
	Function: OHS	Document ID: IOGTA-OHS-FORM-027	Rev. No: 01	Effective Date: 12 Jan 17
	Title/Subject: Incident Report			

This report is to be submitted in accordance with distribution instructions in the Procedure within twenty-four (24) hours of the accident / incident occurring. Information not available at submittal time is to be included and submitted in revised reports.

SECTION 1. INCIDENT DETAILS: (Indicate by ticking relevant check box/es)					
Near Hit	Potential Injury <input type="checkbox"/>	Potential Property Damage <input type="checkbox"/>	Serious Potential Injury <input type="checkbox"/>	Serious Potential Incident <input type="checkbox"/>	
Injury / illness	First Aid <input type="checkbox"/>	MTI <input type="checkbox"/>	Potential LTI <input type="checkbox"/>	Actual LTI <input type="checkbox"/>	
Property Damage	Company <input type="checkbox"/>	Client <input type="checkbox"/>	Contractor <input type="checkbox"/>	Community <input type="checkbox"/>	
Plant / Vehicle	Company <input type="checkbox"/>	Client <input type="checkbox"/>	Contractor <input type="checkbox"/>	Community <input type="checkbox"/>	
Environment	Company <input type="checkbox"/>	Client <input type="checkbox"/>	Contractor <input type="checkbox"/>	Community <input type="checkbox"/>	
Reportable Incident	Mine Dept <input type="checkbox"/>	State OSH Authority <input type="checkbox"/>	Fatality (Police) <input type="checkbox"/>	Other <input type="checkbox"/>	
Describe the Occurrence (Facts Only):					
DATE / TIME OF INCIDENT:	xx/xx/xxxx	am / pm	DATE / TIME REPORTED:	xx/xx/xxxx	am / pm
AREA OF OCCURRENCE:					
WEATHER CONDITIONS:					
		TEMP: Deg C			WIND SPEED: M/S - KNOTS
REPORTED BY:				POSITION:	
WITNESSED BY:				POSITION:	
WITNESSED BY:				POSITION:	
INVESTIGATION COORDINATOR:				POSITION:	
SECTION 2. INJURY DETAILS					
NAME OF INJURED:				MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
OCCUPATION:			FULL / PART / CASUAL	D.O.B.	
EMPLOYER:				SUBCONTRACTOR <input type="checkbox"/>	OTHER <input type="checkbox"/>
EMPLOYED SINCE:		DIRECT SUPERVISOR:			
EXPERIENCE IN CURRENT OCCUPATION:					
PREFERRED LANGUAGE:			TIME STARTED WORK ON DAY OF INCIDENT:		
INJURY DESCRIPTION					
TREATMENT GIVEN:					
BODY LOCATION OF INJURY:					
DATE CEASED WORK:	xx/xx/xxxx	RESUMED WORK:	xx/xx/xxxx	DUTIES:	Restricted <input type="checkbox"/> Normal <input type="checkbox"/>
If an injury has the Injury Management Coordinator been informed? YES <input type="checkbox"/> NO <input type="checkbox"/>					

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SECTION 3. PERSONNEL DIRECTLY INVOLVED WITH THE INCIDENT

Name	Position	Company

SECTION 4. PLANT AND EQUIPMENT DAMAGE Estimated Cost AU\$

Plant Type:	Crane		EWP		Truck		Light Vehicle		Other	
Plant No.:	Serial No.:			Registration No.:						
Damage Details:										

SECTION 5. THIRD PARTY PLANT AND EQUIPMENT DAMAGE Estimated Cost AU\$

Plant Type:	Crane		EWP		Truck		Light Vehicle		Other	
Plant No.:	Serial No.:			Registration No.:						
Damage Details:										

SECTION 6. ENVIRONMENTAL DAMAGE Estimated Cost AU\$


Damage Details:										

SECTION 7. RISK ASSESSMENT RATING

Actual Risk		Future Risk	
Actual Consequence classification		Future Consequence classification	
Actual Likelihood classification		Future Likelihood classification	
Actual Risk Rating		Future Risk Rating Potential	

SECTION 8. INCIDENT TYPES **PART OF BODY** **AGENCY**

Manual Handling	<input type="checkbox"/>	Contact with:	<input type="checkbox"/>	Head	<input type="checkbox"/>	Machinery Operation	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	Electricity	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	Static equipment	<input type="checkbox"/>
Pulling / pushing	<input type="checkbox"/>	Heat / cold	<input type="checkbox"/>	Neck	<input type="checkbox"/>	Power tools	<input type="checkbox"/>
Strain Injury	<input type="checkbox"/>	Dust	<input type="checkbox"/>	Truck (back)	<input type="checkbox"/>	Hand tools	<input type="checkbox"/>

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Strike against	<input type="checkbox"/>	Fume	<input type="checkbox"/>	Arm	<input type="checkbox"/>	Other equipment	<input type="checkbox"/>
Struck by	<input type="checkbox"/>	Harmful substances	<input type="checkbox"/>	Hand	<input type="checkbox"/>	Transport	<input type="checkbox"/>
Fall to below	<input type="checkbox"/>	Toxic substances	<input type="checkbox"/>	Leg	<input type="checkbox"/>	Lifting equipment	<input type="checkbox"/>
Fall on same level	<input type="checkbox"/>	Noise Induced	<input type="checkbox"/>	Foot	<input type="checkbox"/>	Working environment	<input type="checkbox"/>
Caught in	<input type="checkbox"/>	Classified Plant	<input type="checkbox"/>	Multiple	<input type="checkbox"/>		
Caught on	<input type="checkbox"/>			Hair	<input type="checkbox"/>		
Caught between	<input type="checkbox"/>						

Other unspecified Incident:


