icon
TRAINING ACADEMY · RTO: 32126

INCIDENT INVESTIGATION REPORT

This form should be completed following an incident being reported and does not replace the Incident Report itself. The objective of an incident investigation is to ensure all the relevant facts are obtained to help decide upon the appropriate corrective actions required. An incident investigation is not intended to apportion blame for the incident.

INCIDENT DETAILS

Location site:		
Location department:		
Location section/building:		
Date of incident:	Time of incident:	am/pm
Description of Incident:		
Has the incident been reported to the NDIS Commission?	☐ Yes ☐ No	

INVESTIGATION DETAILS

Date of investigation:			Time of investigation:	am/pm
Nature of investigation:	☐ Fatality	☐ Damage	☐ Injury	☐ Near Hit
Person/s conducting investigation				
Name:			Contact:	
Name:			Contact:	
Name:			Contact:	

NAME OF PERSONS INVOLVED IN THE INCIDENT

Name	Position/company	Contact details (phone)

icon
TRAINING ACADEMY · RTO: 32126

WITNESS DETAILS

Name	Position/company	Contact details (phone)

SEQUENCE OF EVENTS THAT LED UP TO THE INCIDENT

1

2

3

4

5

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.

Could the incident have been prevented or the impact minimised? Please write details below.

OTHER CONTRIBUTING FACTORS CONTINUED

Is there an ongoing risk?

Is there an ongoing risk to people with disability?

ACTIONS TAKEN AT TIME OF INCIDENT TO MINIMISE THE IMPACT OF THE INCIDENT

Eg removal of guards, emergency procedures, equipment removal etc.

1

2

3

4

5

ANNEXURES SUPPORTING THIS REPORT

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

1

2

3

4

5

RECOMMENDED CORRECTIVE ACTIONS

E.g. retraining or further training, policy improvements or development of policies and procedures, changes to service environment, changes to delivery of services.

1

2

3

4

5

icon
TRAINING ACADEMY · RTO: 32126

MANAGER AGREED CORRECTIVE ACTIONS

Item	Responsibility	Target date	Completed	
1		… / … / ……	○ Yes	○ No
2		… / … / ……	○ Yes	○ No
3		… / … / ……	○ Yes	○ No
4		… / … / ……	○ Yes	○ No
5		… / … / ……	○ Yes	○ No

PERSON RESPONSIBLE FOR IMPLEMENTING CORRECTIVE ACTIONS

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 notifiable incident?	☐ Yes	☐ No

WORKERS COMPENSATION (WC)

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

icon
TRAINING ACADEMY · RTO: 32126

COPIES OF THIS REPORT HAVE BEEN SENT TO

Date sent	Sent to
… / … / ……	
… / … / ……	
… / … / ……	

ADMINISTRATION

File completed?	☐ Yes	☐ No	Date:
Further action required?	☐ Yes	☐ No	Date:
Details of further action:			

SIGNATURES

Investigation representative	Manager	Person making the report	Witness