NYC DEP WORKPLACE VIOLENCE INCIDENT REPORT

To be completed by appropriate facility personnel (supervisor, manager) and/or EHS personnel with input from other parties (BPS, ODC, etc.) as needed. Section J is to be filled out by OEHS. Please return completed form within 7 days following the incident to the Workplace Violence Prevention Coordinator, Persis Luke, Assistant Commissioner, OEHS (lukep@dep.nyc.gov). Attach victim/witness statement(s) to this form.

Report prepared by:	Date:
Title:	Telephone:

Date of Incident:	Time:
Address/Location of Incident:	

A. Individuals involved in the incident (Note: If there are multiple employees who are victims, an incident form must be filled out for each victim)

Victim's Name:	Aggressor's Name:
	Relationship to Employee:
Title (if employee):	Title (if employee):
Bureau and Division:	Bureau and Division/Company (Non-DEP Employee):
Phone:	Phone:
Immediate Supervisor:	Immediate Supervisor:

Aggressor's Name:	Aggressor's Name:
Relationship to Employee:	Relationship to Employee:
Title (if employee):	Title (if employee):
Bureau and Division/Company (Non-DEP Employee):	Bureau and Division/Company (Non-DEP Employee):
Phone:	Phone:
Immediate Supervisor:	Immediate Supervisor:

B. Was the aggressor involved in any previous incidents involving the same or other DEP employee(s)?

☐ Yes ☐ No ☐ Unknown, skip to C.

If Yes, please provide date(s) and a short description:

C. Apparent Reason for Incident (If known; check all that apply):

☐ Personal Conflict	☐ Alcohol/drugs in the workplace
☐ Family/Domestic Dispute	☐ Mental Health Issues
☐ Job-Related Conflict	☐ Related to issuance of violations/fines to member of the public/business
☐ Related to poor performance review	☐ Related to service to member of the public at agency facility
☐ Related to disciplinary action	☐ Street crime/general criminal conduct
☐ Altercation involving racial/other EEO-related issues	☐ Related to restraint of person in custody
☐ Other (specify)	

D. Type of Conduct Engaged in by Aggressor (Check all that apply)

Verbal/Written Threat

Communicated directly to victim:	☐ Verbal	☐ Written Threat	☐ Mail	☐ Email
Communicated to third party:	☐ Verbal	☐ Written Threat	☐ Mail	☐ Email
☐ Other (specify):				

Repeated Intimidation or Other Threatening Activity

☐ Stalking
☐ Engaging in actions intended to frighten, coerce, or induce duress
☐ Engaging in other threatening behavior Explain:
☐ Verbal harassment
☐ Showing (but not using) weapon or object intended as a weapon
☐ Other (specify)

Assault/Physical Attack

☐ Hitting, fighting, pushing, shoving, tripping, poking or body blocking
☐ Use of gun, knife, or other weapon (specify)
☐ Use of object as weapon (specify)
☐ Other (specify)

E. Was there a physical injury? (Victim)

☐ Yes ☐ No physical Injury, skip to F

If there was a physical injury, was emergency medical services contacted?

