat. Spill/ Release</th>
<th>Near Miss</th>
<th>Other (describe below):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Witness Names and Contact Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  statement attached</td>
</tr>
<tr>
<td>2.  statement attached</td>
</tr>
<tr>
<td>3.  statement attached</td>
</tr>
</tbody>
</table>

## 2.0 Incident Description: Describe the facts of what happened. Include machine, tool, task, object, or substance involved. Be specific regarding what, when, where, and how the incident occurred. Attach supporting documentation and additional pages if necessary for description, photos, drawings, procedures, etc.
### 3.0 Injured Person Information
Sections 3.0 through 5.0 may be copied and pasted if multiple persons were injured.  

<table>
<thead>
<tr>
<th>Name (First, MI, Last):</th>
<th>MIT ID Number (if applicable):</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIT Affiliation or Job Title:</td>
<td>Department (if applicable):</td>
<td>Male □ Female □</td>
</tr>
</tbody>
</table>

Additional Information:

**Supervisor Information:** Name (First, MI, Last) (if applicable)  

☐ Supervisor's Report of Occupational Injury/Illness attached

**Supervisor Telephone No. (if applicable):**

### 4.0 Injury and Illness Categories:

<table>
<thead>
<tr>
<th>☐ Near Miss</th>
<th>☐ First Aid</th>
<th>☐ OSHA Recordable</th>
<th>☐ Work Restriction</th>
<th>☐ Lost workday</th>
<th>☐ Fatality</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Struck by or against (01)</td>
<td>☐ Slip/Trip/Fall (02)</td>
<td>☐ Fall from elevation (03)</td>
<td>☐ Caught in or between (04)</td>
<td>☐ Lifting (05)</td>
<td>☐ Repetitive motion (06)</td>
</tr>
<tr>
<td>☐ Pushing/Pulling (07)</td>
<td>☐ Other bodily motion (08)</td>
<td>☐ Chemical exposure (09)</td>
<td>☐ Thermal burn (10)</td>
<td>☐ Physical agent (11)</td>
<td>☐ Biological agent exposure: Lab microorganism (12)</td>
</tr>
<tr>
<td>☐ Biological agent exp.: Human source material (13)</td>
<td>☐ Biological agent exp.: Research animal bite / scratch (14)</td>
<td>☐ Biological agent exp.: Wild animal or insect bite / scratch (15)</td>
<td>☐ Needlestick (16)</td>
<td>☐ Cut by (17)</td>
<td>☐ Motor vehicle (18)</td>
</tr>
<tr>
<td>☐ Illness (19)</td>
<td>☐ Other: (20)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments / Additional Information:

### 5.0 Injury Types / Body Parts: (Check one or more from each column)

| ☐ Sprain/Strain/Tear (21) | ☐ Bruise / Contusion (22) | ☐ Cut/Laceration/Abrasion (23) | ☐ Amputation/Crush (24) | ☐ Repetitive Stress/ Strain Injury (25) | ☐ Burn ☐ Thermal (26) ☐ Chemical (27) |
| ☐ Hernia (28) | ☐ Fracture (29) | ☐ Foreign Body (30) | ☐ Pain (31) | ☐ Skin Disorder (32) | ☐ Multiple Injury (33) |
| ☐ Other (34) | ☐ Eye (41) | ☐ Head (42) | ☐ Neck (43) | Arm/Elbow/Shoulder (44) | Hand/Finger/Wrist (45) |
| ☐ Back (46) | ☐ Trunk (47) | ☐ Leg/Knee/Ankle (48) | ☐ Foot/Toes (49) | ☐ Body Systems (50) | ☐ Lung / respiratory system (51) |
| ☐ Multiple Body Parts (52) | ☐ Other (53) |

Comments / Additional Information:

If additional documentation is available, please check box and note reference.
### 6.0 Direct Causes: (Check all that may apply in each column.)

<table>
<thead>
<tr>
<th>Contributing Acts &amp; Behaviors</th>
<th>Contributing Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Operating equipment improperly</td>
<td>☐ Inadequate warning system</td>
</tr>
<tr>
<td>☐ Failure to secure or lockout</td>
<td>☐ Inadequate or improper PPE</td>
</tr>
<tr>
<td>☐ Defeating or removing safety devices</td>
<td>☐ Fire or explosion hazards</td>
</tr>
<tr>
<td>☐ Using defective or improper tools / equipment</td>
<td>☐ Exposure to noise</td>
</tr>
<tr>
<td>☐ Improper use of tools</td>
<td>☐ Ionizing/Non-ionizing energy exposure</td>
</tr>
<tr>
<td>☐ Improper use of, or failure to use PPE</td>
<td>☐ Temperature extremes</td>
</tr>
<tr>
<td>☐ Improper lifting or loading</td>
<td>☐ Repetitive task exposures (Poor ergonomic design)</td>
</tr>
<tr>
<td>☐ Failure to follow safe procedure</td>
<td>☐ Inadequate illumination</td>
</tr>
<tr>
<td>☐ Improper position for task</td>
<td>☐ Inadequate ventilation - gas, dust , fumes</td>
</tr>
<tr>
<td>☐ Horseplay</td>
<td>☐ Weather related</td>
</tr>
<tr>
<td>☐ Took shortcut</td>
<td>☐ Congestion or restricted motion activity</td>
</tr>
<tr>
<td>☐ Other’s action or inaction resulted in the injury</td>
<td>☐ Poor housekeeping, disorderly work area, physical layout</td>
</tr>
<tr>
<td>☐ Improper vehicle operation</td>
<td>☐ Defective tools, materials or equipment</td>
</tr>
<tr>
<td>☐ Workplace violence</td>
<td>☐ Inadequate guards or barriers in place</td>
</tr>
<tr>
<td>☐ Other Contributing Acts &amp; Behaviors:</td>
<td>☐ Other Contributing Conditions:</td>
</tr>
</tbody>
</table>

