**Incident/Occupational Illness/Dangerous Occurrence**

**Part 1: Report Form**

To be completed by staff/student/visitor/contractor as soon as possible

after the incident, even if some information is unavailable.

**PLEASE USE BLOCK CAPITALS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Injured Person | Surname | | First Names | | | Title |
| Home Address (include postcode) | | Position & School/Dept | | | |
| Telephone | | Length of Employment/Study | | | |
| Email | | Line Manager/Supervisor | | | |
| Description of Accident/Occupational Illness/Dangerous Occurrence | Date | Location of incident (campus, building & room number)  Was person authorised to be there? YES / NO | | | | |
| Time |
| Describe work/activity being performed | | | | | |
| How did the incident happen? | | | | | |
| What injuries were received/damage occurred/health effect? | | | | | |
| Medical Treatment / Accident Severity | None First G.P. or Hospital Up to 7 More than More than Major  Req'd Aid similar for Days 7 days 24 hours in Injury  Professional Treatment Absence Absence Hospital    (More than one box may be ticked) **Notify Safety Office ASAP ext. 13401** | | | | | |
| Name of First Aider | | | School/Dept. | | |
| Treatment given | | | | | |
| Other Details | Name & address of witness(es) | | | | | |
| Person making report (if other than injured person)  Name  Position | | | | Date  School/Dept. | |
|  | Copy of form sent to School/Dept Safety Officer Yes / No? Date sent: | | | | | |

**Incident/Occupational Illness/Dangerous Occurrence**

**Part 2: Investigation Form**

**Must** be completed by Line Manager/Academic Supervisor (see notes on cover)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CAUSITIVE AGENT** (Tick more than one option if applicable) | | | | | | | | | |
| Live Animal |  | Falls from height | |  | Hot/cold contact |  | Violence/Assault | |  |
| Electricity |  | Struck or trapped by object | |  | Defective premises |  | Defective equipment | |  |
| Explosion |  | Striking against fixed or stationary object | |  | Exposure to toxic substances or pathogenic material |  | Work-related vehicle/traffic accidents | |  |
| Fire |  |
| Falls on level |  | Sharps (incl. Glass & needles | |  | Unintentional spillages/releases of harmful substances |  | Occupational Illness | |  |
| Falls on stairs |  | Handling/Lifting | | Other | |  |
| Describe the precautions which were in place to control the hazards (e.g. reference to risk assessments, safe procedures, training & supervision, protective equipment, condition of premises or equipment). | | | | | | | | | |
| Describe any of the above precautions/control measures which were not taken. Include problems with premises/equipment/facilities. | | | | | | | | | |
| Why were these precautions not taken, i.e., why did the incident happen? | | | | | | | | | |
| Describe the remedial actions proposed  Who is responsible for instigating the action? | | | | | | | | | |
| How long was person (or equipment/facility) unavailable for their usual work in the School/Dept. (if more than 2 hours)? | | | | | | | | | |
| Copy of investigation sent to School/Dept Safety Officer Yes / No?  Name: Date sent: | | | | | | | | | |
| Name of person completing investigation | | | | | | | | Date | |
| Position | | | School/Dept. | | | | | Ext. | |