

Warwickshire County Council Accident/Incident/Near Miss Reporting Form

You should only use this form if you CANNOT access the on-line accident/incident recording system. Schools may use it as an internal school document to assist with inputting onto the on-line recording system

THIS FORM IS CLASSIFIED AS "WCC-CONFIDENTIAL" WCC collects personal information about you on this form in relation to accidents, injuries, diseases, near misses and dangerous occurrences arising out of or in connection with work. We may share your information with the HSE to ensure we meet our legal requirements. For further information on how we maintain the security of your information and your rights to access the information we hold on you please see our WCC Privacy Notice, Information Rights Policy and WCC Accident/Incident Policy.

* **Compulsory field**

A. ACCIDENT/INCIDENT TYPE * tick only one

1. Accident/Incident which **may or may not** have resulted in an injury, work related ill health, violent incident or road traffic incident
2. Near miss, dangerous occurrence, outbreak of fire, environmental incident and security/vandalism/property/equipment damage, that has the potential risk of harm to people on-site

WHICH OF THESE BEST DESCRIBES YOU AS THE AUTHOR OF THIS DOCUMENT? (Please tick)*

Injured person (IP) including reporting ill-health Manager of Injured Person (IP) Other (e.g. colleague)

Author's Group (please tick)* School Resources Communities People Fire & Rescue

Author's Business Unit/Team/Service/School (please detail below)

Authors Contact Telephone Number

B. PERSONAL DETAILS OF INJURED PERSON* (please tick/detail except if reporting accident/incident type 2 (see above) where no personal details are required and you should go direct to section C)

First Name Last Name

Home Address

Male Female Age Date of Birth (if known) Contact Telephone no (if known)

Status: Employee Pupil Contractor Member of Public Customer/Client Work Experience Volunteer Agency Staff

IF WCC employee, state job title Full time Part time

C. DETAILS OF ACCIDENT/INCIDENT/DANGEROUS OCCURRENCE (please continue on separate sheet if necessary)

C.1*	Exact location where incident occurred* (e.g. site/school name and full address)	* Specific area within location/building (e.g. classroom, corridor)	
Date of accident/incident:*(DD/MM/YY)		Time of accident incident:*	am/pm
C.2*	Describe the circumstances of what exactly happened (Please provide as much information as possible including relevant factors, e.g. internal/ external floor conditions/levels, weather, other people involved, use of equipment, chemicals, plant, using PPE, doing something out of the normal or usual activity process, not trained to do, damage to property, etc.) Continue on separate sheet if required		
C.3*	Was there anything defective with the workplace that may have contributed towards the cause of the incident? e.g. lack of supervision, defective faulty equipment, or the way equipment was used, the condition of the premise, spills, etc. If no defects, state 'None'		

C.4*	Describe the immediate actions taken following accident/incident (e.g. who notified (internal and external), who initially checked for defects and when, area made safe, spill cleared up, equipment taken out of use, etc...)
C.5*	Was any first aid treatment given directly, at the location of the/accident/incident? If yes please provide details or State 'None' if no treatment given

D. DETAILS OF ANY INJURY (please detail)

D.1*	Injury Type e.g. fracture, sprain/strain,		D.2*	Details of part of body affected (e.g. arm, leg, face, whole body) include left/right if appropriate	
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D.3*	Name, address and contact details of witness (attach witness form if completed). State 'None' if no witnesses
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Please sign and date this form as the author and give to the manager/nominated manager. If completing this form as a manager/nominated manager of the injured person continue to section E.

Authors Signature*		Job Title*		Date*	
Print Name*					

Sections E, F, G and H to be completed by manager or nominated manager

E. Confirmation of Injury outcome* (please tick only one). If ticked taken to hospital, please also complete Section F

No Fatal Sent/Taken Sent/Taken to Sent /Taken to Prevented from Returned to
 Injury Injury home Medical Practitioner hospital working Normal Activity

F. INJURED PERSON TAKEN TO HOSPITAL

F.1	Were they taken directly to hospital for treatment? (from address in C1) (NB. Examinations and diagnostic tests do not constitute treatment)	Yes <input type="checkbox"/> No <input type="checkbox"/>
F.2	If not taken directly from location of incident, when was the injured person taken to hospital? (Date/Time)	
F.3	What treatment was given at the hospital? Please state.	

G. KIND OF ACCIDENT/INCIDENT* (e.g. 'fall from height' (state how far above or below ground*))

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H. INTIAL FINDINGS AND ACTION TO PREVENT RECURRENCE

H.1*	Investigation findings (Please give details of your initial findings. You may be required to complete an accident/incident investigation form.	
H.2*	Action to prevent recurrence (Specify the actions to be taken to prevent recurrence, when taken and by who)	
H.3*	Expected date of Return (complete with date of accident/injury if no absence)	

Signed by manager/nominated manager*

Signature	Print Name
Job Title	Date

Once this form has been inputted onto the on-line accident/incident recording system if can be confidentially destroyed. If you cannot access the on-line accident/incident recording system please return this form to Accident/Incident Reporting, Health, Safety and Wellbeing Service, Warwickshire County Council, Shire Hall, Warwick CV34 4RL (by post in a sealed envelope marked private & confidential) or email accidentreport@warwickshire.gov.uk (from a secure email address only) Tel No: 01926 476803.