

Incident/Property Damage/ Hazard Report Form

RMSS number _____



THE UNIVERSITY
OF ADELAIDE
AUSTRALIA

TO BE COMPLETED BY PERSON INVOLVED AND BY THEIR SUPERVISOR

(OR BY SUPERVISOR OR HEALTH AND SAFETY REPRESENTATIVE IF WORKER IS INCAPACITATED)

Details of the person involved in the incident/near miss

Staff/Student ID: _____

Contact number: _____

First name (in full): _____

Last name: _____

☐ Male ☐ Female

Date of birth: _____

Occupation: ☐ Staff ☐ Student ☐ Visitor ☐ Contractor ☐ Volunteer ☐ Other

Details of the Incident

Faculty:

Campus:

Building:

Room:

Date:

Time:

am/pm

If the incident is a Notifiable or Dangerous Occurrence, has it been reported to the HSW Unit: ☐ Yes ☐ No

Definition can be found at <http://www.adelaide.edu.au/hr/ohs/hazmanagmt/accreport.html>

Was the incident/near miss reported to your supervisor immediately: ☐ Yes ☐ No

Date:

Time:

am/pm

Name of Supervisor:

Witness Details

Name:

Contact Number:

Activity at time:

Describe the incident/near miss

Describe what action is planned or has been taken to prevent a recurrence of the incident

Incident/Property Damage/ Hazard Report Form (continued)

Mechanism of injury/damage The action, exposure or object that is the direct cause of the injury/damage

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> bite/sting | <input type="checkbox"/> contact/exposure | <input type="checkbox"/> slip/trip/fall | <input type="checkbox"/> striking against/collision |
| <input type="checkbox"/> caught in/on | <input type="checkbox"/> explosion/fire | <input type="checkbox"/> workplace stress/behaviour | <input type="checkbox"/> water/flooding |
| <input type="checkbox"/> electrical incident | <input type="checkbox"/> other | <input type="checkbox"/> collapse/engulfment | <input type="checkbox"/> failure/strain/breakage |

Nature of the injury

- | | | |
|---|---|--|
| <input type="checkbox"/> abrasion/bruise | <input type="checkbox"/> exposure to hazardous material | <input type="checkbox"/> multiple injuries |
| <input type="checkbox"/> amputation | <input type="checkbox"/> foreign body | <input type="checkbox"/> poison/venom |
| <input type="checkbox"/> concussion | <input type="checkbox"/> fracture/dislocation | <input type="checkbox"/> puncture/needle stick |
| <input type="checkbox"/> cut/laceration | <input type="checkbox"/> hearing loss | <input type="checkbox"/> psychosocial/mental disorders |
| <input type="checkbox"/> electric shock | <input type="checkbox"/> infectious/parasitic diseases | <input type="checkbox"/> scald/burn |
| <input type="checkbox"/> environmental exposure | <input type="checkbox"/> internal injury | <input type="checkbox"/> dermatitis/eczema/rash |
| | <input type="checkbox"/> medical symptom | <input type="checkbox"/> sprain/strain/swelling |

Agency of the injury/damage The object, agent or circumstance that directly caused the injury/damage

- | | | |
|--|--|--|
| <input type="checkbox"/> animals/insects | <input type="checkbox"/> maintenance system | <input type="checkbox"/> surfaces/terrain |
| <input type="checkbox"/> asbestos/fibres | <input type="checkbox"/> object | <input type="checkbox"/> temperature extremes |
| <input type="checkbox"/> biological | <input type="checkbox"/> other | <input type="checkbox"/> tools (including powered tools) |
| <input type="checkbox"/> buildings/structures | <input type="checkbox"/> plant & equipment | <input type="checkbox"/> training system |
| <input type="checkbox"/> chemical/radiation | <input type="checkbox"/> poor design/not fit for purpose | <input type="checkbox"/> vehicle/transport/travel |
| <input type="checkbox"/> environmental/weather | <input type="checkbox"/> psychosocial | <input type="checkbox"/> weight/bulk of object |
| <input type="checkbox"/> human/person | <input type="checkbox"/> sharps | <input type="checkbox"/> wilful act |

What training was provided for the person involved prior to the incident/near miss:

- ☐ Induction ☐ Task Specific ☐ No training

Details

Treatment

- ☐ Not required ☐ First Aider/Security ☐ Health Service/Doctors ☐ Ambulance/Hospital

First aid Details

Name of First Aider:

Details of First Aid Treatment:

Shift worker

- ☐ No ☐ Yes If 'Yes' list shift type: ☐ fixed/standard/flexible ☐ rotating

Portion of shift worked:

