

CONSTRUCTION & FIELD OPS NEAR MISS INVESTIGATION TEMPLATE

Near Miss Investigation Checklist

Investigate potential severity, immediate controls, event sequence, evidence, failed barriers, root causes, preventive actions, effectiveness, reporting culture, trends, and closure.

PROJECT / LOCATION

NEAR MISS DATE

CASE / HAZARD TYPE

LEAD / APPROVER

1. Near-miss setup, event definition, potential severity, ownership, and scope

1

Confirm the project, location, near-miss date and time, investigation start date, case number, reporting person, affected employer, investigation lead, reviewer, and approver.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Treat near misses as free warning signals, not events to ignore.

2

Describe what nearly happened, what actually happened, who or what could have been affected, and why the event is being treated as a near miss or close call.

CRITICAL

NEAR MISS

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More follow-up

Escalate now

N/A

Execution tip: Define the event by what nearly happened and what prevented the outcome.

3

Classify the realistic potential consequence if circumstances had been slightly different, including possible fatality, serious injury, property damage, environmental impact, or operational loss.

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More follow-up

Escalate now

N/A

Execution tip: Potential severity is more useful than actual consequence for prioritization.

4

Define the investigation scope, including people, contractors, equipment, task, materials, work area, interfaces, and systems that may have contributed.

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More follow-up

Escalate now

N/A

Execution tip: Include the systems and interfaces that shaped the exposure.

5

Confirm the event is not being dismissed because no injury occurred and that high-potential near misses receive investigation priority proportionate to their credible consequence.

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More follow-up

Escalate now

N/A

Execution tip: OSHA encourages investigating close calls and near misses.

6

Record immediate restrictions, open questions, evidence priorities, responsible owners, investigation milestones, and the expected review and approval route.

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More follow-up

Escalate now

N/A

Execution tip: Make open risks visible from the start.

2. Immediate hazard control, work restrictions, scene preservation, and safe continuation

7

Verify any continuing hazard exposed by the near miss has been controlled before normal work continues.

CRITICAL

NEAR MISS

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More follow-up

Escalate now

N/A

Execution tip: Control the hazard before preserving evidence.

8

Confirm unsafe equipment, tools, materials, temporary works, energy sources, traffic routes, edges, excavations, lifting zones, or work areas have been isolated, secured, or restricted where necessary.

CRITICAL

NEAR MISS

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More follow-up

Escalate now

N/A

Execution tip: Unsafe equipment or areas should be physically restricted where needed.

9

Preserve the near-miss scene and relevant conditions as far as reasonably practicable when doing so does not create additional risk or delay necessary hazard control.

CRITICAL

NEAR MISS

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More follow-up

Escalate now

N/A

Execution tip: Preserve the scene when safe and useful.

10

Document any changes made immediately after the near miss to stabilize the work area, move equipment, restore access, or prevent recurrence before evidence was fully collected.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Document changes that alter the original condition.

11

Establish interim controls for hazards that cannot be permanently corrected immediately and assign an owner and review or expiry point for those controls.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Temporary controls need owners and review points.

12

Do not permit the affected task to restart under the same uncontrolled conditions that produced the near miss.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Do not restart under the same conditions that produced the near miss.

3. Potential consequence, exposure pathway, frequency, and risk prioritization

- 13** Identify the most credible serious consequence that could have resulted if timing, position, energy, distance, load, or worker movement had been slightly different. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Ask what credible serious outcome was narrowly avoided.

- 14** Determine which workers, contractors, members of the public, equipment, structures, environment, or operations were exposed or could have been exposed. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Consider everyone exposed, including nearby workers and contractors.

- 15** Estimate how frequently the same task, condition, equipment configuration, or exposure occurs across the project or organization. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Frequent exposure can make a near miss more urgent.

- 16** Assess whether the event involved high energy, work at height, mobile plant, lifting, electricity, excavation, confined space, pressure, hazardous materials, fire, or another hazard with severe potential. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: High-energy near misses deserve strong escalation.

- 17** Prioritize the investigation and corrective-action timeline based on potential severity and recurrence likelihood rather than actual injury outcome alone. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Prioritize by credible risk, not by luck.

- 18** Escalate high-potential near misses to the appropriate project or management level even when no injury, damage, or loss occurred. NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: High-potential events should be visible to management.

4. Event sequence, work-as-done, changes, and opportunity for prevention

- 19 Build a step-by-step timeline showing what was planned, what actually happened, and the sequence leading to the near miss.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Compare planned work with actual work step by step.

