

Note: Person Reporting Incident to Complete

This is a report of: (tick one or more of the following)

- | | |
|---|---|
| <input type="checkbox"/> Injury to employee | <input type="checkbox"/> Damage to third party property |
| <input type="checkbox"/> Potential Risk/Hazard | <input type="checkbox"/> Injury to member of the public |
| <input type="checkbox"/> Damage to Plant | |
| <input type="checkbox"/> Incident with no injury or damage (ie near miss) | |

1. PERSON MAKING REPORT

Name:		Section:		Date:	/ /
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2. RISK/HAZARD/INCIDENT DETAILS

Please describe details of Risk/Hazard/Incident: (attach separate sheet if more space is required):

Location where Incident occurred or Hazard is located:

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Plant Number:

Date of Incident	/ /	Day of week		Time of Incident	am / pm
Date Reported		Time Reported	am / pm	To Whom	
Name of Witness – to the incident	1.	Signature:	1.		
Name of Witness – to the incident	2.	Signature:	2.		

(Note: Persons listed as a witness must sign the form to verify that they witnessed the incident)

What could or has been done to prevent the incident occurring again, or to eliminate the hazard?

Note: If this risk/hazard has the potential to cause death or serious injury to an employee or member of the public, it must be reported to your supervisor/ manager immediately. You must do everything within your control to prevent injury from the hazard until the hazard is minimised, or where appropriate, eliminated.

Employees Signature:		Date:	/ /
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3. INFORMATION RELATING TO THE INJURY

NOTE: any lost time accident must be reported to your Supervisor / Manager immediately

Treatment:		Outcome:	
• First Aid only		• Returned to Normal Work	
• Sent to Doctor		• Returned on Suitable Duties	
• Sent to Hospital		• Did not complete Shift	
• Nil		• Fatality	

Lost time Injury: Yes / No If yes what time did you cease work? am / pm

Is this a recurrence of an old Injury: Yes / No

If yes when did the original injury occur:

Are you claiming Worker's Compensation? Yes * No Not at this stage

(* if yes contact the Human Resources & WHS/Risk Coordinator for a claim form)

Contributing Factors to Cause of Incident: (Tick one or more)

Uneven ground	Fall from height	Hit by object	Lifting
Stepped on object	Caught in/between object	Hit against object	Pushing/pulling
Stepped in hole	Stretching/over reaching	Electric Shock	Noise
Using power tool	Motor vehicle accident	Sun Exposure	Fire
Using hand tool	Repetitive muscular effort	Other Please Specify:	

Part of the Body Injured – Please circle L for left or R for right side of body

Back	L	R	Trunk	L	R	Elbow	L	R	Knee	L	R
Neck	L	R	Eye	L	R	Wrist	L	R	Ankle	L	R
Shoulder	L	R	Ear	L	R	Hand	L	R	Foot	L	R
Head/Face	L	R	Arm	L	R	Leg	L	R			

Nature of Injury	Fracture	Concussion	Eye Injury	Superficial Injury
	Laceration	Sprain/Strain	Poisoning	Bruising
	Crush	Hearing Loss	Amputation	Multiple Injuries
	Dislocation	Burn	Open Wound	Other:

THIRD PARTY INCIDENT DETAILS

If there was injury to a member of the public, or damage to third party property, please try to obtain the person's name and address? If a minor is involved, please try to obtain parent's name.

Injured Persons Name:			
Address:			
Parents Name:		Age if a minor:	

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4. WITNESS TO THE ACCIDENT INVOLVING THIRD PARTIES

Witness 1:		Signature:	
Address:		Phone:	
Witness 2:		Signature:	
Address:		Phone:	

5. RISK ASSESSMENT

Assess risk associated with hazard/incident/near miss using risk matrix):

Likelihood		Consequence	
Risk Level			

Risk Assessment Matrix		Consequences				
		Negligible No injuries or not requiring first aid	Minor First aid needed	Moderate Medical treatment	Major Serious injury	Severe Death or permanent disability.
Likelihood	Certain to occur Expected to occur in most circumstances	Medium	High	High	Extreme	Extreme
	Very Likely Will probably occur in most circumstances	Medium	Medium	High	Extreme	Extreme
	Possible May occur occasionally	Low	Medium	Medium	High	Extreme
	Unlikely Could happen at sometime	Low	Low	Medium	Medium	High
	Rare May happen only in exceptional circumstances	Low	Low	Low	Medium	High

