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**INCIDENT AND NEAR MISS FORM**

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| **Please attach the incident report to your email and send a copy to the OHS Business Partner and your Line Manager** |
| **INCIDENT /INJURIES:** COMPLETE ALL APPLICABLE SECTIONS *(as a minimum complete sections 1 to 6)* |
| TYPE OF REPORTING | [ ]  PHYSICAL INJURY | [ ]  MENTAL INJURY  | [ ]  COVID-19 |
| 1. DETAILS OF PERSON INVOLVED IN INCIDENT AND REPORTING |
| Name of person **reporting** |       | **Position** |       | **Branch** |       |
| **First Name** of person involved in **incident** |       | **Surname** |       | **Site** | **[ ] RBGV-M [ ] RBGV -C [ ] Others** |
| **Gender** |       | **Age group** | **[ ]** 0-05 **[ ]** 06-10  **[ ]** 11-14  **[ ]** 15-17 [ ]  18-25 [ ]  26-30 [ ]  31-35 [ ]  36-40 [ ]  41-50 [ ]  51-60 **[ ]** 61-70  **[ ]  7**1-80  **[ ]  8**1-90  **[ ]  91+**  |
| **Select a group** | **[ ]  Employee** *(go to 1.1)* | **[ ]  Supplier** / **Contractor** *(go to 1.2)* | **[ ]  Public** *(go to 1.3)* | **[ ]  Volunteer / Student** *(go to 1.3)* |
|  |
| **1.1 ROYAL BOTANIC GARDENS VICTORIA EMPLOYEE** |
| Employment Status | [ ]  Full Time [ ]  Part Time [ ]  Casual  | Branch |       |
| Position Title |       | Employee Line Manager |       |
| Has this type of incident happened to you before? If **YES** provide brief details |       |
| Are you intending to see a Medical Practitioner as a result of this injury? | [ ]  YES [ ]  NO  |
| Where applicable, list PPE used by the person at time of incident?  | [ ]  N/A [ ]  Safety Shoes [ ]  Hand Protection [ ]  Eye protection [ ]  Hi Vis [ ]  Hard Hat [ ]  Straw Hat [ ]  Hearing Protection [ ]  Others (please state)       |
|  |
| **1.2 CONTRACTORS / SUPPLIERS**  |
| Contracting Company |       | Contractor / Supplier Job Title |       |
| Contractor’s Manager’s name and contact no |       | Other details (eg vehicle no) |       |
|  |
| **1.3 MEMBER OF THE PUBLIC / VOLUNTEER / STUDENT** |
| **Contact number** (include name if other than incident person) |       | Relationship to Injured person |       |
| **DETAILS BELOW ONLY REQUIRED FOR SERIOUS INJURIES AND/OR WORKSAFE NOTIFIABLE REPORTING** *(Includes / involving Police investigation incident, Paramedics / Ambulance / Hospitalisation)* |
| Date of Birth |       |  |  |  |  |
| Address: |       | Suburb |       | State |       |
|  |
| 2. INCIDENT OR NEAR MISS DETAILS (USE SEPARATE SHEET IF INSUFFICIENT SPACE) |
| INCIDENT DATE |       | Time |       | am/pm | REPORTED DATE |       |
| **Location of incident** *(eg in front of the Herbarium building entry door)* |       |
| **Incident Resulted in**  | [ ]  Injury | [ ]  Near Miss | [ ]  Report Only | [ ]  Hazard Alert Only | [ ]  Property Damage / Loss / Theft |
| **Incident Category** | [ ]  Lost Time Injury | [ ]  Medical Time Injury | [ ]  First Aid Treatment Injury | [ ]  Restricted Work Injury | [ ]  Near Miss |
| [ ]  Report Only Incident | [ ]  Property Damage / Loss / Security / Theft *(complete 4.2 only)* | [ ]  Workplace Mental Health | [ ]  COVID - 19 |
| **WHAT HAPPENED?** *Describe the sequence of events that resulted in the incident preferably using the term 'Injured worker or contractor or person'.* *Explain what was going on (activity / job / event), what went wrong, what were the consequences (what was the extent of the injury / damage), where exactly it occurred, etc. Assume people reading this report do not know the operation / task / situation. Stick to the facts.* |
|       |