- 20 Identify who was present, their roles, employers, work positions, supervision, and interaction with equipment, materials, controls, or other work groups.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Worker position and equipment movement are often critical facts.

- 21 Compare the actual task with the current risk assessment, method statement, permit, procedure, drawing, work instruction, or pre-task plan.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Use the document revision that actually governed the task.

- 22 Record changes in scope, staffing, schedule, weather, equipment, materials, access, sequence, simultaneous operations, production pressure, or work conditions before the event.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Change points often explain why a stable task became unsafe.

- 23 Identify the earliest realistic point at which the hazard could have been detected, stopped, contained, or escalated and determine which control should have acted.

NEAR MISS

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More follow-up

Escalate now

N/A

Execution tip: Find the earliest realistic prevention opportunity.

- 24 Separate verified event facts from assumptions, estimates, conflicting accounts, and unanswered questions.

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More follow-up

Escalate now

N/A

Execution tip: Clearly label uncertain or disputed facts.

5. Evidence, photographs, records, worker input, and reporting quality

- 25 Capture photographs, video, sketches, measurements, equipment positions, control settings, environmental conditions, and other physical evidence relevant to the near miss.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Capture evidence before normal work changes the scene.

- 26 Collect the actual versions of permits, risk assessments, job plans, procedures, drawings, inspection records, pre-use checks, maintenance records, training records, and shift documents used at the time.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Collect the actual records used during the work.

- 27 Identify and interview workers, supervisors, operators, contractors, witnesses, planners, maintainers, permit issuers, or others with relevant direct knowledge.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Interview people while recollection is fresh.

- 28 Use open, non-leading questions to understand what people saw, heard, did, expected, and believed the hazards and controls to be at the time.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Use open questions before testing specific theories.

- 29 Confirm workers can report near misses without the process being framed primarily as fault-finding or punishment, so useful hazard information is not suppressed.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: A learning culture improves near-miss reporting quality.

- 30 Preserve relevant evidence and worker statements according to project confidentiality, privacy, legal, client, and record-retention requirements.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Protect confidentiality without losing evidence traceability.

6. Failed controls, contributing factors, root causes, and program shortcomings

31

Identify the immediate unsafe conditions or events that created the near-miss opportunity without treating them as the complete cause.

CRITICAL

NEAR MISS

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More follow-up

Escalate now

N/A

Execution tip: Immediate causes explain what nearly happened, not why.

32

Map the preventive controls that should have stopped the event and determine whether each was missing, inadequate, unavailable, bypassed, misunderstood, degraded, or not verified.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Map the controls that should have broken the event chain.

33

Identify contributing factors involving equipment, work environment, procedure, planning, communication, training, supervision, coordination, design, maintenance, staffing, or organizational conditions.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Look across equipment, procedures, supervision, and organizational systems.

34

Ask why each significant condition existed and why it had not been identified or corrected earlier through inspections, audits, planning, maintenance, supervision, or worker reporting.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: OSHA recommends asking why weaknesses existed and were not addressed earlier.

35

Avoid stopping at worker error, inattention, or procedure violation; determine why the system allowed the action or condition and why safeguards did not prevent it.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Do not stop at worker error or blame.

36

Confirm root causes and contributing factors are supported by evidence and are specific enough to guide effective preventive action.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Root causes should lead directly to preventive actions.

7. Corrective actions, hierarchy of controls, ownership, and broader prevention

37

Develop corrective actions that address the identified root causes, failed controls, and contributing factors rather than only the visible near-miss condition.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Correct the system weakness, not only the local condition.

38

Prioritize elimination, substitution, engineering controls, isolation, redesign, physical safeguards, or other higher-level controls before relying mainly on reminders, retraining, or PPE.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Higher-level controls are generally more reliable than reminders.

39

Assign every corrective action a named owner, priority, due date, required resources, affected work areas, objective completion evidence, and effectiveness-verification method.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Every action needs an owner and effectiveness rule.

40

Define interim controls and restrictions for actions that cannot be completed immediately so similar exposure remains controlled.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Interim controls remain important until permanent action is verified.

41

Review similar projects, contractors, equipment, tasks, work locations, and operating conditions for the same hazard and extend preventive action where needed.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Apply lessons to similar exposures before another event occurs.

42

Escalate overdue or ineffective high-priority actions when the credible consequence remains serious or similar exposure continues.

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Controlled

More follow-up

Escalate now

N/A

Execution tip: Overdue high-risk actions should trigger escalation.

