Incident/Injury Report

To be completed for ALL incidents and accidents where an injury has or could have resulted.

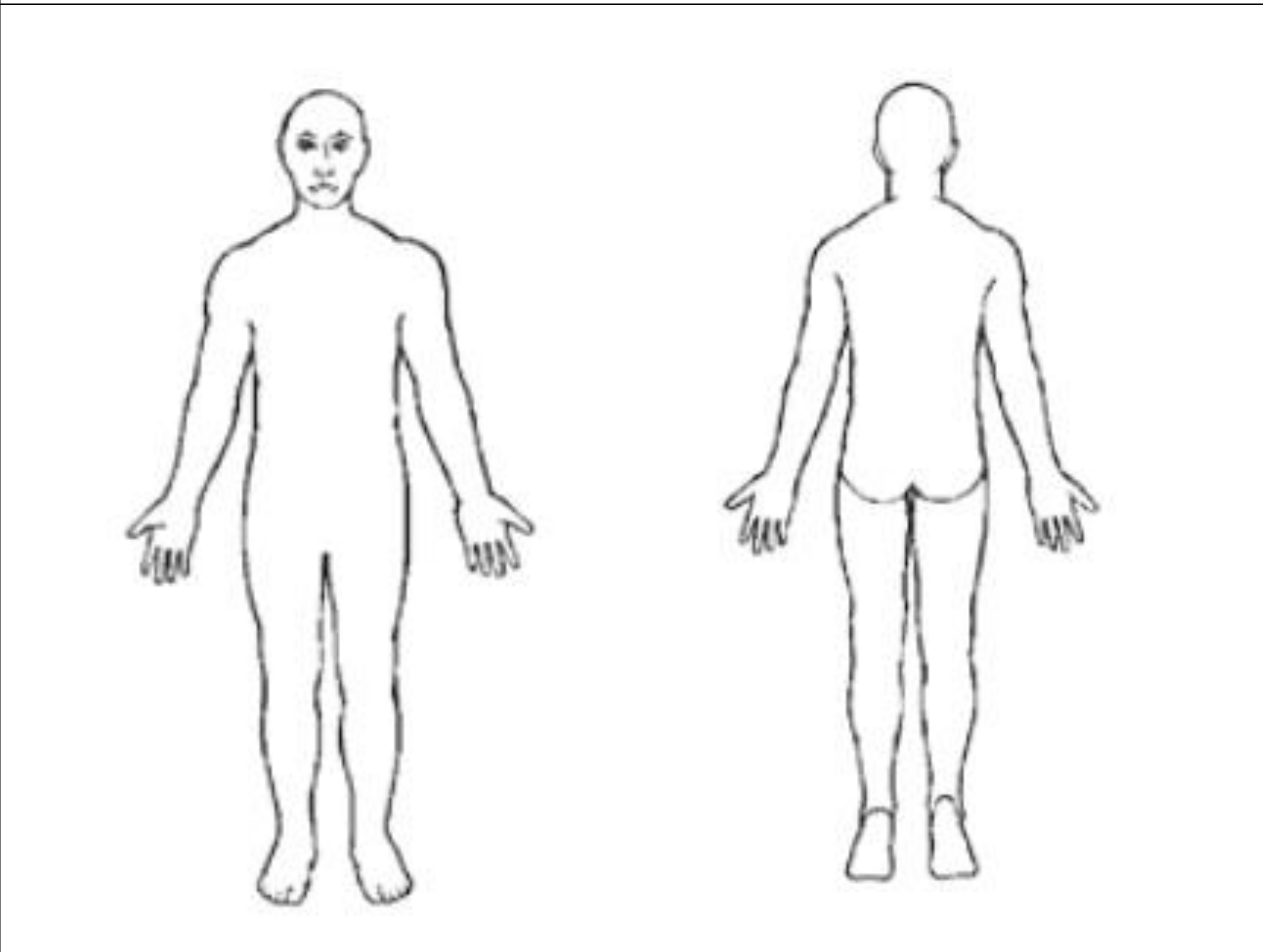
Incident details					
Name of person involved in the incident:					
Status of involved person (please circle): Staff / Client / Visitor / Volunteer / Contractor					
Location of incident:			Date of incident:		
Outcome					
☐ Hazard	☐ Near Miss		☐ Incident	☐ First Aid	
Details of involved person					
First Name:			Surname:		
Date of Birth:			Gender:		
Address:					
Phone:			Mobile:		
Employment Status (please circle): Casual / Permanent / Full Time / Part Time / Contractor					
Experience in Job:					
☐ 0-3 months	☐ 4-12 months	☐ 1-2 years	☐ 3-5 years	☐ 5-10 years	☐ 10 years +
Details of witness/es (if any)					
First Name:			Surname:		
Date of Birth:			Gender:		
Address:					
Phone:			Mobile:		
First Name:			Surname:		
Date of Birth:			Gender:		
Address:					
Phone:			Mobile:		
What task was being performed at the time of the incident?					
What happened? (e.g. 'employee tripped over box' or 'forklift hit wall')					
Cause of Injury					
☐ Lift / bend / push / pull	☐ Posture or arm usage		☐ Hand held tools	☐ Behaviour of client	
☐ Psychological / Stress - Person	☐ Sun exposure		☐ Involuntary movement of client	☐ Vehicle accident – work vehicle	

