## Incident Reporting Form

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| **Incident Report Ref No:** (to be inserted by Incident Reporting Lead): |
| **PART 1:** **Health & Safety related incidents:** To be completed by or on behalf of the injured/affected person.**Information Governance (IG) and other incidents:** To be completed the person who discovered the incident had occurred. |
| **Section 1:**  |
| **Who was injured or affected by the incident?** (please provide full name(s) and contact details – for IG incidents, this will be the person whose confidentiality was breached) |
| **Site and exact location of incident:**  |
| **Date of Incident:** *(please state if actual date/time is not known, and use date/time incident was discovered)* | **Time of incident or time it was discovered:** *(state which and use 24 hour clock)* |
| **Was this an IG Incident?**  | Yes / No |
| **If Yes, state Incident Type:** *(delete options that do not apply)*If No, go to Section 2 below.  | 1. Information lost/left unattended
2. Information sent in error
3. Information sent unnecessarily
4. Information sent insecurely
5. Information incorrect/misplaced
6. Information mis-used
7. Information disposed of insecurely
8. Information stolen.
9. Other (please describe)
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| **Format of Information Governance Breach:** *(delete options that do not apply)* | 1. Electronic
2. Paper
3. Spoken/Verbal
4. Other (please describe)
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| **Section 2: About the Person Affected** *(If the event affected premises or property/assets only, go to section 3)* |
| Status of person(s) injured or affected? (please mark ‘x’)  | Employee |  | Client/Patient |  | General Public |  | Contractor |  | Visitor |  |
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| Date of Birth: *(patients only)* | Sex:  | NHS No.: *(patients only)* |  |  |  |  |  |  |  |  |  |  |
| Phone Number: | Job Title:  |
| Address:  |
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| **Section 3: Details of the Incident** |
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| **Description of incident:** *(facts only, in chronological order that they occurred):* |
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| **Was the incident witnessed?** Yes / No *If yes, please supply details below. Witness statements should be obtained and submitted as soon as possible..*  | **Name of person(s) who made error*:****(if known at the time of reporting)*   |
| Name: | Name:  |
| Phone Number: | Phone Number:  |
| Address:  | Address:  |
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| **Section 4: Action Taken:** |
| **Immediate Action Taken:**  |
| **Action that will be taken to prevent recurrence:** (this should be completed at a later stage if not immediately apparent and/or an investigation is required). |
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| **Section 5: Reporting the Incident:** |
| Name of person reporting incident:  |  | Job Title: | Date:  |
| Who was the Incident reported to? |  | Date: | Time:  |
| **Please pass the form to your line manager to complete PART 2** |

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| **PART 2: To be Completed by Reporters/Injured Party’s Line Manager** |
| **Section 6: Further Action taken to Limit Reoccurrence/Control Measures Instigated** (if applicable) |
| Further Action Taken:  |
| Signature of Line Manager: | Line Manager’s name, position and email address:  | Date: |
| **Please forward this form to the Incident Reporting Lead and pass to the person in charge of the area at the time of the incident for investigation** (maybe same as line manager above) |
| **Section 7: Investigation** |
| Was the incident escalated and reported to an outside organisation? **Yes / No?** | **If Yes**, please state *(delete those that do not apply)*1. Serious Incident – Quality Team.
2. RIDDOR Reportable – Health & Safety Executive.
3. Level 2 SIRI – Information Commissioner/Dept of Health or other regulators via the Data Security & Protection Toolkit.
4. Major Incident – Emergency Planning, Resilience and Response Team.
5. Local Counter Fraud Specialist.
6. Local Security Management Specialist.
7. Other (please state)
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| Investigation Details: *(this should include information and events leading up to the incident and the incident itself – to be submitted in a separate report if necessary).*  |
| **Are any other actions required to reduce or eliminate the likelihood of reoccurrence?** If Yes, please state actions, who will implement and timescales for completion (a separate action plan can be provided if necessary): |
| Signature of investigator counter signed by Service Head if different |  | Print Name: | Date |
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