




In Case of a Spill

Oil, chemicals, liquid foods or bodily fluids

<h2>Stop</h2> 	<ul style="list-style-type: none"> When oil, petrol, diesel, chemicals, paints or varnishes spill Stop work (If safe to do so) Secure the area Find the source and stop any more from spilling 																																										
<h2>Contain</h2> 	<ul style="list-style-type: none"> Wear appropriate PPE Contain the spillage immediately e.g. with spill kits (oil or chemical), trip trays etc. Neutralise the spill where necessary e.g. chemicals in the lab Where spill has landed act fast to prevent it spreading. Bag up the spill kit and/or contaminated soil 																																										
<h2>Protect</h2> 	<ul style="list-style-type: none"> Protect water courses and surface water drains Drain covers can be purchased 																																										
<h2>Notify</h2> <p>REPORT OF AN INCIDENT, ACCIDENT, DANGEROUS OCCURRENCE OR NEAR MISS: This form must be completed and returned within 3 working days of the incident to the Safety Officer for Health & Safety Incidents. If in doubt report the incident immediately to the Safety Officer by telephone x 3744 or x 3743. This document and any copies are confidential and must be filed securely.</p> <p>OXFORD BROOKES UNIVERSITY</p> <table border="1"> <thead> <tr> <th colspan="2">INCIDENT INFORMATION</th> <th>Office Use Only</th> </tr> </thead> <tbody> <tr> <td>Date:</td> <td>Time: (use 24 hr clock)</td> <td>Date received:</td> </tr> <tr> <td colspan="2">Location: (including Campus and Room Number)</td> <td>File No.:</td> </tr> <tr> <td colspan="2">Please classify the accident or incident by ticking the boxes: <input type="checkbox"/> Health & Safety (please also complete parts A & C below) <input type="checkbox"/> Accident <input type="checkbox"/> Incident <input type="checkbox"/> Near Miss <input type="checkbox"/> Environmental (please complete Parts A, B and C below as appropriate) Please state briefly what happened, e.g. slip, trip, chemical spill etc.</td> <td>Ref/Ref:</td> </tr> <tr> <td colspan="2">Names & addresses of witnesses:</td> <td>Sex: <input type="checkbox"/> M <input type="checkbox"/> F</td> </tr> <tr> <td colspan="2">RSJ/IT name of First Aider:</td> <td>Age:</td> </tr> <tr> <td colspan="2">PART A - PERSONAL INFORMATION (INJURED PARTY)</td> <td>Reason:</td> </tr> <tr> <td>Surname:</td> <td>Forename(s):</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> </tr> <tr> <td>Date of Birth:</td> <td>Day:</td> <td><input type="checkbox"/> M <input type="checkbox"/> D</td> </tr> <tr> <td>Address:</td> <td><input type="checkbox"/> Student <input type="checkbox"/> Employee <input type="checkbox"/> Visitor</td> <td>Age:</td> </tr> <tr> <td>Postcode:</td> <td>Occupation/ Course:</td> <td>Reason:</td> </tr> <tr> <td>Phone No.:</td> <td>Supervisor:</td> <td><input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Other</td> </tr> <tr> <td>Faculty/Directorate:</td> <td>Details of Injury: (Please state nature of injury and part of the body affected, state L or R):</td> <td>Hours of Injury:</td> </tr> <tr> <td>First aid given: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Please state first aid treatment given:</td> <td>Treatment:</td> </tr> </tbody> </table>	INCIDENT INFORMATION		Office Use Only	Date:	Time: (use 24 hr clock)	Date received:	Location: (including Campus and Room Number)		File No.:	Please classify the accident or incident by ticking the boxes: <input type="checkbox"/> Health & Safety (please also complete parts A & C below) <input type="checkbox"/> Accident <input type="checkbox"/> Incident <input type="checkbox"/> Near Miss <input type="checkbox"/> Environmental (please complete Parts A, B and C below as appropriate) Please state briefly what happened, e.g. slip, trip, chemical spill etc.		Ref/Ref:	Names & addresses of witnesses:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	RSJ/IT name of First Aider:		Age:	PART A - PERSONAL INFORMATION (INJURED PARTY)		Reason:	Surname:	Forename(s):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Day:	<input type="checkbox"/> M <input type="checkbox"/> D	Address:	<input type="checkbox"/> Student <input type="checkbox"/> Employee <input type="checkbox"/> Visitor	Age:	Postcode:	Occupation/ Course:	Reason:	Phone No.:	Supervisor:	<input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Other	Faculty/Directorate:	Details of Injury: (Please state nature of injury and part of the body affected, state L or R):	Hours of Injury:	First aid given: <input type="checkbox"/> Yes <input type="checkbox"/> No	Please state first aid treatment given:	Treatment:	<ul style="list-style-type: none"> Notify your manager If the spill is contained complete the form OBUHSN-11app2 and send to the Health and safety team. Notify Facilities or the Sustainability Team that a spill has occurred and hazardous materials need to be disposed of. Do not put into normal bins. Tell them whether: <ol style="list-style-type: none"> The material has entered any drains or affecting the environment The materials involved The location Reasons for incident Quantity involved
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