



INCIDENT INVESTIGATION REPORT

This form should be completed following a serious or dangerous incident being reported. The objective of an incident investigation is to ensure that all the relevant facts are obtained to help decide upon the appropriate corrective actions required. It is not intended to apportion blame for the incident. This report does not replace the Hazard and Incident Report Form itself.

Incident details

Location site:

Location department:

Location section/building:

Date of incident:

Time of incident:

am/pm

Description of Incident:

Investigation details

Date of investigation:

Time of investigation:

am/pm

Nature of investigation:

Fatality

Damage

Injury

Near Hit

Person/s conducting investigation

Name:

Contact:

Name:

Contact:

Name:

Contact:

Name of persons involved in the incident

Name

Position/company

Contact details (phone)

Witness details

Name	Position/company	Contact details (phone)

Sequence of events that led up to the incident

- 1
- 2
- 3
- 4
- 5

Other contributing factors

Summary of conditions at the time of the incident, eg *weather, visibility, noise, lighting etc.*

Summary of variations from standard operating procedures

Summary of identified deficiencies that may have contributed

Actions taken at time of incident

Refer to the Hazard and Incident Report form eg *render the area safe, first aid provided to injured person*

Annexures supporting this report

Eg photographs, statements, witness reports, risk assessments, SWMS, etc.

1

2

3

4

5

Recommended corrective actions

1

2

3

4

5

Manager agreed corrective actions

Item	Responsibility	Target date	Completed
1		... / ... /	<input type="radio"/> Yes <input type="radio"/> No
2		... / ... /	<input type="radio"/> Yes <input type="radio"/> No
3		... / ... /	<input type="radio"/> Yes <input type="radio"/> No
4		... / ... /	<input type="radio"/> Yes <input type="radio"/> No
5		... / ... /	<input type="radio"/> Yes <input type="radio"/> No

Person responsible for implementing corrective actions

Name:

Title:

Telephone number (landline):

Telephone number (mobile):

Email:

Follow up

Date for review of corrective actions:

Name of person reviewing actions:

Date corrective actions reviewed:

Does the register of injuries record coincide? Yes No

If it is a notifiable incident has the regulator has been notified? Yes No

Workers Compensation (WC)

Has the WC insurer been notified of the incident? Yes No

Has a claim form been provided to the injured worker? Yes No

Has the claim form been submitted to the WC insurer? Yes No

Is an injury management plan drafted? Yes No

Is a return to work plan in place? Yes No

Copies of this report have been sent to

Date sent	Sent to
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... / ... /

... / ... /

... / ... /

Administration

File completed? Yes No Date:

Further action required? Yes No Date:

Details of further action:

Signatures

**Investigation
representative**

Manager

**Person making the
report**

Witness