Incident and Investigation Report

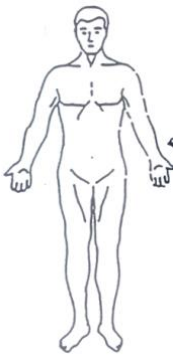
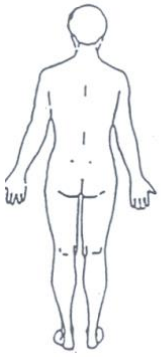
EMPLOYEE DETAILS					
Name:				Date of Birth:	
Address:					
Home Phone:		Mobile:		Occupation:	
Employment:	☐ Full time ☐ Part time ☐ Casual ☐ Contractor ☐ Member of Public ☐ Other				

☐ First aid injury ☐ Medical Treatment Injury ☐ Lost Time Injury ☐ Near Hit (Miss)
☐ Property Damage ☐ Notifiable Event ☐ Motor Vehicle ☐ Complaint
☐ Fire/Explosion ☐ Environmental Incident ☐ Security Breach ☐ Product Withdraw

INCIDENT DETAILS			
Date of Incident:		Time of Incident:	
Date reported:		Who was it first reported to:	
Injured Person Name (if applicable):		Injured person Address	

☐ At work ☐ At work in motor vehicle accident ☐ On a work break
☐ Travelling to or from work ☐ On a job/client site ☐ Work at home ☐ Other:

What was happening when the incident occurred?		
What contributed to the incident / event occurring?		
Did anyone witness the incident? (*Please provide name, address and telephone number*).	Name: Address: Telephone Number:	Name: Address: Telephone Number:

INJURY OUTCOME			
Injury/Illness Description:		FRONT VIEW Right Left	BACK VIEW Left Right
Is any medical attention required for the injury/illness?	☐ Nil ☐ First aid only ☐ Doctor consulted ☐ Hospital Name:		
Workers Compensation form required?	☐ Yes ☐ No		
Did you continue to work after the incident?	☐ Yes ☐ No		

EQUIPMENT BEING USED (if involved in incident)			
Type:		**Model/Make:**	
Was the equipment in good working order?	☐ Yes ☐ No Details:		
Type:		**Model/Make:**	
Was the equipment in good working order?	☐ Yes ☐ No Details:		
Type:		**Model/Make:**	
Was the equipment in good working order?	☐ Yes ☐ No Details:		

PERSONAL PROTECTIVE EQUIPMENT (PPE)		
Should PPE (e.g.. gloves) have been worn for the task being undertaken?	☐ Yes	☐ No
Was it being worn/used?	☐ Yes	☐ No
Was it available?	☐ Yes	☐ No
Details of PPE Type required?		

OTHER DETAILS: *Provide any other information you feel is relevant including* ***effective Control Measure to prevent a reoccurrence.***

EMPLOYEES DELARATION - I declare the above information is correct and not misleading		
Employees Name	**Signature**	**Date**

INCIDENT INVESTIGATION to be completed by the Team Leader/ Manager	
Investigation Team members.	1. 2. 3. 4. 5.
Time Line – sequence of events: *Example: 9.45am Arrived at site and set up equipment etc…*	• • • • • • • • • • •
5 Whys:	Why > Why > Why > Why > Why >
Root Cause/s:	☐ Equipment: ☐ Environment: ☐ People: ☐ Process: ☐ Management System: ☐ Materials:
Photographs taken? *Brief detail to be provided.*	
Notes: *Include date and time that note is made.*	

RISK ASSESSMENT	**Consequences** 1. Disastrous 2. Critical 3. Serious 4. Significant 5. Minor **Likelihood** 1. Almost Certain 2. Quite Possible 3. Unusual but Possible 4. Unlikely to Occur 5. Extremely Unlikely	**Risk Score** (Refer to Risk Assessment Process)

Nature of Injury		Mechanism of Injury	
☐ Slips/trips/falls	☐ Abrasion/Bruise	☐ Equipment/plant	☐ Environment
☐ Repetitive action	☐ Cuts/sharps	☐ Vehicle	☐ Hazardous substances
☐ Hitting an object	☐ Heat/temperature	☐ Client/human factors	☐ Work Factors
☐ Manual Handling (Body Stressing)	☐ Mental stress	☐ Tools/Static equipment (e.g. computer)	☐ Bodily Fluids
	☐ Electricity		
☐ Other _____		☐ Other _____	

CORRECTIVE/PREVENTATIVE ACTIONS
Use Hierarchy of Controls: Elimination, Substitution, Isolation, Engineering, Admin, PPE.

Proposed	Responsibility	Proposed Date	Actual Date

COMMENTS on implementing the corrective/preventative actions recommended above

VALIDATION The undersigned have investigated this incident and do state this information is the best available information according to the known facts.

Investigator	Signature	Date
Manager:	**Signature**	**Date**

Input into Incident Register:

Date: Time: By: