To be completed by QHSE Department	
UFO Number	
Target Date of Closure	

Part 1 – Complete by Originator	
UFO Title Description of Event in one sentence	
Description of event	
WHAT Happened?	
HOW did it Happen?	
WHERE did it Happen?	
WHEN did it Happen?	
WHO was Involved?	
Other Notes	

Location Branch/Site	Raised By	Line Manager Name	Date & Time of Event

Category 1 - Health & Safety (please tick if applicable)
☐ Lost time injury ☐ Restricted work case ☐ First Aid ☐ Medical Treatment
☐ Near Miss ☐ Dangerous Occurrence ☐ Collision ☐ Damage

Category 2 - Quality (please tick if applicable)
☐ Process/procedure ☐ PO not referenced ☐ Later delivery ☐ NCR
☐ Items damaged/missing ☐ Incorrect items/quantity ☐ Paperwork/certification
☐ Other

Category 3 - Environment (please tick if applicable)
☐ Spill/contamination ☐ Near miss ☐ Other

Category 4 - Security (please tick if applicable)
☐ Computer Systems ☐ Fraud ☐ Theft ☐ Vandalism

Once you have completed all the blue fields please send to your **Line Manager** and **CC** QHSE@vikingindustrial.com.au

Part 2 - To be completed by Manager
Risk Potential (LINK TO RISK REGISTER)
☐ Very Low ☐ Low ☐ Medium ☐ High ☐ Very High
Source of UFO
☐ Internal ☐ Worksite ☐ Customer Complaint ☐ Supplier ☐ Subcontractor

Immediate Actions & Correction
Immediate Action Taken to Correct Situation:
Understanding of Immediate Cause:

Part 3 – Actions/ Preventions

Actions:	Responsible Person	Due Date	Actual Date

Attachments:	Tool-Box Meeting	Safety Flash	Drawing	Photos	Injury Report	Investigation Report	Other
☐	☐	☐	☐	☐	☐	☐	☐

Completed By:	Position:	Signature:	Date:

Part 4 – Responsible Manager to Complete if risk potential is above medium	
Root Cause Analysis – Why Did the Problem Occur? The 5 Whys (Reference)	
Q1 - Why	
Q2 - Why	
Q3 - Why	
Q4 - Why	
Q5 - Why	
Root Cause Identified As *(Documents, Design, Material, Process, Equipment, Work, Supervision, Training)*	
Root Cause Solution	

Approved By Name (COO or higher required):	Signature:	Date:

Once you have completed all the green fields please send to COO
craig.watson@vikingindustrial.com.au and **QHSE@vikingindustrial.com.au**

Injury Report *(if required, Use on the case of personnel injury. To be completed by the UFO originator)*

Name of injured person:	Date of birth:	Job title:	
Address:			
Experience in present position:		Number of hours worked in past 7 days:	
Date of incident:	Date incident reported:	Reported by:	Reported to who:
Time of incident:	Time incident reported:		
Absent from work? ☐ Yes ☐ No	First day absent:	Last day absent:	Total number of days:
Restricted work? ☐ Yes ☐ No	First day restricted:	Last day restricted:	Total number of days:

Description of injury:

Point of Injury

☐ Head	☐ Mouth	☐ Elbow	☐ Leg	☐ Foot/Toe
☐ Face	☐ Neck/Throat	☐ Hand/Finger	☐ Hip/Pelvis	☐
☐ Eye	☐ Shoulder	☐ Back	☐ Knee	☐
☐ Ear	☐ Arm	☐ Chest/Abdomen	☐ Ankle	☐

Type of Injury

☐ Abrasion (friction)	☐ Puncture (stab)	☐ Inhalation (breathing)
☐ Contusion (bruising)	☐ Strain	☐ Ingestion (body cavity)
☐ Incision (sharp cut)	☐ Broken bone(s)	☐ Absorption (contact with tissue)
☐ Laceration (tearing cut)	☐ Burn	☐ Other:

Doctor Notified:	Sent Ashore:	Ambulance:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Medic Seen:	Medi-vac:	Hospital Visit:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7 Day LTI:	RIDDOR Reportable?	RIDDOR Report No.:
☐ Yes ☐ No	☐ Yes ☐ No	

Additional Comments:

Attachments:

☐ Risk Assessment(s)	☐ Drawing/Sketch	☐ Photo(s)	☐ Witness Statement(s)	☐ Other

Completed By:	Position:	Signature:	Date: