

### Appendix E - Incident Report and Investigation Form

|                            |                                                                                                                     |
|----------------------------|---------------------------------------------------------------------------------------------------------------------|
| Reference:                 | <input type="checkbox"/> Injury/Illness <input type="checkbox"/> Property Damage <input type="checkbox"/> Near Miss |
| Synod / Congregation Name: |                                                                                                                     |
| Address:                   |                                                                                                                     |

| 1. Injured Person Details (Complete if appropriate)                               |                                     |
|-----------------------------------------------------------------------------------|-------------------------------------|
| Surname:                                                                          | First Name:                         |
| Employee / Contractor / Visitor / Congregation Member / Volunteer (please circle) |                                     |
| Sex:<br><input type="checkbox"/> Male <input type="checkbox"/> Female             | Contact Details and Contact Number: |

| 2. Occupation/Job Title and Details (Complete if appropriate)                                                                                                                                               |                                                                                                         |                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| Job Title:                                                                                                                                                                                                  | How long in this position:                                                                              |                                                                                                       |
| Start time:<br>__:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM                                                                                                                             | Hours worked:<br><input type="checkbox"/> 8 hours or less<br><input type="checkbox"/> More than 8 hours | Shift arrangement:<br><input type="checkbox"/> Fixed shift<br><input type="checkbox"/> Rotating shift |
| Training/Qualifications held (tick more than one if appropriate):<br><input type="checkbox"/> Induction <input type="checkbox"/> Task specific <input type="checkbox"/> Trade <input type="checkbox"/> None |                                                                                                         |                                                                                                       |

| 3. Incident Details                                                                                                                     |                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| Occurred: __/__/__ at __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM                                                  | Where did the incident occur?:                          |
| Reported: __/__/__ at __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM                                                  |                                                         |
| Required to be reported to regulatory authority: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes) __/__/__ at __:__:__ |                                                         |
| Description of incident:                                                                                                                |                                                         |
| Description of injury/illness, property damage, near miss (nature/extent of injuries – include body parts):                             |                                                         |
| <b>Names and contact details of any witnesses:</b>                                                                                      |                                                         |
| 1. Name:                                                                                                                                | Position:      Phone Number:                            |
| 2. Name:                                                                                                                                | Position:      Phone Number:                            |
| <b>Name and signature of reporting person:</b>                                                                                          |                                                         |
| Name:                                                                                                                                   | Synod / Congregation:      Position:      Phone Number: |
| Signature:      __/__/__ at __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM                                            |                                                         |

**4. Investigation** (to be conducted by Contact Person in consultation with relevant employees, contractors, visitors, congregation member or volunteer)

How exactly was the injury, disease or damage sustained (include the name of any chemical, product, process or plant involved)?

Identified hazard(s):

**5. Risk Assessment Information (please circle)**

| EXTREME       | HIGH                                                                                                                                                                                                                                      | MOD | LOW |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| Extreme Risk  | Notify Contact Person and Synod Manager, Insurance Services and/or Synod OHS Unit immediately. Temporary corrective actions should be taken immediately and permanent corrective actions within 24 hours of notification.                 |     |     |
| High Risk     | Notify Contact Person and Synod Manager, Insurance Services and/or Synod OHS Unit immediately. Temporary corrective actions should be taken immediately and permanent corrective actions should be taken within 48 hours of notification. |     |     |
| Moderate Risk | Notify Contact Person in Synod / Congregation – Contact Person is to follow up that corrective action is taken within 7 days.                                                                                                             |     |     |
| Low Risk      | Notify Synod / Congregation – employee is to follow up that corrective action is taken within a reasonable time.                                                                                                                          |     |     |

**Name & Signature of Investigator:**

Name: \_\_\_\_\_ Synod / Congregation: \_\_\_\_\_ Position: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ at \_\_\_/\_\_\_/\_\_\_ at \_\_\_:\_\_\_  AM  PM

**Verification by Synod OHS Unit:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date report received: \_\_\_/\_\_\_/\_\_\_ at \_\_\_:\_\_\_  AM  PM

Signature: \_\_\_\_\_

**All completed forms are to be forwarded to Synod OHS Unit within 24 hours.**

| 6. Control Strategy                                                                                                                                                                                                                                       |                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Please tick....<br><input type="checkbox"/> Elimination<br><input type="checkbox"/> Substitution<br><input type="checkbox"/> Isolation<br><input type="checkbox"/> Engineering<br><input type="checkbox"/> Administrative<br><input type="checkbox"/> PPE | If controlled immediately list details here.<br><br><br><br><br>Date to be implemented: / /            |
|                                                                                                                                                                                                                                                           | If longer term controls required list here.<br><br><br><br><br><br><br><br>Date to be implemented: / / |

| 7. Review Controls                                                        |            |
|---------------------------------------------------------------------------|------------|
| Contact Person in Synod / Congregation verifies controls are effective:   | Name:      |
| <input type="checkbox"/> Effective <input type="checkbox"/> Not effective | Date: / /  |
|                                                                           | Signature: |

**All completed forms are to be forwarded to Synod OHS Unit within 24 hours.**