Incident/Injury Report

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

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| **Work Location:**  Organisation / Facility In the Community  Client Home Other | **Today’s Date:**  / / |
| **Status of the involved person:**  Employee Client  Visitor Volunteer Contractor | **Outcome:**  Hazard Near Miss  Incident First Aid |
| **Details of involved person:**  Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name: \_\_\_\_\_\_\_ DOB: \_ / /  Home Address: \_ Phone:  \_ Sex: M / F  Employment Status:  Casual Full-time Contractor  Permanent P/T Other: \_\_\_\_\_\_ | |
| **Details of witnesses (if any):**  Name: Phone:  Address:  Name: Phone:  Address: | |
| **Details of incident or accident:**  Date: / / Time of Injury: AM / PM  Activity engaged in at time of incident:  Exact location of person at time of incident:  Describe how and what happened (please give full details & include a diagram, if appropriate. Use a separate sheet if necessary. Please include car registration number if reporting a Motor Vehicle Accident). | |

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| **Details of injury if applicable: (supervisor may need to assist completion)**  Cause of Injury:  Lift/bend/push/pull Psychological/Stress - Surface/Material or  Object Bullying/Harassment Sun Exposure  Lift/bend/push/pull Psychological/Stress - Electric Shock  Person Workload/Organisation  Static or Repetitive Hazardous Substance/ Hand Held Tools  Posture or Arm Usage Material  Workplace Violence Biological Agency Contact with  Animal/Insect  Slip/Trip/Fall – Entrapment in Vehicle Accident -  Indoors Equipment/Machinery Work Vehicle  Slip/Trip/Fall – Strike/Struck by Vehicle Accident -  Outdoors Equipment/ Machinery Own Vehicle  Superficial if not Involuntary Movement Behaviour of  cause by above of client client  Other:  Nature of injury/illness (e.g. burn, sprain, cut etc.)  Location on body (please circle and specify):    How did the injury occur? (e.g. fall, grabbed by person, muscular stress): |

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| **Treatment administered if required:** Yes No  Treatment:    Referral required: Yes No Who to:  First aid attendant (Print Name): Signature: |
| **THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY A SENIOR STAFF MEMBER ON DUTY** |
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| **Incident or accident investigation:**  Did the incident occur as part of the involved person’s normal activities? **Yes** □ **No** □ **N/A** □  Did equipment contribute? **Yes** □ **No** □ **N/A** □  Was the equipment used designed for activity? **Yes** □ **No** □ **N/A** □  Was the equipment properly maintained? **Yes** □ **No** □ **N/A** □  Did the equipment fail? **Yes** □ **No** □ **N/A** □  Had a risk assessment been undertaken? **Yes** □ **No** □ **N/A** □  Did safety instructions accompany activity? **Yes** □ **No** □ **N/A** □  Are there documented safe work procedures (SWP) for activity? **Yes** □ **No** □ **N/A** □  Were these SWP followed? **Yes** □ **No** □ **N/A** □  Was appropriate PPE used? **Yes** □ **No** □ **N/A** □  Was the involved person trained in this activity? **Yes** □ **No** □ **N/A** □  Did a known behaviour problem contribute? **Yes** □ **No** □ **N/A** □  Was there a known behaviour management plan? **Yes** □ **No** □ **N/A** □  Was it followed? **Yes** □ **No** □ **N/A** □  Did poor housekeeping contribute? **Yes** □ **No** □ **N/A** □  Did the work environment contribute? **Yes** □ **No** □ **N/A** □ |
| After reviewing the above prompts and through interview/site visits what are the identified cause(s):                                  **Remedial actions recommended:**  □Conduct task analysis □ Re-instruct persons involved □ Improve Infrastructure  □ Conduct hazard systems audit □ Improve skills mix □ Add to inspection program  □ Develop/review task procedures □ Provide debriefing and/or counselling □ Improve communication/  reporting procedures  □ Improve work environment □ Request maintenance □ Improve security  □ Review WHS policy/programs □ Improve personal protection □ Temporarily relocate employees involved  □ Provide or replace □ Improve work congestion/ □ Behaviour Support Plan  equipment/tools Housekeeping Review    □ Improve work organisation □ Investigate safer alternatives □ Request MSDS  □ Develop and/or provide training □ Other: |
| **What, in your own words, has been implemented or planned to prevent recurrence:** |
| **Remedial actions completed:** |
| **Did the injured person stop work: Yes No**  If yes, state date: / / Time: AM / PM  Outcome:  □ Treated by Doctor □ Lodged workers comp claim □ Contacted by RTW Coordinator  □ WorkCover notified □ Insurer notified □ Returned to normal duties  □ Returned to modified duties □ Hospitalised □ OHS Committee/  representative advised |
| **Signature (Staff):**   **Date:**  / / |