

Accident, Incident, Dangerous Occurrence Third Party Report

Before completing this form, please read the [People and Development Privacy Notice](#) which explains how we process your personal data.

A. Accident / Dangerous Occurrence Details

(To be completed by employee or immediate supervisor if employee is incapacitated or by OIC / Area Supervisor)

Injured Party Details

Name			
Address			
Age		Male <input type="checkbox"/>	Female <input type="checkbox"/>
If Contractor, name of Organisation / Company			
Contractor Telephone Number			
Designation			

Injury Details

Give precise information on type of injury including part of body affected (specifying left or right side) where applicable

When did accident happen?	(date)	(time in 24hrs)
Who was it reported to?		
When was it reported?	(date)	(time in 24hrs)
Name of Supervisor / Manager in Charge		

Report Completed by

Name			
Department / Division			
PSI		Shoulder No.	
Base Station / Location			

OFFICIAL: POLICE AND PARTNERS

Location of Accident / Dangerous Occurrence and Precise Details

Where did the accident occur? Describe exactly the type of work being carried out, what happened and how. Give details of any plant or equipment involved, weather conditions (if applicable) and personal protective equipment in use at time of accident and other relevant information. If fall from height, give distance.

Continue on form [076-003A](#) if necessary and attach to form

OFFICIAL: POLICE AND PARTNERS

OFFICIAL: POLICE AND PARTNERS**Names and Addresses of Witnesses Include Police Witnesses and Station**

Continue on form [076-003A](#) if necessary and attach to form

Name of Employee			
Signature of Employee		Date	
Name of Supervisor			
Rank / Position			
Signature of Supervisor		Date	

B. Background Information

(To be completed by supervisor / departmental manager where incident occurred)

Were safe working procedures being adhered to at the time of the incident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If No, give details		
Has this or a similar incident occurred before or been subject to question previously?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, give details		
Was first aid / medical treatment given?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, give full details of treatment at location of accident		
Was medical treatment required?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, state name of hospital and doctor		
Out patient <input type="checkbox"/>	In patient <input type="checkbox"/>	
Treatment Given (if known)		

OFFICIAL: POLICE AND PARTNERS

Was the injured person absent from work as a result of accident?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, state from	(date)	(time in 24hrs)	
to	(date)	(time in 24hrs)	

Note – A more detailed investigation must be completed for more serious and lost time accidents refer to [Accident Incident Near Miss Reporting and Investigation Guidance](#) or contact the Health and Safety Advisor for advice.

C. Investigation Details

(To be completed by supervisor / departmental manager where incident occurred)

Action Taken to Determine the Cause of the Accident

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Action Required Preventing Recurrence

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Name of Supervisor (print details)	
Signature of Supervisor	
Date	

Form to be forwarded to the Health and Safety Advisor

To be Completed by the Health and Safety Advisor

Has the Health and Safety Executive been informed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Has the Local Authority been informed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
If Yes state	(date)	(time)	
HSE RIDDOR Form Ref No.			
Name			
Signature		Date	
Designation			