### 7.0 Root Causes: (Check all that may apply.)

#### Root Causes of Inappropriate Acts & Behaviors

**Knowledge**
- ☐ The hazard was not recognized.
- ☐ The hazard was not fully understood.
- ☐ Training not conducted on established procedures.
- ☐ Policies and procedures were not established or not updated.
- ☐ Policies/procedures did not adequately address known hazards.
- ☐ Other:

**Ability**
- ☐ Specific job training not conducted
- ☐ On the job training program not sufficient
- ☐ Job skills not developed
- ☐ Job task exceeded physical capability
- ☐ Job task exceeded cognitive capability
- ☐ Other:

**Motivation**
- ☐ Competing priorities interfered with proper behaviors
- ☐ Desire to complete task quickly
- ☐ Distracted by other situations

#### Examples / Guidance

- **Knowledge**
  - Wet lab located above computer room was not recognized as a hazard until after incident
  - Individual working with a chemical did not realize extent of hazard (toxic as well as flammable)
  - Relevant training not available, or Individual did not attend required classroom training on relevant topics
  - Chemical Hygiene Plan, Exposure Control Plan, LOTO program or procedures missing or outdated
  - Chemical Hygiene Plan, Exposure Control Plan, LOTO program or procedures inadequate

- **Ability**
  - On the job training did not occur
  - On the job training relevant to the incident occurred but did not sufficiently cover topics relevant to the incident
  - New task; Individual inexperienced at performing task
  - Too heavy a lift required, job tasks involves repetitive motion
  - Worker not qualified for job; better worker choice necessary

- **Motivation**
  - PPE is uncomfortable to wear; comfort takes priority over safety
  - Failure to take time to perform Lockout Tagout or to don PPE
  - Physical distractions (people, other operations, noise) or mental distractions (what else is going on in the person’s life)
<table>
<thead>
<tr>
<th>Root Causes of Inappropriate Conditions</th>
<th>Examples / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Easier to take a short cut</td>
<td>Crossing street in middle of block to avoid the effort of walking to a crosswalk</td>
</tr>
<tr>
<td>□ Incentives for safe behaviors not established or not awarded</td>
<td>No positive reinforcement of good safety behaviors</td>
</tr>
<tr>
<td>□ Discipline for inappropriate behaviors not established or not applied</td>
<td>No disciplinary consequences for taking shortcuts (getting done faster) at the expense of working safely</td>
</tr>
<tr>
<td>□ Alertness compromised</td>
<td>Individual was tired, ill, medicated</td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
</tr>
</tbody>
</table>

**Design**
- □ Design standards not established.
- □ Design standards not sufficient.
- □ Design standards not applied.
- □ Safety review / Hazards analysis not conducted
- □ Safety Review / Hazards analysis not adequate.
- □ Other

**Maintenance**
- □ Preventive maintenance (PM) standards not established
- □ Maintenance standards not sufficient
- □ PM not conducted
- □ PM implementation not adequate
- □ Other:

**Other Root Causes**
- □

**Comments / additional information. Attach additional pages as needed:**
### 8.0 Recommended Corrective Actions

After reviewing the root cause(s) of the incident, list recommended corrective actions below, as well as the person(s) responsible for implementing each action and an estimated time frame for completion.