SECTION 9. IMMEDIATE CAUSES

Unsafe Actions		Unsafe Conditions					
What did employee do or fail to do that caused or contributed to the accident?		What conditions of tools, equipment or job site caused or contributed to the accident?					
Operating without authority	<input type="checkbox"/>	Used wrong tool / equipment	<input type="checkbox"/>	Inadequate guard safety device	<input type="checkbox"/>	Close clearance / congestion	<input type="checkbox"/>
Failure to make secure	<input type="checkbox"/>	Failure to make inoperative	<input type="checkbox"/>	Hazardous personal attire	<input type="checkbox"/>	Hazardous arrangement / storage	<input type="checkbox"/>
Operating at unsafe speed	<input type="checkbox"/>	Riding hazardous equipment	<input type="checkbox"/>	Inadequate warning system	<input type="checkbox"/>	Defective tools / equipment	<input type="checkbox"/>
Failure to warn / signal	<input type="checkbox"/>	Took unsafe position / posture	<input type="checkbox"/>	Fire or explosion hazard	<input type="checkbox"/>	Environment	<input type="checkbox"/>
Nullified safety device	<input type="checkbox"/>	Horseplay, distractive actions	<input type="checkbox"/>	Unsecured against movement	<input type="checkbox"/>	Illumination / noise hazard	<input type="checkbox"/>
Used defective equipment	<input type="checkbox"/>	No protective equipment	<input type="checkbox"/>	Poor housekeeping	<input type="checkbox"/>	Inadequate / no JSA, procedure, WI	<input type="checkbox"/>
Used equipment unsafely	<input type="checkbox"/>	No unsafe action determined	<input type="checkbox"/>	Protruding object hazard	<input type="checkbox"/>	No unsafe action	<input type="checkbox"/>

Other unspecified Actions or Conditions:

SECTION 10. INFLUENCING CAUSES

What caused or influenced above unsafe actions?		What caused or influenced above unsafe conditions?					
Unaware of job hazards	<input type="checkbox"/>	Influence of emotions	<input type="checkbox"/>	Defective from normal use	<input type="checkbox"/>	Outside contractor	<input type="checkbox"/>
Instructions given	<input type="checkbox"/>	Production	<input type="checkbox"/>	Unstable ground	<input type="checkbox"/>	Unstable excavation	<input type="checkbox"/>
Failure to make secure	<input type="checkbox"/>	Influence of fatigue	<input type="checkbox"/>	Defective via abuse / misuse	<input type="checkbox"/>	Failure to maintain	<input type="checkbox"/>
Unaware of safe method	<input type="checkbox"/>	Influence of intoxicant drugs	<input type="checkbox"/>	Safety inspection failure	<input type="checkbox"/>	Purchasing practice	<input type="checkbox"/>
Low level job skill	<input type="checkbox"/>	Defective vision / hearing	<input type="checkbox"/>	Housekeep / cleanup failure	<input type="checkbox"/>	Deteriorating exposure	<input type="checkbox"/>
Tried to gain or save time	<input type="checkbox"/>	Influence of illness	<input type="checkbox"/>	Faulty design / construction	<input type="checkbox"/>	Management acceptance	<input type="checkbox"/>

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Tried to avoid extra effort <input type="checkbox"/>	Other personal factors <input type="checkbox"/>	3 rd party action <input type="checkbox"/>	Other unknown source cause <input type="checkbox"/>
Other unspecified Actions or Conditions:			

SECTION 11. CORRECTIVE ACTIONS

What action has been taken (mark X) or is planned (mark P) to prevent recurrence?

Use safer materials / supplies <input type="checkbox"/>	Action to improve enforcement <input type="checkbox"/>	Improve design, construction, JHA, procedure <input type="checkbox"/>
Improve illumination <input type="checkbox"/>	Order job analysis to be done <input type="checkbox"/>	Eliminate congestion <input type="checkbox"/>
Improve ventilation <input type="checkbox"/>	Order job analysis revision <input type="checkbox"/>	Reinstruction of employees involved <input type="checkbox"/>
Mandatory pre-job instructions <input type="checkbox"/>	Install / revise safety guard / device <input type="checkbox"/>	Reprimand / warning of employees involved <input type="checkbox"/>
Job reassignment of employee <input type="checkbox"/>	Require protective equipment <input type="checkbox"/>	Penalty / discipline of employees involved <input type="checkbox"/>
Improve inspection procedure <input type="checkbox"/>	Repair / replace equipment <input type="checkbox"/>	Preventative instruction of others who do job <input type="checkbox"/>
Improve cleanup procedure <input type="checkbox"/>	Improved storage / arrangement <input type="checkbox"/>	Correction other than above <input type="checkbox"/>

Other unspecified Actions or Conditions:


SECTION 12. ACTION PLAN

Action	By Whom	Target Date	Date Completed

Remarks:

SECTION 13. NOTIFICATIONS

To Whom	How	Time and Date	By Whom	How
Director				

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Director				
Client				
Contractor				

SECTION 14. REPORT ATTACHMENTS

Investigation analysis report		First Aid report	
Witness # 1 statement		Medical report	
Witness # 2 statement		AOD test results	
Plant operator statement		Photographs	
Other statement # 1		Site drawings	
Other statement # 2		Sketches	
Procedure		Certificate of competency	
JHA or SWMS or SWP		Competency assessment	
Risk assessment		Other analysis	
Plant / vehicle inspection			

SECTION 15. EMPLOYEE /CONTRACTOR COMMENT *(Do Not Complete Until Complete)*

Signature:		Name:	Date:

SECTION 16. DIRECTOR COMMENT *(Do Not Complete Until Complete)*

Signature:		Name:	Date:

SECTION 17. CLIENT COMMENT *(Do Not Complete Until Complete)*

Signature:		Name:	Date: