|  |  |
| --- | --- |
|  | |
| E:\NEW LOGO.jpg | |
|  | Incident Investigation Report  Incident Cause Analysis Method (ICAM) |
|  |  |
|  | [Event Name]  [Event Location/College/School/Portfolio/Organisational Unit]  [Date of Event] |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Revision** | **Description** | **Author (name & date)** | **Reviewer (name & date)** | **Approver (name & date)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Table of Contents

[1.0 About This Document 3](#_Toc459126325)

[1.1 Assumptions and Exclusions 3](#_Toc459126326)

[1.1. Definitions 3](#_Toc459126327)

[2.0 Incident Details 3](#_Toc459126328)

[2.1. Event Notification 3](#_Toc459126329)

[2.2. Description of Event 3](#_Toc459126330)

[2.3. Details of Injury/Damage/Impact 3](#_Toc459126331)

[2.4. Immediate Actions Taken by Line Management following Event 3](#_Toc459126332)

[3.0 Key Findings 3](#_Toc459126333)

[3.1. Basic Cause 4](#_Toc459126334)

[3.2. Contributing Factors 4](#_Toc459126335)

[3.2.1. Absent or Failed Defences 4](#_Toc459126336)

[3.2.2. Individual or Team Actions 4](#_Toc459126337)

[3.2.3. Task or Environmental Condition 4](#_Toc459126338)

[3.2.4. Organisational factors 4](#_Toc459126339)

[4.0 Conclusions and Observations 4](#_Toc459126340)

[5.0 Recommendations 4](#_Toc459126341)

[5.1. Heading 5](#_Toc459126342)

[5.2. Heading 5](#_Toc459126343)

[6.0 Significant Learning’s 5](#_Toc459126344)

[6.1. Heading 5](#_Toc459126345)

[6.2. Heading 5](#_Toc459126346)

[6.3. Heading 5](#_Toc459126347)

[7.0 Corrective Action Plan 5](#_Toc459126348)

[8.0 PEEPO 6](#_Toc459126349)

[8.1. People 6](#_Toc459126350)

[8.2. Environment 6](#_Toc459126351)

[8.3. Equipment 7](#_Toc459126352)

[8.4. Procedures 8](#_Toc459126353)

[8.5. Organisation 8](#_Toc459126354)

[9.0 Chronology of Events 10](#_Toc459126355)

[10.0 Photos 10](#_Toc459126356)

[11.0 Document Control 10](#_Toc459126357)

[12.0 Appendix 12](#_Toc459126358)

# About This Document

This investigation report adopts the Incident Cause Analysis Method (ICAM) for analysis of root causes and determining recommendations.

The aim of this method and this report is not to apportion blame or liability but to identify failures within organisations, systems and communication which have contributed to the event and to provide recommendations that should prevent recurrence.

## Assumptions and Exclusions

List otherwise None.

## Definitions

|  |  |
| --- | --- |
| **Term** | **Definition** |
|  |  |
|  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Event Title** |  | | | | |
| Event Type |  | | | | |
| Event Date |  | Event Time |  | Ref Number |  |
| Employee, Contractor and/or Third Party Incident | | | |  | |
| Building Number, Floor, Room Number | | | |  | |
| Description of Location | | | |  | |
| Is the activity Controlled, Monitored or Uncontrolled? | | | |  | |
| What risk assessment was conducted for this task? | | | |  | |
| What site standard or procedure exist to control this risk? | | | |  | |

# Incident Details

## Event Notification

## Description of Event

(Where, Who, What, How, When)

## Details of Injury/Damage/Impact

(Nature and Extent of Injuries/Damage/Impact)

## Immediate Actions Taken by Line Management following Event

Details

# Key Findings

The key findings outline why the incident occurred and the contributing factors deduced from the investigation have been categorised using the Incident Cause Analysis Method (ICAM). The ICAM analysis chart is shown as an Appendix in Section 6 of this report.

## Basic Cause

Why did the incident occur?

## Contributing Factors

Based on the evidence to hand, the Investigation Team believe the following were the main contributing factors to the incident:

### Absent or Failed Defences

The ‘last minute measures which did not prevent the outcome of the incident or mitigate/reduce its consequences’.

