

Incident Report



PROJECT \ LOCATION:	INCIDENT DATE:
PROJECT NO: (where applicable)	INCIDENT TIME:
PROJECT MANAGER:	REPORT NO.:

Type of Incident (More than one may have to be ticked)

- | | | |
|---|---|---|
| <input type="checkbox"/> Near miss | <input type="checkbox"/> Plant /Property/Product Damage | <input type="checkbox"/> Environmental Damage |
| <input type="checkbox"/> Fatality | <input type="checkbox"/> Lost Time Injury | <input type="checkbox"/> Work caused Illness |
| <input type="checkbox"/> Medically Treated Injury | <input type="checkbox"/> First Aid Injury | <input type="checkbox"/> Other, specify: |

Location of Incident:

Report and Investigation By:

Date:

Details of Injured Person

Given Names:	_____	Surname:	_____
Date of Birth:	_____	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:	_____	Suburb:	_____
	_____	Postcode:	_____
Employer:	_____	Occupation:	_____
Employment Status:	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="checkbox"/> Casual <input type="checkbox"/> Other
Shift Length (hours):	<input type="checkbox"/> Current Shift	<input type="checkbox"/> 24 hrs Prior	<input type="checkbox"/> 48 hrs Prior <input type="checkbox"/> 72 hrs Prior

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First Issued:	11.01.2018	Last Reviewed:	01.12.2021	Next Review:	01.12.2022
Version:	1.0	Owner:	Bartsch Builders	Authorisation:	Kristie Bartsch

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Mechanism of Injury (Please tick appropriate box/es)			
<input type="checkbox"/> 01 Falls from heights	<input type="checkbox"/> 07 L/Term exposure to sound	<input type="checkbox"/> 13 Exposure to radiation	<input type="checkbox"/> 19 Slide or cave-in
<input type="checkbox"/> 02 Falls from same level	<input type="checkbox"/> 08 Exposure of var. in pressure	<input type="checkbox"/> 14 Contact with chemical	<input type="checkbox"/> 20 Vehicle accident
<input type="checkbox"/> 03 Hitting object/s	<input type="checkbox"/> 09 Repetitious movements	<input type="checkbox"/> 15 L/Term contact chemical	<input type="checkbox"/> 21 Other mechanisms
<input type="checkbox"/> 04 Exposure to vibration	<input type="checkbox"/> 10 Other muscular stress	<input type="checkbox"/> 16 Other contact chemical	<input type="checkbox"/> 22 Unspecified mechanisms
<input type="checkbox"/> 05 Hit by moving object/s	<input type="checkbox"/> 11 Contact with electricity	<input type="checkbox"/> 17 Contact biological factors	
<input type="checkbox"/> 06 Exposure to sudden sound	<input type="checkbox"/> 12 Exposure to heat or cold	<input type="checkbox"/> 18 Exposure to mental stress	
Nature of Injury (Please tick appropriate box/es)			
<input type="checkbox"/> 01 Fractures	<input type="checkbox"/> 06 Internal chest	<input type="checkbox"/> 11 Foreign body eye, ear, nose	<input type="checkbox"/> 16 Multiple Injury
<input type="checkbox"/> 02 Fractures of vertebral col.	<input type="checkbox"/> 07 Traumatic amputation	<input type="checkbox"/> 12 Burn	<input type="checkbox"/> 17 Damage to artificial aids
<input type="checkbox"/> 03 Dislocation	<input type="checkbox"/> 08 Open wounds	<input type="checkbox"/> 13 Injury to spine, cord, nerves	<input type="checkbox"/> 18 Other
<input type="checkbox"/> 04 Sprains and strains	<input type="checkbox"/> 09 Superficial injury	<input type="checkbox"/> 14 Poisoning or toxic effects	
<input type="checkbox"/> 05 Intracranial injury	<input type="checkbox"/> 10 Contusion with intact skin	<input type="checkbox"/> 15 Effects of weather, air	
Body Location of Injury (Please tick appropriate box/es)			
<input type="checkbox"/> 01 Eye	<input type="checkbox"/> 05 Neck	<input type="checkbox"/> 09 Hands / fingers	<input type="checkbox"/> 13 Multiple locations
<input type="checkbox"/> 02 Ear	<input type="checkbox"/> 06 Back	<input type="checkbox"/> 10 Hips / legs	<input type="checkbox"/> 14 Unspecified
<input type="checkbox"/> 03 Face	<input type="checkbox"/> 07 Trunk	<input type="checkbox"/> 11 Feet / toes	
<input type="checkbox"/> 04 Head	<input type="checkbox"/> 08 Shoulders / arms	<input type="checkbox"/> 12 Internal organs	
Treatment			
<input type="checkbox"/> Nil	<input type="checkbox"/> First Aid	<input type="checkbox"/> Doctor Only	<input type="checkbox"/> Hospital as Inpatient

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SECTION 1. WHAT LED UP TO THE INCIDENT (Describe the situation & events preceding the incident)

SECTION 2. DESCRIBE THE INCIDENT (Description of the actual incident / accident)

SECTION 3. LIST THE ELEMENTS INVOLVED IN THE INCIDENT

- People - List each person directly involved and any witnesses
- Equipment - List each piece of plant/ equipment
- Environment - List the physical surroundings

People:	
Equipment:	
Environment	

SECTION 4. RESULTS OF INVESTIGATION - (attach photographic evidence and or sketch) :

Had the person attended the Pre-start Meeting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was the person Site Inducted:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Had the person signed onto the relevant SWMS / JSEA:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was the correct PPE being worn:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was the person correctly trained for the task:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Contributing Factors to the Incident:

-
-
-

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Root Cause of the Incident:			
-			
Investigated By:		Name:	Signature:
		Name:	Signature:
		Date:	Date:
SECTION 5. RECOMMENDED CORRECTIVE AND / OR PREVENTATIVE ACTION			
Actions & Controls:		Person Allocated to Actions	Proposed Completion Date
Raise at the next [type of, e.g. prestart] Meeting	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Should the JSEA / SWMS be reviewed	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Further Actions & Controls: (Utilising "hierarchy of controls")			

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Corrective & Preventative Actions Approved By:

Name & Signature:

Date:

[Management Position] Signature

Name & Signature:

Date:

[Executive Position] Signature

Corrective & Preventative Actions Completed:

Name & Signature:

Date:

[Management Position] Signature

Name & Signature:

Date:

[Executive Position] Signature

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