☐ Yes ☐ No

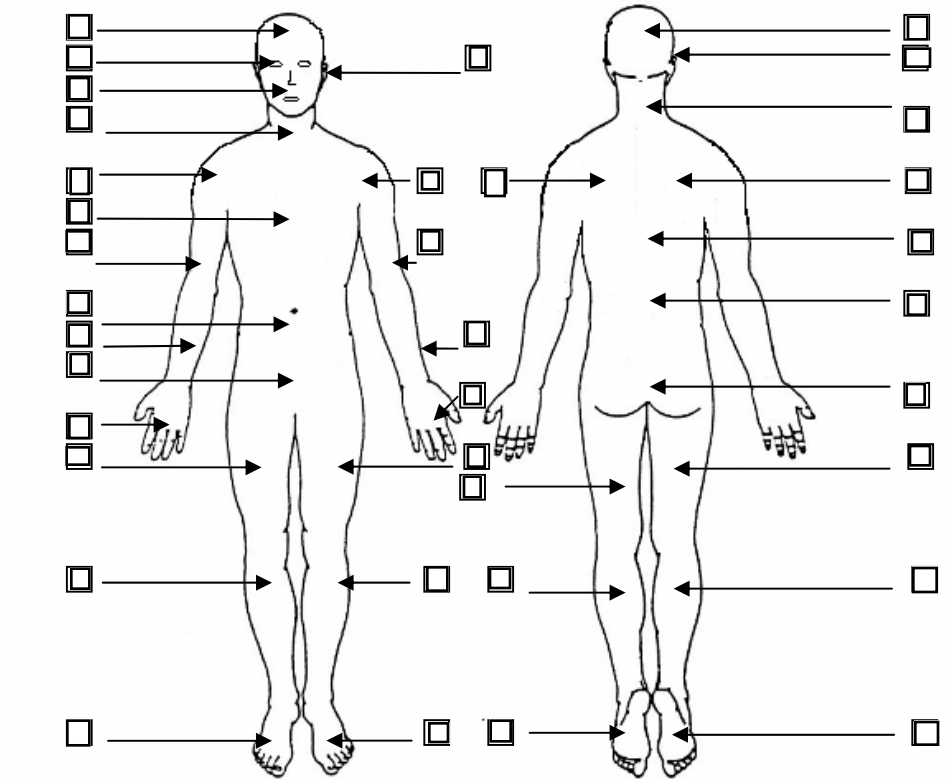
If there was a physical injury, was an injury and illness report completed?

☐ Yes ☐ No

Severity of Injury (check only one)

☐ Slight (medical attention beyond first aid)	☐ Severe (permanent impairment or loss of body part)
☐ Minor (1-7 lost workdays non-hospital)	☐ Critical (total incapacitation or permanent total disability where employee cannot follow any gainful occupation, or loss of use of both hands, feet or eyes, or loss of combination of any listed)
☐ Moderate (8+ lost workdays or admission to hospital for 1-4 days)	
☐ Major (admission to hospital 5+ days; major fracture, unconsciousness > 5 minutes; dislocation of major joints; internal organ injury; burns over 10% body)	☐ Fatal(from work related mishap or complications arising from the mishap)

Indicate approximate location(s) of injury or injuries on the diagrams below.



F. Provide a brief description of the incident

G. Was employee alone when the incident occurred?

☐ Yes (Skip to H) ☐ No

Witnesses Contact Information:

Name:	Name:
Address:	Address:
Phone:	Phone:

Name:	Name:
Address:	Address:
Phone:	Phone:

H. Initial Response (check all that apply)

☐ Situation defused By Whom: How:	☐ Law Enforcement called Time called (Approx) Time responded (Approx) Responding Unit/Name: Badge: Report Number:
☐ Security called Time called Time responded Responding Unit/Name: Badge:	☐ Other (specify)

I. Follow-up Response by Supervisor/Employer (check all that apply)

☐ Injury and Illness report filled out	☐ Arrest made/other law enforcement action
☐ Workplace Violence Prevention Coordinator Notified OEHS A/C (required)	☐ Notifications made pursuant to DEP and Bureau Policies on incident reporting.
☐ Referral to Employee Assistance Program or other counseling	☐ Workers Compensation Forms filled out
☐ Disciplinary action initiated	☐ Other

J. Incident Review (Should be completed by OEHS with input from BEHS Facility personnel)

What preventive controls were in place at the time of incident?
What preventive controls were not effective and why?
What were the contributing factors/root cause of the incident?
What new controls are required/recommended?
WPV Program changes recommended (OEHS with BEHS input):

Document Control/Review

Report Submitted by:	
Case Designation: ☐ Incident ☐ Report	OEHS Case Number assigned:
Report Accepted by (OEHS A/C):	
IG Notification by OEHS: ☐ No ☐ Yes, notification date:	
Internal DEP notification (check all that apply): ☐ BPS ☐ ODC ☐ BLA ☐ HRA ☐ EEO ☐ BEHS	
Incident Report (excluding witness reports) forwarded to Supervisor to review with Employee ☐ Yes, date:	
Supervisor communicated the final Incident Report to Employee and Employee received a copy of report ☐ Yes, confirmation date:	