* Type – Description of contributing factor
* Type – Description of contributing factor
* Type – Description of contributing factor

### Individual or Team Actions

Errors or violations that led directly to the incident. They are typically associated with personnel such as operators and maintainers having direct contact with equipment or material. They are always committed ‘actively’ (someone did or didn’t do something) and have a direct relation with the incident’.

* Type – Description of contributing factor
* Type – Description of contributing factor
* Type – Description of contributing factor

### Task or Environmental Condition

Task and environmental conditions are those conditions in existence immediately prior to or at the time of the incident that directly influence human and equipment performance in the workplace.

* Type – Description of contributing factor
* Type – Description of contributing factor
* Type – Description of contributing factor

### Organisational factors

Organisational factors are those aspects which can be implicated in producing the task/environmental conditions, individual or team actions, or absent/failed defences that have allowed the incident or accident to happen.

* Type – Description of contributing factor
* Type – Description of contributing factor
* Type – Description of contributing factor

# Conclusions and Observations

The investigation concluded the following findings were or could have been contributory factors to the incident:

* Insert Conclusion or Observation
* Insert Conclusion or Observation
* Insert Conclusion or Observation
* Insert Conclusion or Observation
* Insert Conclusion or Observation

# Recommendations

The following recommended corrective actions are put forward for consideration. The recommendations address the Absent or Failed Defences and Organisational Factors identified as key findings of the investigation. These recommendations are applicable to College / School / Portfolio / Organisational Unit / Contractor and could benefit other RMIT operations.

## Heading

Detail and explanation. Include stakeholders and timeframes

## Heading

Detail and explanation. Include stakeholders and timeframes

# Significant Learning’s

The investigation has raised a number of key learnings which are covered in the body of the report. The significant learnings for RMIT are:

## Heading

Detail and explanation. Include stakeholders and timeframes

## Heading

Detail and explanation. Include stakeholders and timeframes

## Heading

Detail and explanation. Include stakeholders and timeframes

# Corrective Action Plan

The following are to be referenced against the incident report

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Item Ref | Recommendation | Responsible Department | Responsible Person | Completion Date | Sign Off |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

# PEEPO

## People

|  |  |  |
| --- | --- | --- |
| **Item** | **Detail** | **Comment** |
| **Records** | Personnel, medical, training and incident history records |  |
| **Roster** | Time sheets, shift rosters and work cycles. |  |
| **History** | Previous 72 hour history of key personnel involved. |  |
| **Psychology** | Assessment of personality, safety attitude, motivation, conflict, stress, external influences ie. social and domestic pressures. |  |
| **Physiology** | Assessment of physical and mental state prior to the incident including fatigue, substance abuse, physical stress, illness or impairment, environmental discomfort, age physical condition. |  |
| **Ability** | Assessment of training, experience and competence for the task |  |
| **Supervision** | Levels and quality of supervision |  |
| **Alertness** | Assessment of situational and hazard awareness |  |
| **Communication** | Assessment of communication adequacy and effectiveness. |  |
| **Teamwork** | Assessment of teamwork, workload sharing and coordination of effort |  |

