**Queen’s University Belfast**

USS Ref No:

**ACCIDENT/DANGEROUS OCCURRENCE/NEAR MISS REPORT FORM (AC1)**

**If there is a serious incident and completion of this form is likely to be delayed then details should be reported to the University Safety Service by telephone as soon as practicable. Ext 4681.**

FORM TO BE COMPLETED IN **BLOCK CAPITALS** BY THE **SUPERVISOR/RESPONSIBLE PERSON IN CHARGE**

FOLLOWING INVESTIGATION OF THE INCIDENT. *(\*Delete where applicable)*

**Data Protection:** This form and the information it contains will be held securely by the Occupational Health and Safety Unit and will only be disclosed to those able to demonstrate a legal right to the data therein. Information will normally be held for a period of five years or in the case of relevant medical information may be held indefinitely by the University Occupational Health Physician.

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| SECTION 1: Details of person involved in Accident/Dangerous Occurrence/Near Miss |
| Title (Prof/Dr/Mr/Ms/Miss\*) Full Name………………………….……………………………………. DOB……./……./…….….. Home Address………………………………………………………………………………………………………………………………..  ………………………………………………………………………………………………………... Post Code…….……………….. ….. QUB Department (if applicable)…………………………………………………………………………………………………………… Telephone Number : (Work)…………………………... (Home)……………………………………………………………... Status : STAFF/QUB STUDENT (UNDERGRAD/POSTGRAD\*)/CONTRACTOR/OFFICIAL VISITOR/MEMBER OF THE PUBLIC.\*  Sex : MALE/FEMALE\* Staff/Student Number(If applicable)……………………………….……………….  Job Title or Occupation ………………………………………………………………………………………..………….……………. |
| SECTION 2: Details of Accident/Dangerous Occurrence/Near Miss |
| When did it happen ? DATE………/…../……. Time : ………………………………………….AM/PM\* In which **BUILDING** did it happen?……………………………………… **DEPARTMENT**………………………………………… **WHERE**, in the building stated above? i.e. office, store, corridor, laboratory, lecture theatre, etc. (Please **include Room Number**)  …………………………………………………………………………………………………………………………………………………  **FULL POSTAL ADDRESS OF BUILDING**……………………………………………………………………….  ………………………………………………………………………… **Post Code** ………………………  Give a **full account** of how accident/incident occurred and, if applicable, how the person was injured : …………………………  ……………………………………………………………………………………………………………..  ……………………………………………………………………………………………………………..  ……………………………………………………………………………………………………………..  ……………………………………………………………………………………………………………..  ……………………………………………………………………………………………………………..  ……………………………………………………………………………………………………………..  ……………………………………………………………………………………………………………..  (If further space is required please continue on blank page at the back of form.)  Was the work activity under **SUPERVISED** INSTRUCTION/**UNSUPERVISED** AUTHORISED PRACTICE/**UNAUTHORISED** PRACTICE ?\* Was the person **EXPERIENCED/INEXPERIENCED** ?\*  To whom was the incident first reported? i.e. Supervisor/Responsible Person in Charge.  NAME ……………………………………………………………………………………….. Date of reporting…………………………………….  If applicable, give details of any **STRUCTURAL**/**MATERIAL DAMAGE**/**LOSS** sustained . ……………………………………………………….  …………………………………………………………………………………………………………………………………………………………………….  Was a PERSONAL INJURY sustained? YES/NO \* (If No then go to SECTION 4). |

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| SECTION 3 : Details of Injury Sustained |
| Give details of the type, severity and part(s) of body injured (i.e. Left or Right, leg, shoulder, hand, etc ):  ……………………………………………………………………………………….…………………………………………………………  ………………………………………………………………………………………………………………………………………………….  Did the person require : No Treatment First Aid Medical Treatment  Where was the treatment given? ……………………………………………………………………………….…………………………………..  Give details of treatment given, if known : ………………………………………………………………………………………………….….  …………………………………………………………………………………………………………………………………………………  Who administered above treatment? …………………………………………………. Person’s Signature………………………………………  (BLOCK CAPITALS)  Was the injured person taken directly to hospital from the scene of the accident? YES/NO\*  If YES was the person detained for more than 24 hours? YES/NO/DON’T KNOW\*  Is it likely that the injured person will be unable to work or will be unable to perform their normal  work duties for more than 3 consecutive days (Include Saturday/Sunday and Public Holidays)? YES/NO/NOT YET DETERMINED\* |
| SECTION 4 : WITNESS(ES) REPORT |
| Were there any witnesses to the incident/dangerous occurrence/near miss? YES/NO If YES then ensure that **SECTION 4(a)** is completed, otherwise go to **SECTION 5** below. |
| SECTION 5 : PREVENTATIVE MEASURES |
| What immediate measures have or will be taken to prevent a recurrence of this type of incident? **SUPERVISOR/PERSON IN CHARGE** to give details below:  ………………………………………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………………………………….    ………………………………………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………………………………….  Has the department conducted a Risk Assessment in relation to this undertaking? YES/NO Has this been documented? YES/NO If YES, and in the light of the above incident , does this assessment now need to be reviewed? YES/NO Has the Departmental Accident Book been filled out as required? YES/NO Name of Supervisor/Responsible person in Charge investigating incident and making this report :  (BLOCK CAPITALS)…………………………………………………… Signature………………………………………………… Department………………………………………….. Date :……/……./……. Tel/ Ext. No : ………………………………… |

PLEASE NOTE THAT **ALL RELEVANT SECTIONS**, WITH ACCOMPANYING SIGNATURE, SHOULD BE COMPLETED **BEFORE RETURNING** THIS FORM TO THE UNIVERSITY SAFETY SERVICE,

5a Lennoxvale, Malone Road, Belfast, BT9 5BY

SECTION 4(a) : WITNESS STATEMENTS (if applicable )

**WITNESS (i)**

Name : ……………………………………………………………………. Occupation………………………………………………………

Home Address : ………………………………………………………………………………………………………………………………………………...

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Telephone Number : (Work) …………………………………………… (Home) …………………………………………………………..

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**WITNESS (ii)**

Name : ……………………………………………………………………. Occupation………………………………………………………

Home Address : ………………………………………………………………………………………………………………………………………………...

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THIS SECTION FOR UNIVERSITY SAFETY SERVICE USE ONLY

Code………………… Type : WR / NWR / NMI Pics: Y / N File No……………….………………

UHS notified…………………………………….… QUB Insurance office notified…………………………………….

Enforcing Authority Informed…………………………………………………. NI2508………………………………

(Name of EA/Date/Time/Means) (Date sent)

Date of Investigation……………………………….. Investigating S.O. Signature……………………………………...