

Incident: An event or circumstance which could have, or did lead to unintended and / or unnecessary harm. Please complete this form to the best of your knowledge at the time of reporting the incident.

SECTION A: GENERAL INCIDENT DETAILS

Date of incident

Time of incident Use 24 hour clock

Location

Onsite Offsite

Description of incident:

The description should be brief and factual

SECTION B: WHAT TYPE OF OCCURRENCE DID THIS RELATE TO?

(Tick 1 option from Sub Hazard, Please Specify & Problem/Cause)

Sub Hazard Type	Please Specify	Problem/Cause
<input type="checkbox"/> Staff Factors	<input type="checkbox"/> Competence <input type="checkbox"/> Equipment Resources <input type="checkbox"/> Knowledge and Skills <input type="checkbox"/> Staff Resources <input type="checkbox"/> Other, Please Specify _____	<input type="checkbox"/> Inadequate/Insufficient <input type="checkbox"/> Unavailable
<input type="checkbox"/> Organisational & Management Factors	<input type="checkbox"/> Fire Regulations <input type="checkbox"/> Infection Control Policy <input type="checkbox"/> Medication Safety Policy <input type="checkbox"/> Other Protocols/ Policies/ Regulations <input type="checkbox"/> Smoking Policy <input type="checkbox"/> Security <input type="checkbox"/> Other, Please Specify _____	<input type="checkbox"/> Breached/Non-Compliant <input type="checkbox"/> Inadequate/Insufficient
<input type="checkbox"/> Environmental Factors	<input type="checkbox"/> Food Safety <input type="checkbox"/> General Hygiene <input type="checkbox"/> Noise Level <input type="checkbox"/> Overcrowding <input type="checkbox"/> Disposal of Clinical Waste <input type="checkbox"/> Pest Control <input type="checkbox"/> Work Environment <input type="checkbox"/> Water Supply <input type="checkbox"/> Other, Please Specify _____	<input type="checkbox"/> Breached/Non-Compliant <input type="checkbox"/> Inadequate/Insufficient
<input type="checkbox"/> Systems / Installations	<input type="checkbox"/> CCTV Systems <input type="checkbox"/> Electrical Installation <input type="checkbox"/> Fire Systems <input type="checkbox"/> IT Systems <input type="checkbox"/> Power <input type="checkbox"/> Telephone/Beeper Systems <input type="checkbox"/> Other, Please Specify _____	<input type="checkbox"/> Breached/Non-Compliant <input type="checkbox"/> Failure <input type="checkbox"/> Inadequate/Insufficient
<input type="checkbox"/> Occupational Disease	<input type="checkbox"/> Anthrax <input type="checkbox"/> Malaria <input type="checkbox"/> COVID-19 <input type="checkbox"/> Measles <input type="checkbox"/> Other, Please Specify _____	<input type="checkbox"/> Notifiable <input type="checkbox"/> Unnotifiable
<input type="checkbox"/> HSA Dangerous Occurrence	<input type="checkbox"/> Building under Construction/Demolition <input type="checkbox"/> Breathing Apparatus <input type="checkbox"/> Closed Vessel <input type="checkbox"/> Dangerous Substance/Pathogen <input type="checkbox"/> Explosives <input type="checkbox"/> Flammable Chemical <input type="checkbox"/> Load Bearing Part <input type="checkbox"/> Pipeline <input type="checkbox"/> Plant/Place <input type="checkbox"/> Revolving Mechanical Component <input type="checkbox"/> Scaffolding <input type="checkbox"/> Vehicle/Tank Carrying Dangerous Substance <input type="checkbox"/> Vehicle/Train/Locomotive <input type="checkbox"/> Walls/Floors of Building <input type="checkbox"/> Other, Please Specify _____	<input type="checkbox"/> Accidental Collision <input type="checkbox"/> Burst <input type="checkbox"/> Collapse <input type="checkbox"/> Contact with Overhead Lines <input type="checkbox"/> Explosion <input type="checkbox"/> Failure <input type="checkbox"/> Fire <input type="checkbox"/> Ignition <input type="checkbox"/> Overturning <input type="checkbox"/> Uncontrolled/Accidental Release
<input type="checkbox"/> Other	<input type="checkbox"/> Other, Please Specify _____	<input type="checkbox"/> Breached/Non-Compliant <input type="checkbox"/> Failure <input type="checkbox"/> Inadequate/Insufficient

SECTION C: IMMEDIATE ACTIONS TAKEN

SECTION D: REPORTED BY: person who discovers the incident and unless otherwise stated within the organization, this person is responsible for completing the NIRF.

First name _____

Surname _____

Date notified

DD	MM	YYYY
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Category of person *E.g. Social Worker, Public Health Nurse, etc.*

Local system reference no. _____

SECTION E: WITNESS DETAILS (Name, Contact No. etc.)

SECTION F: NOTES

SECTION G: SIGNATURES

Reporter Signature: _____ **Date:**

DD	MM	YYYY
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Title: _____

Line Manager Signature: _____ **Date:**

DD	MM	YYYY
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(where required)

Title: _____