

# NATIONAL INCIDENT INVESTIGATION FORM (NIIF)

Please attach NIIF to the original NIRF/NIMS record

NIMS record Number:

**Incident Investigation:** An investigation is a systematic review and appropriate examination of an incident, considering all available accounts, versions and evidence of the event, to determine the root cause or causes of the incident, to prevent/reduce the likelihood of reoccurrence.

## SECTION A: GENERAL INCIDENT DETAILS

Date of incident

Time of incident  Use 24 hour clock

## SECTION B: PERSON AFFECTED DETAILS

First Name

Surname

## SECTION C: HAS THE OUTCOME/INJURY WORSENER SINCE THE INCIDENT OCCURRED?

✓ Outcome		Additional Details:
No Change	<input type="checkbox"/> No change in the outcome/injury since the incident occurred	<input type="text"/>
Near Miss	<input type="checkbox"/> Near miss e.g. slipped and nearly fell on a wet floor	<input type="text"/>
No Harm	<input type="checkbox"/> No injury e.g. slipped and fell on a wet floor but no injury sustained	<input type="text"/>
Harm	<input type="checkbox"/> Injury not requiring first aid	<input type="text"/>
	<input type="checkbox"/> Injury or illness, requiring first aid	<input type="text"/>
	<input type="checkbox"/> Injury requiring medical treatment	<input type="text"/>
	<input type="checkbox"/> Long-term disability/incapacity (incl. psychosocial)	<input type="text"/>
	<input type="checkbox"/> Permanent incapacity (incl. psychosocial)	<input type="text"/>
	<input type="checkbox"/> Death	<input type="text"/>

## SECTION D: STAFF MEMBER/AGENCY/PANEL STAFF/STUDENT/VOLUNTEER DETAILS ONLY

Date absence commenced:  Date returned to work:

## SECTION E: INVESTIGATION/REVIEW PROCESS

Date investigation/review started :  Lead investigator/reviewer:

Type of investigation:  Local investigation  
 Regional investigation  
 National investigation  
 Other please specify \_\_\_\_\_

Has there been/is there an independent or external or third party investigating this incident?  Yes  No

Please specify name('s) of independent or external or third party investigating: \_\_\_\_\_

## SECTION F: INFORMATION/DOCUMENTATION COLLECTED

<input type="checkbox"/> Risk assessments	<input type="checkbox"/> Photographs	<input type="checkbox"/> Engineers reports
<input type="checkbox"/> Inspection/maintenance records	<input type="checkbox"/> Physical evidence	<input type="checkbox"/> Guidelines
<input type="checkbox"/> Policies/protocols/procedures	<input type="checkbox"/> CCTV footage	<input type="checkbox"/> Statements/observations
<input type="checkbox"/> Training records	<input type="checkbox"/> Fire Register	<input type="checkbox"/> Other please specify: _____

Please tick to confirm all relevant documents have been uploaded onto NIMS where available

## SECTION G: INCIDENT INVESTIGATION

**Sequence of events leading up to the incident:**  
 (Including the conditions at the scene which may be relevant e.g. dry floor, signs displayed, wet road, congestion, untidy, etc.)

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\_\_\_\_\_

\_\_\_\_\_

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**SECTION H: ACTIONS TAKEN (IMMEDIATE AND/OR MITIGATING)** (Please select all options applicable)

<input type="checkbox"/> Isolate area/equipment	<input type="checkbox"/> Reimbursement of expenses (e.g. medical, travel, specialist)
<input type="checkbox"/> Management/treatment of injury or disease	<input type="checkbox"/> Referred to employee assistance programme
<input type="checkbox"/> Contact emergency services (e.g. Garda etc.)	<input type="checkbox"/> Referred to occupational health
<input type="checkbox"/> Response in accordance with local policies/procedures/agreements etc.	<input type="checkbox"/> Referred to return to work scheme
<input type="checkbox"/> Transparent communication strategy	<input type="checkbox"/> Referred to estates/facilities
<input type="checkbox"/> Open disclosure/apology	<input type="checkbox"/> Referred to specialist
<input type="checkbox"/> Next of kin/parent contacted	<input type="checkbox"/> Other Critical Incident Stress Management (CISM) interventions
<input type="checkbox"/> No action taken	<input type="checkbox"/> Other please specify: _____

**SECTION I: IMMEDIATE CAUSE (What was the Dominant/Obvious/Main cause which led to the incident?)**

(Please select one option)

