

INCIDENT REPORT



Please note that any personal data submitted onto this document will be processed in compliance with Data Protection Laws and TMC's Personal Data Protection Policy. Please file confidentially.

Section 1. Incident Information

Workplace / Project			
Address			
Exact incident location			
Incident Reference Number (HSEQ Admin)			
Date		Time	

A COPY OF THIS REPORT MUST BE SENT TO THE HSEQ ADMINISTRATOR

Section 2. Incident Facts

<p>Basic Factual Description Provide a full description of the incident; include any sketches/ site layout/ photographs available. Key people involved and estimated timeline of events. Who dealt with the incident and how? And where applicable, name and quantities of substance(s) involved and who/what was affected?</p>					
Incident Type	Personal Injury (Complete all sections except 6-7)	Non-lost Time (Level 1)	<input type="checkbox"/>	Lost Time Injury. Less than 7 Days (Level 2)	<input type="checkbox"/>
		Over 7 Days or specified injury under RIDDOR (Level 3)	<input type="checkbox"/>	Fatality (Level 4)	<input type="checkbox"/>
	Tick if the person was taken to a hospital:				<input type="checkbox"/>
	Member of Public (Complete all sections except 6-7)	Injury – Not requiring immediate hospital treatment (Level 2)	<input type="checkbox"/>	Injury – Requiring immediate hospital treatment (Level 3) RIDDOR	<input type="checkbox"/>

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	Environmental Impact *Level as agreed with Environmental Manager (Go to section 6)		Minor (Level 1) *	<input type="checkbox"/>	Moderate (Level 2) *	<input type="checkbox"/>
			Major (Level 3) *	<input type="checkbox"/>	Significant (Level 4) *	<input type="checkbox"/>
	Asset / Property / Service Damage (Go to section 7)	<input type="checkbox"/>	Minor to Moderate damage (low risk) (Level 1 -2)	<input type="checkbox"/>	Significant damage (Level 3 -4)	<input type="checkbox"/>
	Near Miss / Intervention			<input type="checkbox"/>	Recordable events - *Level as agreed with HSEQ Director/Snr. HSEQ / Environmental Manager	
	Dangerous occurrence (Level 3) RIDDOR			<input type="checkbox"/>		
INCIDENT CLASSIFICATION (please tick all that are applicable)						
H&S Incidents						
Injured while handling, lifting or carrying	<input type="checkbox"/>	Slips / trips / falls on the same level				<input type="checkbox"/>
Falls from height	<input type="checkbox"/>	Struck by a moving vehicle				<input type="checkbox"/>
Struck by moving (flying/falling) object	<input type="checkbox"/>	Contact with electricity or electrical discharge				<input type="checkbox"/>
Equipment failure / misuse	<input type="checkbox"/>	Contact / exposure to harmful substance				<input type="checkbox"/>
Cut/ puncture by sharp objects	<input type="checkbox"/>	Contact with foreign matter (object/particle in eye)				<input type="checkbox"/>
Other H&S Incidents						
Health Risk Exposure	<input type="checkbox"/>	Assaults and Violent Acts				<input type="checkbox"/>
Fire	<input type="checkbox"/>	Near Miss – Unsafe Condition				<input type="checkbox"/>
Delivery (Loading/unloading)	<input type="checkbox"/>	Positive Intervention – Unsafe Act/Condition				<input type="checkbox"/>
Near Miss – Unsafe Act	<input type="checkbox"/>	Other (Specify)				<input type="checkbox"/>
Asset/Property Damage (Specify)						
Environmental Incidents						
Spillage	<input type="checkbox"/>	Light pollution				<input type="checkbox"/>
Dust/Windblown litter	<input type="checkbox"/>	Waste Management (escape or improper storage /disposal)				<input type="checkbox"/>
Contamination to ground	<input type="checkbox"/>	Contamination to drains				<input type="checkbox"/>
Damage to trees under TPO	<input type="checkbox"/>	Air quality (fumes and odours)				<input type="checkbox"/>

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Noise	<input type="checkbox"/>	Mud deposits on road	<input type="checkbox"/>
Injury/death to protected species/natural habitats	<input type="checkbox"/>	Archaeological damage	<input type="checkbox"/>
Other (Specify)			
Weather at time of Incident			
Ground conditions (if applicable)			
WITNESS DETAILS (if any)			
	Witness 1		Witness 2
Name			
CSCS or ID reference			
Phone			

Section 3. Injured Person Details

Name	N/A		
Gender		Age	
Home Address			
Phone Number (Home)		Phone Number (Work)	
Occupation			
Employers Details			
Employment Details	Staff		Contractor
	Operative		Visitor