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| **WITNESS TO INCIDENT OR FIRST PERSON ON SCENE** |
| **Witness name or first person on scene:** |       | **Branch / Relationship** |   |
| **If non RBGV employee, state name and contact no** |       |
| Witness observation of the incident:      |
|  |
| 3. Treatment AND MEDICAL ATTENTION REQUIRED *(Tick all applicable boxes)* |
| [ ]  None required | [ ]  RBGV First Aider *(Complete First Aider Report / Response form)* |  [ ]  Sent to Medical Centre | [ ]  Ambulance attendance | [ ]  Sent to Hospital |
| *If treated externally, provide information (e.g., Hospital or Clinic name)* |       |
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| 4. INJURY / INCIDENT DETAILS |
| 4.1 FOR INJURY DETAILS |
| Areas of injuries including parts and sides of body: *(eg cuts to left finger)* |       |
| *Nature of Injury*  | [ ]  Amputation [ ]  Abrasion/Bruise [ ]  Bite/Sting [ ]  Burns [ ]  Chem Exposure [ ]  Crushing [ ]  Cuts/Lacerations [ ]  Electric Shock [ ]  Fracture [ ]  Foreign Object [ ]  Heat Stress [ ]  Inhalation [ ]  Muscular Discomfort [ ]  Over-exertion [ ]  Puncture [ ]  Respiratory [ ]  Strain / Sprain  [ ]  Skin Disease [ ]  None – Hazard Alert Only |
| 4.2 FOR Property Damage / Vandalism / Loss / Security DETAILS |
| Was there forced entry? | [ ]  YES [ ]  NO  | If Yes, which entry was forced? (eg front door, back window, etc) |       |
| Lists of items stolen / damaged / vandalised |       |
| Additional information that would assist with identifying or contacting the people involved with the incident |       |
| Was incident reported to police? | [ ]  **YES** [ ]  **NO**  | If YES, officer name |       |
| If applicable, please attach the police report to this incident report. |

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| 5. Immediate corrective Actions taken |
|  | **IMMEDIATE ACTIONS TAKEN** | **ACTION BY** | **DUE DATE** | **DATE COMPLETED** |
| 1 |       |       |       |       |
| 2 |       |       |       |       |
| 3 |       |       |       |       |
| 4 |       |       |       |       |

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| 6. ACKNOWLEDGEMENT |
| Person Name |       | Sign |  | Date |       |
| Supervisor / Manager |       | Sign |  | Date |       |
| HSR / First Aider |       | Sign |  | Date |       |
|  |  |  |  |  |  |

**NEXT STEPS:**

1. Complete this form and submit within 24 hours of the injury or incident happening to your line manager who will review and take the appropriate actions. The line manager will submit to the OHS Advisor (P&C) for registering into the Incident Register, as soon as practicable. Submission can be made by submitting hard copy or by emailing a scanned copy.
2. Where WorkCover Claim is to be made, an Employee WorkCover Claim form and Certificate of Capacity are to be sent to the OHS Advisor (P&C) as soon as practicable. P&C will follow the CGU and VWA procedures for all WorkCover Claims. The Employee WorkCover Claim Form **MUST** be lodged to CGU within 10 days of the employee submission date of the Employee WorkCover Claim form.

**PRIVACY STATEMENT**

The RBGV will only use your personal information in accordance with the Privacy and Data Protection Act and the Health Records Act. Your personal information may be given to others in the handling of this injury or incident.

**All** Lost Time incident (**LTI**), Medical Time Incident (**MTI**), Restricted Work Injury (**RWI**) and Notifiable Incidents **MUST** complete **Section 7 to Section** **9**

