



TriOak Foods, Inc. Incident Review Process

Purpose

The purpose of the TriOak Foods, Inc. Incident Review Process is to gather information about incidents to identify the root cause(s) and develop corrective actions that can be taken to prevent future occurrences. Assigning blame to employees is **not** the purpose of this document.

Scope

TriOak Foods, Inc. strives to provide all employees and on-site contractors with a safe and healthy workplace. Reviewing incidents is a process that must include employees and management.

Responsibilities

Management.

- Support the review process related to incidents in the workplace.
- Evaluate improvement recommendations the result from reviews.
- Support improvements financially when suggestions are appropriate and necessary.

Managers and Supervisors.

- Accountable for the health and safety of all employees within their departments including completing incident reviews.
- Responsible for reporting any incident / injury requiring medical care to Human Resources and as soon as possible.
- Responsible for completing the incident review process within 2 days of an incident / injury.
- Responsible for implementing approved corrective actions to ensure that they are completed in a timely manner.

Employees.

- Report all incidents and injuries as soon as possible to their supervisor.
- Participate in the Accident Investigation Process.

Reporting

All employees are required to report any incident and/or injury as soon as possible to their immediate supervisor. The Incident Review Report Form is to be used by the supervisor to document the details of an incident and/or injury along with proposed corrective action(s) for future prevention. A copy of the review is to be forwarded to the Human Resource and Safety Department within **2 days** of an incident or illness.

Incident Review Report

Incident Information	
Name of Injured Employee:	Date of Incident/Illness:
Employee's Normal Occupation:	Date Review Began:
Task and Activity at Time of Incident:	Specific Location of Incident:
Supervision at Time of Incident: (check one) Directly Supervised Indirectly Supervised Not Supervised	Employee was working: (check one) Alone With co-worker Other, please specify:
Names of Others Injured in Same Incident:	
Witness Information	
Witness #1 Name:	Phone:
Witness's Description of Incident:	
Witness's Signature:	
Witness #2 Name:	Phone:
Witness's Description of Incident:	
Witness's Signature:	

Review Results

Describe How Incident Occurred:

Incident Root Causes and Contributing Factors:

Was a safe workplace practice not followed?

Yes

No

If yes, please describe:

Do additional mandatory safe work practices need to be implemented?

Yes

No

If yes, please describe safe work practice:

List corrective actions taken or those that will be implemented along with dates:

Signature of Reviewer #1:

Date:

Signature of Reviewer #2:

Date:

Signature of Person Responsible for Corrective Actions:

Date: