PERSPECTIVE
INDUSTRIAL ASSURANCE GROUP LTD.
Global Solutions. Trusted Protection.

PIAG PRACTICAL ASSURANCE SERIES

Incident Reporting and Investigation Toolkit

A structured template for notification, evidence, causal analysis, corrective action and learning.

2026 EDITION

Perspective Industrial Assurance Group Ltd.
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Practical reference only. Verify applicable legal, client and site-specific requirements.

01 / IMMEDIATE NOTIFICATION AND INITIAL CONTROL

Immediate Notification and Initial Control

Use this template to capture facts, protect people, preserve evidence and initiate a proportionate investigation. Complete legal and client notifications separately as required.

FIRST PRIORITIES
Provide emergency care, make the area safe without destroying evidence, notify required parties, preserve perishable evidence and prevent uncontrolled recurrence.

Incident title / reference	
Date and time	
Site / exact location	
Department / contractor	
Reported by / contact	
Incident category	
Actual severity / potential severity	
Immediate actions and current status	

02 / PEOPLE, EQUIPMENT AND EVIDENCE

People, Equipment and Evidence

Record what is known and identify evidence before memories change, equipment moves or digital records are overwritten.

Evidence item	Source / location	Collected by / time	Reference / preservation
Scene photographs			
CCTV / digital records			
Permit, JSA and procedures			
Training / competence records			
Equipment and maintenance data			
Witness accounts			

Persons involved and condition	
Witnesses and contact details	
Equipment / material involved	
PPE and controls in use	
Environmental conditions	

03 / EVENT CHRONOLOGY

Event Chronology

Separate verified facts from assumptions. Record the normal work plan, deviations, control status and response sequence.

Time / sequence	What happened	Evidence source	Fact / assumption / gap

Planned work sequence	
Point where conditions changed	
Immediate cause / energy transfer	
Unresolved factual gaps	

04 / CAUSAL AND BARRIER ANALYSIS

Causal and Barrier Analysis

Do not stop at an unsafe act. Examine why prevention, detection, mitigation or recovery barriers were absent, failed or bypassed.

Causal area	Questions	Finding / evidence
Task / process	Was the method clear, realistic and followed? Were changes controlled?	
People / competence	Were people trained, competent, fit and adequately supervised?	
Equipment / design	Was equipment suitable, guarded, maintained and fail-safe?	
Environment	Did layout, weather, lighting, congestion or exposure contribute?	
Management system	Were risk, resources, workload, communication and assurance adequate?	
Barriers	Which prevention or mitigation barriers failed, and why?	

Immediate causes	
Contributing factors	
Underlying causes	
Root / systemic causes	

05 / CORRECTIVE ACTIONS AND LEARNING

Corrective Actions and Learning

Actions should address the identified causes, specify required evidence and include an effectiveness review.

Action linked to cause	Owner	Due date	Priority	Required evidence	Status

Lessons to communicate	
Other sites / tasks potentially affected	
Effectiveness review method and date	
Investigation lead / approval	
Closure authority / date	

DIGITAL INVESTIGATION

Sentinel can connect notification, investigation, root cause, corrective actions, evidence, approval and management dashboards in one traceable workflow.