|  |  |
| --- | --- |
| Internal reference:  |  |

ERROR / INCIDENT / NEAR MISS \*delete

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Child: |  | Date of Incident: |  |
| Children’s Home:  |  | Time of incident: |  |
| Other related records: |  | Location of incident: |  |
| Lead staff member involved: |  | Other staff involved:  |  |

|  |
| --- |
| What happened (brief summary of incident): |
|  |
| What led up to the incident (describe any factors or events that may have led to the incident taking place) |
|  |
| Description of any health-related impact of the incident |
|  |
| Medical treatment sought  |
|  |
| Medical treatment provided (include whether this was accepted or declined) |
|  |
| Child’s views of the incident |
|  |
| Child’s signature  |  | Date  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Person completing report: |  | Signature |  | Role / Position |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Action taken**  | **Date**  | **Time**  | **Person completing action**  |
| Safeguarding referral to SW and/or PM (**office hours**) |  |  |  |
| Safeguarding referral to MASH (**out of hours**) |  |  |  |
| Reg 40 notification to Ofsted  |  |  |  |
| Child debrief meeting arranged/held (delete) |  |  |  |
| Staff debrief meeting arranged/held (delete) |  |  |  |
| HSW3 completed (if injured) |  |  |  |
| Police /Paramedics/Fire Brigade contacted (if needed) |  |  |  |
| Other (please state) |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Agency updates** | **Named person**  | **Date**  | **Time**  | **Person completing action** |
| Social Worker  |  |  |  |  |
| IRO  |  |  |  |  |
| LAC Nurse (if injured) |  |  |  |  |
| Parent/Carer |  |  |  |  |
| Ofsted (via Reg 40) |  |  |  |  |
| LADO |  |  |  |  |
| Keyworker & staff team  |  |  |  |  |
| Other (please state) |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of document reviewed** | **Date updated**  | **Date sent**  | **Person completing the update**  |
| Safety Plan  |  |  |  |
| Support Plan  |  |  |  |
| Positive Handling Plan  |  |  |  |
| Missing plan  |  |  |  |
| Medication Plan  |  |  |  |
| Other (please state) |  |  |  |

|  |
| --- |
| **Section to be completed by a manager** |
| Manager’s initial review and comments |
|  |
| Print name  |  | Signature |  | Role / Position |  | Date |  |

|  |
| --- |
| Follow up actions:  |
|  |

|  |
| --- |
| Manager’s final review and sign off: |
|  |
| Print name |  | Signature |  | Role / Position |  | Date |  |
| Print name  |  | Signature  |  | Role / Position | Regulation 44 Visitor  | Date  |  |