<input type="checkbox"/> People factor(s) (e.g. failure to comply with policies/procedures, behavior, human error/use etc.)	<input type="checkbox"/> Training/information/instruction/communication (e.g. inadequate/lack of etc.)
<input type="checkbox"/> Equipment/facilities (defective/damaged)	<input type="checkbox"/> Design (e.g. layout, system, workshop, traffic plan etc.)
<input type="checkbox"/> Equipment/facilities (unavailable/unsuitable)	<input type="checkbox"/> External/environmental factor(s) (e.g. weather, third party etc.)
<input type="checkbox"/> No identified cause	<input type="checkbox"/> Other please specify: _____

**SECTION J: UNDERLYING CAUSE (What was the Root/Conditional/Hidden cause which led to the incident?)**

(Please select one option)

<input type="checkbox"/> Staff (insufficient)	<input type="checkbox"/> Hazard identification & risk assessment (inadequate/lack of)
<input type="checkbox"/> Support/Structure/direction from management (insufficient)	<input type="checkbox"/> External factor/third Party (e.g. product, supplier, contractor)
<input type="checkbox"/> Inspection & maintenance schedules (inadequate/lack of)	<input type="checkbox"/> Policy/procedures (inadequate/lack of)
<input type="checkbox"/> Equipment/facilities (insufficient)	<input type="checkbox"/> Implementation and/or monitoring (inadequate/lack of)
<input type="checkbox"/> Financial (constraints)	<input type="checkbox"/> No identified cause
<input type="checkbox"/> Other please specify: _____	

**SECTION K: CORRECTIVE ACTION REQUIRED/TAKEN TO REDUCE REOCCURENCE** (Please select all options applicable)

<input type="checkbox"/> Review/update relevant risk assessment	<input type="checkbox"/> Review/update relevant policies and/or procedures
<input type="checkbox"/> Repair or replace defective equipment/facilities	<input type="checkbox"/> Substitution (e.g. task, equipment etc.)
<input type="checkbox"/> Engineering control (e.g. adding guard to machine)	<input type="checkbox"/> Elimination (e.g. task, equipment etc.)
<input type="checkbox"/> Increase inspection frequency	<input type="checkbox"/> Training (including refresher)
<input type="checkbox"/> Increase audit frequency	<input type="checkbox"/> Transparent communication strategy (e.g. briefing/email etc.)
<input type="checkbox"/> Review of maintenance/inspection programme	<input type="checkbox"/> No action required/taken
<input type="checkbox"/> Other please specify: _____	

**SECTION L: DATE INVESTIGATION COMPLETED**

Date

Lead investigator/reviewer signature \_\_\_\_\_

**SECTION M: INVESTIGATION CONCLUSION**

<input type="checkbox"/> This incident occurred and was preventable	<input type="checkbox"/> This investigation was inconclusive
<input type="checkbox"/> This incident occurred and was unpreventable	<input type="checkbox"/> This incident did not occur

## SECTION N: STATEMENTS/OBSERVATIONS

First name	_____	Statement Type:	
Surname	_____	<input type="checkbox"/> Person affected	<input type="checkbox"/> Witness to incident
Date of statement	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>	<input type="checkbox"/> Line Manager	<input type="checkbox"/> Lead investigator/reviewer
Contact number	_____	<input type="checkbox"/> First aid/medical professional	
Address	_____	<input type="checkbox"/> Other please specify : _____	
Signature	_____	Date	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>

First name	_____	Statement Type:	
Surname	_____	<input type="checkbox"/> Person affected	<input type="checkbox"/> Witness to incident
Date of statement	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>	<input type="checkbox"/> Line Manager	<input type="checkbox"/> Lead investigator/reviewer
Contact number	_____	<input type="checkbox"/> First aid/medical professional	
Address	_____	<input type="checkbox"/> Other please specify : _____	
Signature	_____	Date	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>

First name	_____	Statement Type:	
Surname	_____	<input type="checkbox"/> Person affected	<input type="checkbox"/> Witness to incident
Date of statement	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>	<input type="checkbox"/> Line Manager	<input type="checkbox"/> Lead investigator/reviewer
Contact number	_____	<input type="checkbox"/> First aid/medical professional	
Address	_____	<input type="checkbox"/> Other please specify : _____	
Signature	_____	Date	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>

Please tick to confirm all relevant witness statements have been uploaded onto NIMS where available

## SECTION O: FURTHER INFORMATION

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## SECTION P: AUTHORITIES REQUIRING NOTIFICATION

Please state below, Authorities or other Departments which required notification e.g. Coroner, An Garda Síochána, Tusla, GSOC, Health and Safety Authority and Environmental Protection Agency etc.

Name of Authority or Department: _____	Date notified: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>
_____	Notified by (Name) : _____

Name of Authority or Department: _____	Date notified: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>
_____	Notified by (Name) : _____

Name of Authority or Department: _____	Date notified: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>
_____	Notified by (Name) : _____

Please reprint this page if you require additional statements/observations and/or authorities requiring notification.