<table>
<thead>
<tr>
<th>Recommended Corrective Action</th>
<th>Responsible Person(s)</th>
<th>Estimated Completion Date</th>
<th>Actual Completion Date / Initials</th>
</tr>
</thead>
</table>
### 9.0 Investigator Approval

<table>
<thead>
<tr>
<th>Team Leader Name/Title: (Print)</th>
<th>Telephone:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/Title: (Print)</td>
<td>Telephone:</td>
<td>Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Name/Title: (Print)</td>
<td>Telephone:</td>
<td>Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Name/Title: (Print)</td>
<td>Telephone:</td>
<td>Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Name/Title: (Print)</td>
<td>Telephone:</td>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Comments / Additional Information:

### 10.0 EHS Approval

<table>
<thead>
<tr>
<th>Name/Title: (Print)</th>
<th>Telephone:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/Title: (Print)</td>
<td>Telephone:</td>
<td>Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Name/Title: (Print)</td>
<td>Telephone:</td>
<td>Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Name/Title: (Print)</td>
<td>Telephone:</td>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Comments / Additional Information:
Appendix C -- EHS Incident Emergency Response Template

Emergency Incident / Day Call Report Form

Date of event:____ __________ Time:________ Location: ____________________________ IHP day call:

Short event description:__________________________ □ This is an update to a previous report

Persons involved:

<table>
<thead>
<tr>
<th>#</th>
<th>Role</th>
<th>Name</th>
<th>Method of contact (e.g. phone, email, pager)</th>
<th>Date/time of contact with EHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Injured Person (Person affected by event)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Non-injured Person (Person involved in event)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Person reporting incident / caller</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Eye witness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Person at agency that EHS contacted (e.g. OSHA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Action assignee (Corrective Action)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Investigation lead / EHS responder*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Is this the person filling out this form?  Yes  No  If no, name of person filling out this form:

Incident Details – description of incident and response (please attach more pages as needed):

Incident Investigation – investigation is required if this incident involved an injury or fatality, property damage, environmental release or threat, CFD Hazmat on scene, extended building evacuation, unresolved issues, or if EHS was requested at the scene. Please describe the causes of the incident and fill in any recommended actions below:

Recommended Actions – please describe

<table>
<thead>
<tr>
<th>Person asked to complete</th>
<th>Completed(Yes/No/Unknown)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 1 of 2
Appendix C -- EHS Incident Emergency Response Template

Emergency Incident / Day Call Report Form

Incident Type (please check one or more)

**IAQ/ ODOR**
- ☐ CHEMICAL ODOR / CHEM USE
- ☐ ODOR: VEHICLE EXHAUST
- ☐ ODOR: DRAINS
- ☐ ODOR: CONSTRUCTION
- ☐ ODOR: OTHER
- ☐ HVAC FAILURE
- ☐ TOXIC GAS ALARM
- ☐ SMOKE ODOR
- ☐ ASBESTOS CONTAINING MAT
- ☐ MOLD COMPLAINT
- ☐ OTHER IAQ: ____________________________________________

**CHEMICAL**
- ☐ MINOR CHEMICAL SPILL LAB
- ☐ MAJOR CHEMICAL SPILL LAB
- ☐ MINOR CHEMICAL SPILL NONLAB
- ☐ MAJOR CHEMICAL SPILL NONLAB
- ☐ HAZARDOUS WASTE ISSUE
- ☐ OTHER CHEM: ____________________________________________

**BIOLOGICAL**
- ☐ BIOLOGICAL SPILL
- ☐ BIOLOGICAL WASTE ISSUE
- ☐ UNSAFE SHARPS DISPOSAL
- ☐ OTHER BIO: ____________________________________________

**RADIOLOGICAL**
- ☐ RADIOACTIVE SPILL
- ☐ RADIOACTIVE WASTE
- ☐ OTHER RAD: ____________________________________________

**UTILITY**
- ☐ ELECTRICAL SYSTEM PROBLEM
- ☐ NATURAL GAS LEAK
- ☐ COMMUNICATIONS PROBLEM
- ☐ WATER MAIN BREAK
- ☐ PLUMBING
- ☐ OTHER UTILITY: ____________________________________________

**SAFETY**
- ☐ CONSTRUCTION INCIDENT
- ☐ UNSAFE CONDITION
- ☐ VEHICULAR ACCIDENT
- ☐ OTHER SAFETY: ____________________________________________

**FIRE**
- ☐ WATER FLOW OR WATER ALARM
- ☐ FIRE ALARM DUE TO COOKING
- ☐ FIRE OR SMOKE IN LAB
- ☐ FIRE OR SMOKE NON- LAB
- ☐ FIRE ALARM SYSTEM IMPAIRMENT
- ☐ SPRINKLER SYSTEM IMPAIRMENT
- ☐ ALARM UNDER INVESTIGATION
- ☐ OTHER FIRE: ____________________________________________

**OTHER**
- ☐ OTHER: ____________________________________________

Responder Role (please check one)
- ☐ PRIMARY EHS RESPONDER
- ☐ SECONDARY EHS RESPONDER
- ☐ IHP DAY CALL
- ☐ OTHER: ____________________________________________

Type of Response (please check one)
- ☐ DURING WORK HOURS
- ☐ AFTER HOURS

How was issue resolved (please check one)
- ☐ ONLY BY PHONE
- ☐ ONLY BY EMAIL
- ☐ RESPONDER REPORTED TO SCENE

Please save a copy of this form in M:\0_EHSMS_EMERGENCY\EHS Response in the “Incident Reports To Be Entered” folder, or give a paper copy of completed form to Kelsey Magnuson