

Occurrence Investigation Report



The purpose of a safety investigation is to identify the causal factors that led to the incident or accident. This allows you to put in place changes to your operations to manage the risks of reoccurrence. It also allows the CAA to monitor the aviation sector as a whole to identify emerging safety issues. The CAA has produced [Advisory Circular 12-2](#) to give you guidance on how to undertake an investigation.

PLEASE EMAIL AN ATTACHMENT OF COMPLETED FORM TO: ca005@caa.govt.nz

Occurrence date	<input type="text"/>	Location	<input type="text"/>	Operator Client ID	<input type="text"/>
Aircraft registration ZK -	<input type="text"/>	Aircraft make and model	<input type="text"/>		
Operator/reporter name	<input type="text"/>			Contact phone	<input type="text"/>

Investigation guide

This investigation report form is designed to assist in determining the causes of the occurrence. The categories of causal factors are the ones that most commonly underpin accidents and incidents in New Zealand aviation. Please review each of the four categories of causation below, against what took place, and indicate which factors applied. This should give you a good understanding of what caused it: use this understanding to complete the 'lessons learned' section at the end of the report.

The four causal categories

- Human factors** Factors related to human performance, decision-making, situational awareness, etc.
- Environmental** Includes conditions that prevailed at the time of the occurrence: weather, light, etc.
- Mechanical/equipment** Factors related to any equipment involved— including aircraft, role equipment, ground equipment, tooling, parts, aerodrome facilities, etc.
- Organisational/regulatory** Factors related to policies, procedures, aviation rules and safety culture.

What happened & why it happened? Please provide a brief summary of the occurrence

Human factors - please indicate if any of the factors below may have contributed to the occurrence

<input type="checkbox"/> Decision-making	<input type="checkbox"/> Situational awareness	<input type="checkbox"/> Flight/mission planning	<input type="checkbox"/> Communication
<input type="checkbox"/> Operating experience	<input type="checkbox"/> Training	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Flight discipline
<input type="checkbox"/> Distraction	Other	<input type="text"/>	

Comment on how human factors may have contributed to the occurrence

Equipment/mechanical - please indicate if any of the factors below may have contributed to the occurrence

(Note: if you have supplied engineering/defect information in CA005D occurrence report this will usually be sufficient for this part of the investigation)

- | | | | |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> Engine/powerplant | <input type="checkbox"/> Airframe | <input type="checkbox"/> Fuel/oil system | <input type="checkbox"/> Avionics |
| <input type="checkbox"/> Flight controls | <input type="checkbox"/> Propeller/rotor systems | <input type="checkbox"/> Maintenance/tooling facilities | |
| Other | <input type="text"/> | | |

Comment on how equipment/mechanical factors may have contributed to the occurrence

Environmental factors - please indicate if any of the factors below may have contributed to the occurrence

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Wind level/direction | <input type="checkbox"/> Turbulence | <input type="checkbox"/> Light level | <input type="checkbox"/> Sunstrike |
| <input type="checkbox"/> Cloud | <input type="checkbox"/> Rain/drizzle | <input type="checkbox"/> Low-level hazards (e.g. wires, trees, poles etc.) | |
| <input type="checkbox"/> Airstrip surface conditions | <input type="checkbox"/> Facility environment | Other | <input type="text"/> |

Comment on how environmental factors may have contributed to the occurrence

Organisational/regulatory - please indicate if any of the factors below may have contributed to the occurrence

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Operating procedures | <input type="checkbox"/> Training policies | <input type="checkbox"/> Maintenance procedures | <input type="checkbox"/> Safety culture |
| <input type="checkbox"/> CAA rules and regulations | Other | <input type="text"/> | |

Comment on how organisational/regulatory factors may have contributed to the occurrence

Lessons learned - what advice would you give to another operator to reduce their chances of something like this happening to them?

[THANK YOU. CLICK HERE TO SUBMIT THE FORM BY EMAIL](#)

[SUBMIT FORM](#)