

**WIGAN COUNCIL INCIDENT REPORT FORM**

Wigan Council handles personal data in accordance with the Data Protection Act 1998

**Part 1 - to be completed by the individual involved where possible.**

Person Involved  Age  Gender  M/F

Home address & telephone   
No. of person involved.

Status: (Please tick)  Employee  Trainee  Public  Student  Service User  Contractor  Agency staff  Other

Department

Premises of person involved/  
premises of incident for other

Section

Occupation if employee  Pay number

Date of incident  Time of incident

Actual site of incident

Which best describes the incident (please tick one box only)  Personal accident  Near miss  Occupational disease (work related)  Violent incident  Dangerous occurrence

Please indicate type(s) of violent incident: (Please tick)

<input type="checkbox"/> Aggressiveness	<input type="checkbox"/> Intimidation/harassment	<input type="checkbox"/> Physical attack
<input type="checkbox"/> Physical sexual assault/harassment	<input type="checkbox"/> Verbal sexual harassment	<input type="checkbox"/> Racial harassment
<input type="checkbox"/> Threats of violence	<input type="checkbox"/> Shouting insults	<input type="checkbox"/> Other (please specify)

Name of other persons involved (please tick)

<input type="checkbox"/>	<input type="checkbox"/> Employee	<input type="checkbox"/> Trainee	<input type="checkbox"/> Public	<input type="checkbox"/> Student	<input type="checkbox"/> Service User	<input type="checkbox"/> Contractor
<input type="checkbox"/>	<input type="checkbox"/> Employee	<input type="checkbox"/> Trainee	<input type="checkbox"/> Public	<input type="checkbox"/> Student	<input type="checkbox"/> Service User	<input type="checkbox"/> Contractor
<input type="checkbox"/>	<input type="checkbox"/> Employee	<input type="checkbox"/> Trainee	<input type="checkbox"/> Public	<input type="checkbox"/> Student	<input type="checkbox"/> Service User	<input type="checkbox"/> Contractor

Description of how the incident occurred

Name address & telephone number of any witnesses

Injuries sustained, Ill health or adverse effect

Was medical treatment needed? (please tick all that apply)  None  First aid  Doctor  Hospital

First aid details, name and contact number

Signature of employee to verify details of incident:

**Person completing Part 1:**

Name	Signature	Tel No.	Date
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Please include your home address and occupation if you are filling this form in on behalf of the person involved.

## INCIDENT INVESTIGATION

### Part 2

**(To be completed by immediate Supervisor or Line Manager – use separate sheets if required)**

The Corporate Procedure Incident Reporting and Investigation gives guidance on completing Part 2

Review of specific circumstances (How the incident resulted)

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What happened following the incident: (please tick)	<input type="checkbox"/> Had to go home	<input type="checkbox"/> Discussed with Manager	<input type="checkbox"/> Nothing	Police involved (Give incident No.)
	<input type="checkbox"/> Felt supported	<input type="checkbox"/> Other please specify:		

Possible immediate and underlying factors. See guidance. (Tick the most appropriate boxes)

Immediate factors				Underlying Factors			
Premises/ Place of work	People	Procedures	Plant, equipment & substances	Planning and Risk assessment	Control	Consultation and co operation	Communication
Challenging behaviour	Mental health issues	Medication	family contact	Competence	Monitoring	Review	Training
Relationship issues	Staffing issues	Impositions of sanctions	life events	Inappropriate placement			
Give explanation of factors identified:				Give explanation of factors identified:			

Was that person authorised to perform the task? (Please tick)  YES  NO

Has person involved been offered: (Tick as appropriate)

<input type="checkbox"/> Counselling	<input type="checkbox"/> Legal advice	<input type="checkbox"/> Trade Union representation	<input type="checkbox"/> other	<input type="checkbox"/> N/A
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Describe current control measures

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Summary of improvements to raise standards(key actions to address underlying factors)

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Was the accident reportable under RIDDOR? (Please tick)  YES  NO

Date qualifying incidents reported to HSE  Date F2508 sent to HSE

Was sick leave taken as a result of the incident? (Please tick)  YES  NO

Date of first day of sick leave  Date of last day of sick leave

Total sick days taken

Details of person completing Part 2

Print name	Signature	Telephone No	Date completed:
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