Risk level	Recommended actions
Extreme	Immediate action required – Activity must not proceed until steps are taken to reduce risk to as low as reasonably practicable using the hierarchy of controls
High	Risk control measures required to reduce risks to as low as reasonably practicable using the hierarchy of controls
Medium	Review risk assessment and ensure control measures to reduce risk to as low as reasonably practicable using the hierarchy of controls
Low	Manage risks by routine procedures and monitor

6. RISK/HAZARD/INCIDENT INVESTIGATION REPORT

RISK/HAZARD/INCIDENT INVESTIGATION REPORT

NOTE: This section is to be completed by the **Supervisor & Manager** of the person or area concerned and is aimed at identifying causes to eliminate a potential risk/hazard or prevent a recurrence, not attributing blame.

1. RISK/HAZARD/INCIDENT CAUSES - What were the main contributing factors to the Incident / Hazard? (more than one box may be ticked)

Procedures		Work Environment	
Employee not aware of procedures		Inappropriate workplace design	
Employee was aware, but failed to follow correct procedures		Inappropriate task allocation	
Procedure followed, but was inappropriate for the task		Poor Housekeeping	
No formal procedure in place			
External Influences		Training	
Incident caused by another person or object		Employee was not adequately trained	
		Training insufficient or out of date	
		Manual handling training	
Equipment		Action by Supervisor	
Appropriate equipment available but not used		No action required	
Appropriate equipment not supplied		Temporary corrective action taken	
Equipment failure or malfunctioned		Work suspended immediately	
Equipment not properly repaired or maintained			
Equipment not used correctly			
Equipment not appropriate for task			

2. INVESTIGATION FINDINGS – (i.e. what circumstances led to this incident occurring?)

3. CORRECTIVE/PREVENTATIVE ACTION - What has been or will be done to prevent this Incident / Hazard from recurring? (attach sheet if required)

3. CORRECTIVE/PREVENTATIVE ACTION (CONT') - What has been or will be done to prevent this Incident / Hazard from recurring? (attach sheet if required)

	Proposed	Taken
Change to induction training	<input type="checkbox"/>	<input type="checkbox"/>
Equipment/machinery modifications	<input type="checkbox"/>	<input type="checkbox"/>
Change to site specific training	<input type="checkbox"/>	<input type="checkbox"/>
Job specific training required	<input type="checkbox"/>	<input type="checkbox"/>
New SWMS required	<input type="checkbox"/>	<input type="checkbox"/>
Change to existing SWMS required	<input type="checkbox"/>	<input type="checkbox"/>
Equipment/machinery maintenance	<input type="checkbox"/>	<input type="checkbox"/>
Other job redesign	<input type="checkbox"/>	<input type="checkbox"/>
Other preventive action	<input type="checkbox"/>	<input type="checkbox"/>

4. NOTIFICATION

Action Taken	YES	NO	N/A	<u>WorkCover/Insurer Reporting Requirements</u>
Relevant Council personnel notified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Serious incidents or a serious injury or illness report to WorkCover immediately (1310 50) and Scheme Insurer within 48 hrs. 2. Serious incidents involving injury or illness to non-workers report to WorkCover Immediately (13 10 50) 3. Other incidents where workers comp is payable report to Scheme Insurer within 48 hrs.
Reported to Insurer? Date:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reported to: WorkCover? Date: Workcover Ref No:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reported by: Managers Name Signature Date				

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5. PERSON RESPONSIBLE FOR TAKING ACTION

Name:			
Position:			
Date Corrective Action Taken:	/ /		
Is the matter Finalised?	<input type="checkbox"/> YES	<input type="checkbox"/> NO – If no, further action is scheduled for: / /	

6. MANAGERS REVIEW OF INCIDENT

Name:			
Signature:		Date:	/ /

7. HUMAN RESOURCES & WHS/RISK COORDINATORS

Comments:			
Closed Off:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Signature:		Date:	/ /