Section 4. Injury Details

Abrasion	<input type="checkbox"/>	Amputation	<input type="checkbox"/>
Bruises	<input type="checkbox"/>	Burns/scald	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	Crush injury	<input type="checkbox"/>
Cuts / lacerations	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>
Electrical contact injury	<input type="checkbox"/>	Eye injury	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	Sprain and strain	<input type="checkbox"/>
Other (please state below)	<input type="checkbox"/>		<input type="checkbox"/>
Details of Other			

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Body Parts Injured							
Neck		<input type="checkbox"/>		Back		<input type="checkbox"/>	
Trunk		<input type="checkbox"/>		Head (excluding face)		<input type="checkbox"/>	
Other parts of face		<input type="checkbox"/>					
	Left	Right		Left	Right		
Eye	<input type="checkbox"/>	<input type="checkbox"/>	Ear	<input type="checkbox"/>	<input type="checkbox"/>		
One or more fingers	<input type="checkbox"/>	<input type="checkbox"/>	One or more toes	<input type="checkbox"/>	<input type="checkbox"/>		
Hand	<input type="checkbox"/>	<input type="checkbox"/>	Foot	<input type="checkbox"/>	<input type="checkbox"/>		
Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	<input type="checkbox"/>		
Rest of upper limb	<input type="checkbox"/>	<input type="checkbox"/>	Rest of lower limb	<input type="checkbox"/>	<input type="checkbox"/>		

Section 5. Injured Party Treatment

First Aid Administered	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	By Whom	
Did the Emergency Services attend?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details	
Details of Treatment						
Destination of Injured Person after First Aid Treatment	Return to work	<input type="checkbox"/>	Home	<input type="checkbox"/>	Hospital	<input type="checkbox"/>
Details of Hospital, Treatment Advice and IP Response					Expected return date	

Section 6. Environmental Impact Details

Remediated/ Cleaned up? (Please specify)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If a spillage- what type of ground? (Please specify)	Solid (concrete / tarmac etc.)	<input type="checkbox"/>	Permeable (gravel, soil, etc.)	<input type="checkbox"/>		
Was the spill kit available and adequate for the situation?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>

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Was the incident near waterway/ surface drain?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Has the incident impacted any sensitive areas? (Please specify)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If waste related, what type of waste was it?	Hazardous		<input type="checkbox"/>	Non-Hazardous		<input type="checkbox"/>
If air pollution. What was the source of emissions?						
What parts of the tree was damaged and what is the level of damage caused? Please detail.						
Extent of the damaged caused to the archaeological findings.						
Specify protected species/natural habitants involved.						
Other (please specify)						

Section 7. Asset / Property Damage Information

Type of Asset / Property / Service Damaged						
Asset / Property Owner						
Incident Notified to Owner	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Reference	
Emergency Service Notified (If required)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Reference	
Minor to moderate damage to property or assets (low risk), such as utility damage to Cable TV, BT Cable, Water or Gas Service 23mm Diameter or below.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details	
Significant damage to property or assets (high risk), such as utility damage to Water or Gas Service above 23mm, High / Medium Pressure Water Main, HV and LV Cables, 3 rd Party Oil, Gas Pipelines, Fibre Optic Cables.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details	

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Detailed extent, Location and Party Responsible for Damage					
In case of Utility Service strike, was the service known to us?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Reference
Depth of service?					
Should this damage be contested?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Reasons

Section 8. Initial findings if known (Root cause Analysis):

Details	<ul style="list-style-type: none"> Operative carried out unplanned works. Operative used unapproved choice of equipment. Operative did not follow the safe systems of work. Operative did not request a hot works permit prior to using the grinder.
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Section 9. Actions Taken & to be taken (Phronesys)

Action	Completed By:	Date Completed:
1. TMC internal investigation carried out		
2. Internal disciplinary action taken against the operative		
3. All future operations within any buildings, a supervisor needs to be present at all times.		
4. All operatives TMC (Operatives) have been re-briefed to our standard operation procedures (tool box talk)		
5. No hot works allowed on any of the facilities without prior approvals from Global Switch.		

Section 10. Incident Photos / Sketches

Photos / Sketches attached	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Reference
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Section 11. Investigator Appointment

Is HSEQ Department assistance required for investigation?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Lead Investigator Details (Name, role etc.)				

Section 12. Distribution

	Yes	No	N/A	Details
Client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HSEQ Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Contracts Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other				

Section 13. Incident Reporter

Print Name			
Position			
Signature		Date	

EACH INCIDENT WILL BE CONSIDERED ON ITS OWN MERIT AS TO WHETHER IT REQUIRES AN INVESTIGATION AND TO WHAT LEVEL.