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| 7. INVESTIGATION AND CORRECTIVE / PREVENTATIVE ACTION |
| Investigation results (how and why it occurred?) |
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| Where applicable (**LTI, MTI, RWI**), conduct **ROOT CAUSE ANALYSIS (RCA).** You can use the **5 WHYs** method to help find the ROOT CAUSE.**ROOT CAUSE STATEMENT:**       |
| Is this activity usually performed by this person as part of normal activity? **[ ]**  **YES** **[ ]  NO [ ]  N/A**  |
| Was this activity carried out in accordance with normal procedures? *If NO give reasons* [ ] **YES [ ]  NO [ ]  N/A** *Reasons (if any):*      |
| Was the person trained in / aware of the activity to be performed safely? *If NO give reasons* [ ] **YES [ ] NO [ ]  N/A** *Reasons (if any):*       |
| Were safety instructions available / provided prior to performing the activity? [ ]  **YES [ ]  NO [ ]  N/A** *Comments (if any):*      |
| If plant/equipment involved, was it in good condition (eg serviced, safety guards in place)? [ ]  **YES [ ]  NO [ ]  N/A** *Comments (if any):*      |
| Were there any other factors involved *(eg climatic conditions, time of day, etc)?* [ ] **YES [ ]  NO [ ]  N/A** *Comments (if any):*      |
|  |
| 8. PREVENTATIVE / corrective action PLAN |
| *Consider Corrective / Preventative actions to be taken to prevent recurrence:*  |
|  | **PLANNED ACTIONS** | **ACTION BY** | **DUE BY** | **DATE COMPLETED** |
|  |       |       |       |       |
|  |       |       |       |       |
|  |       |       |       |       |
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| 9. REVIEW INVESTIGATION OUTCOMES AND PREVENTATIVE ACTION PLANS |
| **ONLY FOR NOTIFIABLE & LOST TIME INCIDENTS REQUIRE REPRESENTATIVE REVIEW.** *\*As a minimum, HSR and OHS Business Partner only required* |
| **Representative** | **Print Name** | **Signature** | **Date** |
| **\*HSR**  |       |  |  |
| **\*OHS BUSINESS PARTNER** |       |  |  |
| **BRANCH MANAGER / HEAD** |       |  |  |
| **EXECUTIVE DIRECTOR** |       |  |  |
| **COMMENTS:**  |
|       |

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| **FIRST AIDER REPORT / RESPONSE FORM** |  |

1. Part **a)** or **b)** to be completed if public treatment consent by parent or guardian is required.

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| 1. **Parent/Guardian Consent**

As a parent/guardian of the above-mentioned casualty, I consent to the Royal Botanic Gardens Victoria providing First Aid or Treatment |
| Family Name |       |  | Given Name |       |
| Signature |  |  | Date Signed |  |
| 1. **Casualty Consent**
 |
| Casualty name |       |  | Date Signed |  |
| 1. **Witness Details (If any)**
 |
| Family Name |       |  | Given Name |       |
| Signature |  |  | Contact No |  |
|  |

**First Aider Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Aider Name |       |  | First Aider Signature |  |
| Time provided first aid |       |  |  |  |

**FIRST AIDER ASSESSMENT CHECKLIST**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Past Medical History** | [ ]  Not known  | [ ]  Nil | [ ]  Loss of consciousness | [ ]  Diabetes | [ ]  Cardiac  |
| [ ]  Asthma | [ ]  Epilepsy | [ ]  Medications (*state type)* | [ ]  Allergies (*state type)* |
| **For Allergies /Medications** *(State type)* |       |

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| **CASUALTY ASSESSMENT** |
| **Pulse** | **Breathing** | **Skin** | **Conscious Level** | **Other Signs and Symptoms** |
| [ ]  Regular [ ]  Irregular | [ ]  Regular [ ]  Shallow | [ ]  Flushed [ ]  Pale | [ ]  Alert |       |
| [ ]  Slow [ ]  Rapid | [ ]  Rapid [ ]  Wheeze | [ ]  Moist / Clammy | [ ]  Confused |
| [ ]  Strong [ ]  Weak | [ ]  Gasping [ ]  Absent | [ ]  Dry [ ]  Sweaty | [ ]  Drowsy |
|  |  | [ ]  Cold [ ]  Hot | [ ]  Unconscious |

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| **OBSERVATIONS AND INTERVALS** |
| **Time** | **Pulse** | **Respiratory/Breathing** | **Pupils** | **OVERALL ASSESSMENT** |
|       |       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|  |
| **LOCATIONS OF INJURY** |
| **INDICATE AREA/S OF INJURY** | **CIRCLE INJURY AREA/S** |
| **LOCATION OF INJURY** | **LEFT/RIGHT** |  | **LOCATION OF INJURY** | **LEFT/RIGHT** |  |
| [ ]  facial / head |       | [ ]  mid body / hips |       |
| [ ]  shoulder / upper arm |       | [ ]  thighs |       |
| [ ]  lower arm |       | [ ]  knees |       |
| [ ]  hand / wrist / fingers |       | [ ]  lower leg / calf |       |
| [ ]  upper body / chest |       | [ ]  foot / ankle / toes |       |

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| **FIRST AID TREATMENT PROVIDED** |
|       |
| **ASSESSMENT OUTCOME AND REFERRED TO:** |
| [ ]  Refused First Aid [ ]  Ambulance [ ]  Hospital [ ]  Own Doctor [ ]  Employee Returned to Work [ ]  Other |
| **Comments:**      |

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| **To add photos, save photo in your drive. Click on the image below and upload the photos.** |
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