

INCIDENT INVESTIGATION REPORT

The objective of incident investigation is not to apportion blame but to get the relevant facts.

Incident details

Location site:		
Location area:		
Date of incident:	Time of incident:	am/pm
Description of Incident:		

Investigation details

Date of Investigation:	Time of investigation:	am/pm
Nature of investigation:	<input type="radio"/> Fatality	<input type="radio"/> Damage
	<input type="radio"/> Injury	<input type="radio"/> Near Hit
Investigation Team		
Manager:	Contact:	
Name:	Contact:	
Name:	Contact:	
Name:	Contact:	

Name of persons involved in the incident

Name	Contact Number	Email Address

Witness details

Name	Contact Number	Email Address

Sequence of events that led up to the incident

1	
2	
3	
4	
5	
6	

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 to minimise the impact of the incident

Eg emergency procedures, equipment removal etc.

1	
2	
3	

4

5

6

Annexures supporting this report

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

1

2

3

4

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 details

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

Is this a WorkCover notifiable incident? ☐ Yes ☐ No

Workers Compensation WC (if applicable)

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
... / ... /	HR
... / ... /	CEO
... / ... /	

Administration

File completed? ☐ Yes ☐ No Date:

Further action required? ☐ Yes ☐ No Date:

Details of further action:

Signatures

Investigating
team member

Manager

Person making the
report

Witness