***Occurrence Investigation Report***

|  |
| --- |
| **Why investigate?** |
| A safety investigation aims to provide certificate holders with the opportunity to determine the underlying causes of a Part 12 reportable incident or accident. By identifying these factors, safety performance can be enhanced and changes implemented that prevent reoccurrence and strengthen an organisation’s resilience against future safety risks. Additionally, safety investigations enable the Civil Aviation Authority (CAA) to oversee the aviation sector as a whole and detect any emerging safety concerns. The Advisory Circular on participant occurrence investigations ([AC12-2](https://www.aviation.govt.nz/rules/advisory-circulars/show/AC12-2)) gives further guidance on how to undertake a safety investigation. |
| **Filling in this investigation report** |
| This investigation report form is designed to assist certificate holders determine the cause(s) of an occurrence. Four causal factor categories that most commonly underpin accidents and incidents in New Zealand aviation are listed below. Each category of causation should be examined against what took place. Additionally, those factors which contributed to the occurrence should be explained.To best support CAA and the sector improve the safety of the aviation system:* note the steps taken to mitigate any issue in section 7, and
* list in section 8 any learnings identified during the investigation.

When complete, email this form as soon as possible to: triage@caa.govt.nz. |

|  |
| --- |
| **1. Occurrence details** |
| Occurrence date  |       | Location |       |
| Aircraft make and model  |       | Aircraft registration | ZK -       |
| CAA participant no. |       | CAA occurrence report no. *(if known)* |       |
| Organisation/reporter name |       | Phone |       |

|  |
| --- |
| **2. What happened and why?** |
| Provide a brief summary of the occurrence |
|       |

|  |
| --- |
| **3. Causal factor 1: Human factors –** *Factors related to human performance, decision-making, situational awareness, etc.* |
| Consider the factors below and indicate if any may have contributed to the occurrence |
| [ ] Decision-making | [ ]  Situational awareness | [ ]  Flight/mission planning | [ ]  Communication |
| [ ]  Operating experience | [ ]  Training | [ ]  Fatigue | [ ]  Flight discipline |
| [ ]  Distraction | [ ]  Other:       |
| Explain how human factors may have contributed to the occurrence |
|       |

|  |
| --- |
| **4. Causal factor 2: Mechanical/equipment factors –** *Factors related to any equipment involved, including aircraft, role equipment, ground equipment, tooling, parts, aerodrome facilities, etc.* |
| Consider the factors below and indicate if any may have contributed to the occurrence*Note: if you have supplied engineering/defect information through the appropriate defect reporting form (either via the online* [*occurrence reporting form*](https://occurrencereporting.services.aviation.govt.nz/) *or using the CA005D form), this should be noted in addition to the information provided in this section* |
| [ ] Engine/powerplant | [ ]  Airframe | [ ]  Fuel/oil system |
| [ ]  Flight controls | [ ]  Propeller/rotor systems | [ ]  Maintenance/tooling facilities |
| [ ]  Avionics | [ ]  Other:       |
| Explain how mechanical/equipment factors may have contributed to the occurrence |
|       |

|  |
| --- |
| **5. Causal factor 3: Environmental factors –** *Includes conditions that prevailed at the time of the occurrence, eg, weather, light, etc.* |
| Consider the factors below and indicate if any may have contributed to the occurrence |
| [ ] Wind level/direction | [ ]  Turbulence | [ ]  Light level | [ ]  Sunstrike |
| [ ]  Cloud | [ ]  Rain/drizzle | [ ]  Low-level hazards, eg, wires, trees, poles etc. |
| [ ]  Airstrip surface conditions | [ ]  Facility environment | [ ]  Other:       |
| Explain how environmental factors may have contributed to the occurrence |
|       |

|  |
| --- |
| **6. Causal factor 4: Organisational/regulatory factors –** *Factors related to policies, procedures, aviation rules and safety culture* |
| Consider the factors below and indicate if any may have contributed to the occurrence |
| [ ] Operating procedures | [ ]  Training policies | [ ]  Maintenance procedures | [ ]  Safety culture |
| [ ]  CAA rules and regulations | [ ]  Other:       |
| Explain how organisational/regulatory factors may have contributed to the occurrence |
|       |

|  |
| --- |
| **7. Steps taken to mitigate or eliminate the identified issue(s)** |
| Describe what has been/will be done to ensure this occurrence doesn’t happen again? *Ensure to include what steps have/will be put in place to mitigate or eliminate the above identified causal factors which may have contributed to the occurrence, and how these are intended to work long term, eg, yearly review, addition to training programme etc.* |
|       |

|  |
| --- |
| **8. Lessons learned** |
| What lessons were learnt during the investigation process which would help future investigations?*Include what advice could be given to other organisations to reduce their chances of a similar incident happening to them* |
|       |

|  |
| --- |
| **Email this form as an attachment to** **triage@caa.govt.nz** |