## Environment

| **Item** | **Detail** | **Comment** |
| --- | --- | --- |
| **Illumination** | Too much or too little light that was a negative influence on vision. |  |
| **Precipitation** | Climatic precipitation that has a negative influence on human or equipment performance. This includes condensation, fog, frost, hail, ice, mist, rain, sleet, or snow. |  |
| **Contaminants** | Natural or man-made elements that render material or the environment unsatisfactory for human or equipment use and have a negative influence on performance. These include carbon dioxide, carbon monoxide, chemicals, dust, foreign objects, debris, fumes, gases, impurities, mists, smog, smoke, toxic materials, or vapours. |  |
| **Noise** | Unwanted sound that produces hearing loss, disturbs / distracts attention from the task at hand, or interfered with communication. |  |
| **Temperature / humidity** | Extremes of heat, cold, and humidity that have a negative influence on human or equipment performance. |  |
| **Wind / turbulence** | Natural or man-made air movement that has a negative influence on human or equipment performance. |  |
| **Vibration** | Repeated / periodic motions that have a negative influence on human or equipment performance. |  |
| **Acceleration / deceleration** | Forces experienced by personnel /equipment due to rate of change of velocity. |  |
| **Radiation** | Radiant energy emitted in waves or particles that have a negative influence on human or equipment performance. This includes alpha radiation, beta radiation, gamma radiation, ionising, laser, maser, neutron radiation, non-ionising, radio waves, sunlight, ultraviolet, or X radiation. |  |
| **Work surface / space** | Conditions (excluding precipitation) of natural or man-made work surfaces on which personnel and equipment operate that have a negative influence on performance. This includes holes, inclines, rocky, rough, rutted, slippery, steep, or uneven wave action. |  |
| **Electricity** | Natural or man-made electrical current that has a negative influence on human or equipment performance. This includes burn out, electrocution, discharge, earth faults, lightning, shock, short, or static. |  |
| **Air pressure** | Sudden or gradual changes in air pressure that have a negative influence on human or equipment performance. This includes altitude, bends, blast, chokes, decompression, explosion, or hypoxia. |  |
| **Wildlife** | The actions or presence of animals that injure personnel, cause personnel to make errors, damage equipment, or cause equipment to malfunction |  |

## Equipment

|  |  |  |
| --- | --- | --- |
| **Item** | **Detail** | **Comment** |
| **Design** | The design of the equipment should be adequate to meet the requirements and operational conditions under which they were being used. |  |
| **Construction** | The equipment should be constructed to specifications within the design standard. |  |
| **Testing** | The equipment should be tested to ensure that it meets the design standard and construction specifications. |  |
| **Inspection** | There should be an inspection procedure for monitoring the status of the equipment on initial delivery, periodically throughout its life, at critical times before, during and after operation. |  |
| **Modification** | Equipment modification should be carried out by controlled procedure to ensure performance, safety and reliability are not adversely affected. Modifications should also account for changes to: maintenance procedures, inspection procedures, operating procedures, ergonomics, man-machine interface |  |

## Procedures

|  |  |  |
| --- | --- | --- |
| **Item** | **Detail** | **Comment** |
| **Utilisation** | The documented procedures should be used for conducting the operation in a correct, safe and efficient manner. |  |
| **Content** | The documented procedures should be adequate for the scope of the work to be conducted. The procedure should cover all tasks, contain emergency provisions, contain work-around provisions, cover exemptions where the entire procedure does not apply. |  |
| **Criteria** | The procedures should contain the necessary information, in a user friendly language. The format should successfully link people and equipment to provide a risk minimised or risk eliminated operation. |  |
| **Validated** | The procedures should be reviewed, checked and tested by qualified people to ensure that the personnel that use the procedure can carry out the operation correctly safely and efficiently. |  |
| **Control** | The procedure should have a method of revision control to ensure only current procedures are in use. |  |

## Organisation

|  |  |  |
| --- | --- | --- |
| **Item** | **Detail** | **Comment** |
| **Organisational culture** | The organisation should have a systemic approach to safety. There should be evidence of management leadership and commitment to setting high standards of safety, quality and productivity performance. Measurable factors include: people management, provision and quality of tools and equipment, commercial and operational pressures, planning, maintenance of facilities and equipment, communication. |  |
| **Training programme** | The organisation should have a structured training programme for the provision and consolidation of technical skills, safety awareness and safety knowledge. The effectiveness of training should be measurable. |  |
| **Visible support** | The organisation should demonstrate support for the work site operational staff including provision of adequate manning levels, suitable equipment and material and adequate facilities and services. |  |
| **Operational feedback processes** | The organisation should have a formal and effective operational feedback system for system monitoring and improvement. |  |

# Chronology of Events

# Photos

|  |  |
| --- | --- |
|  |  |
|  |  |

|  |  |
| --- | --- |
|  |  |
|  |  |

# 

# Document Control

|  |  |  |
| --- | --- | --- |
| Version | Issue Date | Summary of Changes |
|  |  |  |
|  |  |  |

# Appendix

Attach relevant documents such as statements, rosters, floor plans etc that should be referenced throughout the investigation.