8. Effectiveness checks, field verification, recurrence monitoring, and reopening

43
Verify completed corrective actions physically or objectively through inspection, testing, observation, document review, worker interview, or other suitable evidence.
CRITICAL
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More follow-up
Escalate now
N/A

Execution tip: Completion and effectiveness are different checks.

44
Confirm the action controls the near-miss hazard and underlying cause rather than simply changing the appearance of the work area.
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More follow-up
Escalate now
N/A

Execution tip: Verify the real hazard is controlled in the field.

45
Check revised risk assessments, procedures, permits, inspections, training, maintenance plans, drawings, or equipment controls reflect the approved corrective changes where relevant.
CRITICAL
NEAR MISS

Controlled
More follow-up
Escalate now
N/A

Execution tip: Controlled documents should reflect the changed system.

46
Observe the task after restart to verify workers can use the new controls effectively under real operating conditions.
CRITICAL
NEAR MISS

Controlled
More follow-up
Escalate now
N/A

Execution tip: Observe the new method under normal operating pressure.

47
Monitor repeat near misses, unsafe-condition reports, deviations, audit findings, precursor events, or other indicators that could show the same risk is returning.
CRITICAL
NEAR MISS

Controlled
More follow-up
Escalate now
N/A

Execution tip: Near-miss recurrence is an early indicator of weak control.

48
Reopen the near-miss investigation or corrective action when evidence shows recurrence, weak implementation, unintended consequences, or ineffective controls.
NEAR MISS

Controlled
More follow-up
Escalate now
N/A

Execution tip: Reopen the case when the evidence shows the risk remains.

9. Communication, worker learning, reporting culture, and cross-site lessons

- 49 Communicate relevant near-miss findings, hazards, failed controls, corrective actions, and prevention lessons to workers, supervisors, contractors, and managers exposed to similar risk.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: OSHA recommends communicating investigation results to prevent recurrence.

- 50 Protect personal and confidential information while sharing enough operational detail for others to recognize and control the same hazard.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Share operational learning without unnecessary private details.

- 51 Use toolbox talks, pre-task planning, supervisor briefings, onboarding, contractor coordination, inspections, or targeted training to reinforce changed controls where appropriate.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Training is useful when it supports, not replaces, stronger controls.

- 52 Encourage continued reporting of close calls and near misses by showing workers how reported events lead to visible hazard correction and prevention.

CRITICAL

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Visible action builds confidence in near-miss reporting.

- 53 Review whether the event reveals weaknesses in inspections, maintenance, design, procurement, permit systems, risk assessment, contractor management, supervision, or other safety-program elements.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Use the event to test the wider safety-management system.

- 54 Capture lessons learned in a reusable format that can be shared across projects before the same conditions produce an actual injury or loss.

NEAR MISS

Controlled

More follow-up

Escalate now

N/A

Execution tip: Share learning before another project repeats the same exposure.

10. Final review, trend analysis, records, approval, and near-miss closure

- 55 Summarize the near miss, credible potential consequence, evidence, event sequence, failed controls, root causes, corrective actions, broader rollout, and effectiveness status. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Close only when high-risk recurrence is controlled.

- 56 Confirm all high-priority actions are closed or formally transferred into an authorized longer-term plan with visible ownership and effective interim controls. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Long-term actions still need owners after local closure.

- 57 Trend near misses by hazard, task, contractor, equipment, location, potential severity, failed control, root cause, repeat event, and corrective-action performance. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Trend near misses by failed control and potential severity.

- 58 Compare near-miss trends with injuries, incidents, inspections, audits, maintenance defects, and worker hazard reports to identify common precursors before harm occurs. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Compare near misses with other leading and lagging indicators.

- 59 Verify required records are complete, accessible to authorized users, retained appropriately, and linked to the near-miss case reference. CRITICAL NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Retention rules vary by organization and jurisdiction.

- 60 Record final closure or conditional closure, remaining long-term actions, next effectiveness review date, investigation lead, problem owner, HSE reviewer, project or contractor manager, approver, date, time, and sign-off. NEAR MISS
- Controlled More follow-up Escalate now N/A

Execution tip: Conditional closure should state exactly what remains open.

RUN THIS CHECKLIST DIGITALLY

Turn close calls into preventive action before the next event causes harm

Capture severity, evidence, failed controls, root causes, actions, field verification, and lessons in Taqtics.

Try Near Miss Investigation in Taqtics