Incident Reporting

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WHS incident reporting involves recording all notifiable incidents (as outlined in the WHS Act) arising out of the conduct of a business or undertaking at a workplace.

A notifiable incident, as outlined, in the WHS Act is:

- Death of a person;
- Serious injury or illness; or
- Dangerous incident

Acceptable evidence includes (but not limited to):

- Self-declaration of incident statistics and
- WHS prosecutions

Contributing Factors to Incidents

TOP TEN KNOWN PRIMARY CONTRIBUTING FACTORS OF ACCIDENTS

Accident Rank	Contributing Factor	Number of Accidents	Number of Deaths	Number of Injuries
1	Operator Inattention	583	58	363
2	Improper Lookout	514	31	391
3	Operator Inexperience	364	43	255
4	Excessive Speed	349	28	321
5	Machinery Failure	319	18	120
6	Alcohol Use	296	125	243
7	Hazardous Waters	258	88	122
8	Weather	235	54	114
9	Rules of the Road	214	6	186
10	Force of Wave/Wake	201	6	183

Incident Reporting Form

Incident Reporting Form

Use this form to report any workplace accident, injury, incident, close call or illness.
Return completed form to the Operations Supervisor, or Management.

This is documenting an:

☐ Lost Time/Injury ☐ First Aid ☐ Incident ☐ Close Call ☐ Observation

Details of person injured or involved (to be filled in by person injured / involved if possible)

Person Completing Report:_____ Date:_____

Person(s) Involved:_____

Equipment or Truck ID:_____

Event Details

Date of Event:_____ Location of Event:_____

Time of Event:_____ Witnesses:_____

Description of Events (Describe tasks being performed and sequence of events):

_____

_____

_____

_____

_____

*If more space is required please use the back of this sheet

Was event / injury caused by an unsafe act (activity or movement) or an unsafe condition (machinery or weather)? Please explain:

_____

_____

TO BE COMPLETED ONLY IF LOST TIME/INJURY OR FIRST AID WAS REQUIRED	
Type of injury sustained:	
Cause of lost time/ injury or first aid:	
Was medical treatment necessary?	Yes_____ No_____ If yes, name of hospital or physician:

Signature of Employee:_____ Date:_____

Signature of Supervisor:_____ Date:_____