Basic hours:

- Rehabilitation** ☐ is required ☐ is not required ☐ is unknown as yet

Part of the body injured

- | | | | | | | |
|-------------------------------|--|--|-----------------------------------|--|--------------------------------|------------------------------------|
| <input type="checkbox"/> eye | <input type="checkbox"/> neck | <input type="checkbox"/> internal organs | <input type="checkbox"/> shoulder | <input type="checkbox"/> hands and fingers | <input type="checkbox"/> knee | <input type="checkbox"/> feet/toes |
| <input type="checkbox"/> ear | <input type="checkbox"/> hips | | <input type="checkbox"/> arm | | <input type="checkbox"/> ankle | |
| <input type="checkbox"/> face | <input type="checkbox"/> chest/stomach | | <input type="checkbox"/> elbow | | <input type="checkbox"/> leg | <input type="checkbox"/> |
| <input type="checkbox"/> head | <input type="checkbox"/> groin | | <input type="checkbox"/> wrist | | | psychosocial |
| | <input type="checkbox"/> back | | | | | |
| | <input type="checkbox"/> buttocks | | | | | |

Incident/Property Damage/ Hazard Report Form (continued)

1. Breakdown Event First event in the chain which led to the most serious injury

- | | | |
|--|---|---|
| <input type="checkbox"/> bite/sting | <input type="checkbox"/> failure of plant or equipment | <input type="checkbox"/> poor work space/storage |
| <input type="checkbox"/> caught in/on | <input type="checkbox"/> incorrect work method/practice | <input type="checkbox"/> property damage |
| <input type="checkbox"/> contact/exposure | <input type="checkbox"/> medical incident/physical injury | <input type="checkbox"/> slip/trip/fall |
| <input type="checkbox"/> explosion/fire | <input type="checkbox"/> other | <input type="checkbox"/> workplace stress/behaviour |
| <input type="checkbox"/> failure of buildings/structures | <input type="checkbox"/> failure of emergency system | <input type="checkbox"/> striking against/collision |

2. Breakdown Agency The object, substance or circumstance that was related most closely to the breakdown event

- | | | |
|---|---|--|
| <input type="checkbox"/> animals/insects | <input type="checkbox"/> maintenance system | <input type="checkbox"/> surfaces/terrain |
| <input type="checkbox"/> asbestos/fibres | <input type="checkbox"/> object | <input type="checkbox"/> temperature extremes |
| <input type="checkbox"/> biological | <input type="checkbox"/> other | <input type="checkbox"/> tools (including powered tools) |
| <input type="checkbox"/> buildings/structures | <input type="checkbox"/> plant & equipment | <input type="checkbox"/> training system |
| <input type="checkbox"/> chemical/radiation | <input type="checkbox"/> poor design/ not fit for purpose | <input type="checkbox"/> vehicle/transport/travel |
| <input type="checkbox"/> environment/weather | <input type="checkbox"/> psychosocial | <input type="checkbox"/> weight/bulk of object |
| <input type="checkbox"/> human/person | <input type="checkbox"/> sharps | <input type="checkbox"/> wilful act |

Does this incident/near miss also pertain to: ☐ Security ☐ Insurance ☐ Legal

PROPERTY DAMAGE DETAILS (if applicable)

Description:	Asset Type: Fixed Plant, Mobile
Make:	Model:
Serial #:	Asset #:
Repair/Replace(\$):	Insurance Claim #:

Prevention of incident/near miss recurrence Long term action against hierarchy of controls:

1. **Elimination:** ☐ ceased event/method/work practice ☐ removed item/plant disposal ☐ other ☐ not applicable

Description of control/Reason for no elimination:

2. **Substitution:** ☐ item(s) relocated ☐ replaced substance/plant ☐ outsourcing ☐ other ☐ not applicable

Description of control/Reason for no substitution:

3. **Engineering:** ☐ repair ☐ redesign ☐ guarding ☐ isolation ☐ housekeeping ☐ other ☐ not applicable

Description of control/Reason for no engineering control:

4. **Administration:** ☐ health surveillance ☐ review method/practice ☐ signage ☐ training ☐ other ☐ not applicable

Description of control/Reason for no administration:

5. **Personal Protective Equipment:** ☐ PPE maintenance ☐ PPE review ☐ PPE provision

Description of control/Reason for no PPE:

OFFICE USE ONLY

Workers Compensation Claim: ☐ Yes ☐ No ☐ Unknown

Insurance Claim: ☐ Yes ☐ No ☐ Unknown

Business Process

