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| Corruption and Crime Commission WA |
| Incident root cause analysis form |
| To be completed by the person responsible or delegated responsibility for investigating Root Cause and providing recommendation on corrective actions. |

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| Name[Pick the date] |

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| Notes: This document is created as a guide for the incident investigator to identify the root cause of an incident and provide recommendation to prevent the incident reoccurring. To use the guide, follow each step and answer each question as best as possible. Words written in light grey are for reference only and can be deleted when producing the final report.  |

# Report Summary and Introduction

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| Complete this section last.Explain:1. the purpose of the report
2. what the report found
3. a brief summary of the incident
 |

# Incident Details

## Where did the incident happen?

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| Specific location:Address: |

## When did the incident happen?

|  |  |
| --- | --- |
| Day: |  |
| Date: |  |
| Time: |  |

## What tools or equipment where involved?

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| 1.2.3.4. |

## What action was being carried out at the time of the incident?

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| Explain what the person or people were doing at the time of the incident. This relates to their work task. Examples are driving, moving archiving boxes etc. |

## Who was involved?

|  |  |
| --- | --- |
| Name: |  |
| Payroll number: | This serves as a unique identifier  |
| Start date : | This is the date that the employee commenced their employment in the CCC |

## What happened?

|  |  |
| --- | --- |
| TimeEnter the time of each step before, during and after the incident, that adds understanding to the nature and circumstances of the incident. | ActionsWhat was happening  |
| 10:00am | Employee xxx was instructed by xxx to move archive boxes to the second floor |
| 10:15am  | Whilst carrying the archive boxes, employee xxx slipped …… |
| 10:20am | Etc etc |
| 10:27am | Etc etc |
|  |  |
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# Root Cause Analysis

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| Note: When identifying the root cause behind an incident it is important to remember that you are looking for the management system the caused the effect. The reason being is that by understanding the management system that lead to the incident we can make systemic changes that are within our control to prevent the injury from happening again. An example of this would be if someone is sunburnt. That is the incident. The root cause would not be that the sun causes sun burn. We have no control over the sun. We do have control over the exposure that employees have to the sun's ultraviolet light. Employees could work in the shade or wear protective clothing as an example. Often the investigation may find that the incident was related to someone's behaviour. This often causes confusion when looking for the management system failure if it is clear that someone acted in an unsafe manner. It is important to understand that individuals behave in particular ways because of a range of issues. These include Personality (Individual Characteristics), Motivation, Ability, Role Perception and Situational Factors. It is therefore important to identify the management systems that can positively affect Motivation, Ability, Role Perception and Situational Factors.  |

## Five Why Analysis

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| Incident Statement (Step 1) | A clear and compelling statement that describes the incident including the harm that was caused.Example: Sam Smith fell over whilst carrying archive boxes and fractured his wrist in the fall. |
| WHY(Step 2) | A clear statement as to why step 1 happened. |
| WHY(Step 3) | A clear statement as to why step 2 happened. |
| WHY(Step 4) | A clear statement as to why step 3 happened. |
| WHY(Step 5) | A clear statement as to why step 4 happened. |
| WHY - Root cause(Step 6) | A clear statement explaining the root cause. You may find that you would like to ask WHY more times but often five iteration is enough.  |

Ishikawa Analysis (Fishbone Root Cause Analysis)

EFFECT

CAUSE

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| Note: the following diagram helps identify the specific areas of the management system that have failed and caused the incident. Used in conjunction with the Five Why Analysis the investigator will gain deeper insight and be able to improve their recommendations for corrective actions. |

Incident:

Environment:

Policies:

People:

Work Methods and Procedures:

Plant and Equipment:

# Recommendations

|  |  |  |  |
| --- | --- | --- | --- |
| Recommendations | Actions | Assigned to | Monitor and Review Date |
|  |  |  |  |
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# Conclusion

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| Note: Conclude the report by summarising the following: 1. What the report found
2. What the key recommendations were

(remember to go back to the summary and introduction and complete that section) |