☐ Psychological / Stress – Bullying/Harassment	☐ Slip / trip / fall	☐ Contact with animal / insect	☐ Vehicle accident – own vehicle
☐ Psychological / Stress – Workload /Organisation	☐ Hazardous substance / material	☐ Electric Shock	☐ Struck by vehicle
☐ Workplace Violence	☐ Drugs / alcohol	☐ Equipment / Machinery	☐ Illness
☐ Other			

Details of injury

Nature of injury (e.g. burn, cut, scrape, etc.):

Location on body (please circle and specify):



Treatment

Treatment Administered:	☐ No	☐ Yes	☐ Not applicable
Referral Required:	☐ No	☐ Yes, to:	

First aid attendant (print name):	Signature:

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY A SENIOR STAFF MEMBER ON DUTY:

Incident investigation

Did the incident occur as part of the involved person's normal activities?	☐ No	☐ Yes	☐ NA
Did equipment contribute?	☐ No	☐ Yes	☐ NA
Was the equipment used designed for activity?	☐ No	☐ Yes	☐ NA
Was the equipment properly maintained?	☐ No	☐ Yes	☐ NA
Did the equipment fail?	☐ No	☐ Yes	☐ NA
Had a risk assessment been undertaken?	☐ No	☐ Yes	☐ NA

Did safety instructions accompany the activity?	☐ No	☐ Yes	☐ NA
Are there documented safe work procedures (SWP) for the activity?	☐ No	☐ Yes	☐ NA
Were the SWP followed?	☐ No	☐ Yes	☐ NA
Was appropriate Personal Protective Equipment (PPE) used?	☐ No	☐ Yes	☐ NA
Was the involved person trained in this activity?	☐ No	☐ Yes	☐ NA
Did a known behaviour problem contribute?	☐ No	☐ Yes	☐ NA
Was there a known behaviour management plan?	☐ No	☐ Yes	☐ NA
Was it followed?	☐ No	☐ Yes	☐ NA
Did poor housekeeping contribute?	☐ No	☐ Yes	☐ NA
Did the work environment contribute?	☐ No	☐ Yes	☐ NA

After reviewing the above prompts and undertaking interviews and/or site visits, what are the identified cause(s) of the injury?

Remedial actions recommended

☐ Conduct task analysis	☐ Reinstruct person(s) involved	☐ Improve design / construction / guarding	☐ Conduct hazard systems audit
☐ Improve skills mix	☐ Develop / review task procedures	☐ Provide debriefing and/or counselling	☐ Improve communication / reporting procedures
☐ Improve work environment	☐ Request maintenance	☐ Improve security	☐ Review WHS policies / programs
☐ Improve personal protection	☐ Temporarily relocate person involved	☐ Provide or replace equipment / tools	☐ Provide, review or replace Behaviour Support Plan
☐ Housekeeping review	☐ Improve work organisation	☐ Investigate safer alternatives	☐ Request Safety Data Sheet
☐ Develop and/or provide training	☐ Other		

What, in your own words, has been implemented or planned to prevent recurrence?

Remedial actions completed:

Name (print name):	Signature:
Position:	Date:

Outcomes

Did the injured person stop work?	☐ No	☐ Yes – date and time:

☐ Treated by doctor	☐ Lodged workers compensation claim	☐ Contacted by Return to Work Coordinator	☐ WorkCover notified
☐ Insurer notified	☐ Returned to normal duties	☐ Returned to modified duties	☐ Hospitalised
☐ WHS committee / representative notified	☐ Other		

Manager’s review comments:

Name (print name):	Signature:
Position:	Date: