|  |  |
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| **Gold Fields Location** | **Classification** |
| **Country:** |  |  | **SPI: Serious Potential Incident** |
| **Site:** |  |  | **Serious Injury: Safety** |
| **Department:** |  |  | **Serious Incident: Environment** |
| **Date / Time:** |  |  | **Serious Incident: Community** |
| **Incident Location:** |  |  | **Serious Incident: Security** |
| **Incident Title:** |  | **ID#** |  |

**Part A**

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| **Incident Alert** |

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| **Incident Description:** Brief summary of what is understood to have happened (*written before investigation*)“Type here” |
| **Actual Injury / Impact of Incident:** Describe the actual injury or impact “Type here” |
| **Potential Injury / Impact of Incident:** Explain the reasons for the high potential.“Type here” |
| **MUE:** Is the Incident associated with an MUE? If so which one?“Type here” |
| **Define key Stakeholders:** Outline potential impacts and action required.“Type here” |
| **Sketch / Photos:** Provide annotated photos of the scene to enable understanding of the incident.“position photo’s to be effective in terms of size, formatting” … try to keep the Alert to the first page only, not mandatory, but best effect as an alert not to have too much information … that will come in the Investigation Findings. |

**Part B**

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| **Investigation Findings: Lessons Learnt** |
| **Incident Description:** Provide a accurate explanation *describing what actually happened*. (*written after investigation*)“Type here” |
| **Describe what went wrong!** Outline facts only, *tell the story so understanding is gleaned on* *how the incident happened*. Focus on contributing and causal factors, that led to absent or failed defences, particularly any controls (and critical controls) that have failed previously. (ie is this a repeat event)“Type here” |
| **Critical Control:** What Critical Controls Worked?*(ie Critical Controls that prevented the full impact being realised)*“Type here” | **Critical Control:** What Critical Controls Failed? ***Focus on identifying repeat control failures!***“Type here” |
| **Courageous Safety Leadership** (displayed / absent?)“Type here” | **Vital** (More/Less Safe) **Behaviours enacted OR absent**.“Type here” |
| **Reasons for Risk Taking** (Highlight reasons)1. **Overlooked:** Risk not seen, visible or recognised.
2. **Underestimated:** Misjudged likelihood, exposure, magnitude or potential impact.
3. **Rewarded / Penalized:** Incentives to take shortcuts, easier, quicker etc.
4. **Inherent:** Risk is inherent to process, system, resource constraints.
5. **Balanced:** Consequence of production pressure, necessary.
6. **Tolerated:** Person(s) accept, tolerate and ignore risks.
 | **Explain / Justify findings** (link to evidence)“Type here” |
| **Describe what must be fixed (Lessons Learnt):** To *prevent* the incident from happening again!“Type here and link learnings to CSL, Vital Behaviours, Catastrophic Risk, Critical Control Management, Safety Systems etc” |

| **#** | **Critical Preventative Actions(List Actions specifically designed to prevent re-occurrence)** | **Hierarchy ofControls** | **WHO(Responsible)** | **WHEN(Date)** |
| --- | --- | --- | --- | --- |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** | delete unused rows |  |  |  |

| **#** | **Secondary Corrective Actions(Opportunities – 5 maximum)** | **Hierarchy ofControls** | **WHO(Responsible)** | **WHEN(Date)** |
| --- | --- | --- | --- | --- |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** | delete unused rows |  |  |  |

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| --- |
| **Responsible Manager** |
|  |  |  |
| **Name** | **Contact Details** | **Date** |