Incident report form

Type of Incident: (Refer to list eg. Physical assault, absconding, client death)	**Medical attention/ Assault** **If assault, injury, or otherwise relevant, was medical attention required?** **If Assault: perpetrator > victim** (eg. Client > staff)
Category: *(check with Program Manager)* ☐ **1** ☐ **2** ☐ **3**	

Section A

To be completed by most senior witness to the incident or the person to whom the incident was reported where there were no witnesses

Reporting Details

Region: **If "other" please specify:** **Regional Ref. Number:** (for regional use)

Name of Funded Agency: (if relevant):

Facility: **Cost Centre Code Number:** (for regional use)

Reporting Officer's Name: **Phone:**

Position: **Program:**

Signed: …… **Date of report:** **Time:**

Incident Details

Incident Date: **Incident time:**
Location of incident:

Description of incident:

Equipment damaged? ☐ Yes ☐ No

Details of damage:

_____

_____

_____

_____

(Please complete the following for each person involved in the Incident, including witnesses)

	Name	Gender M/F	Client DoB	Staff Posn. Title	Location	Phone	Participant / Witness (P/W)	Tick box if injured	Tick box if Medical Attention Required
1								☐	☐
2								☐	☐
3								☐	☐
4								☐	☐
5								☐	☐
6								☐	☐

If more than six individuals are involved in an incident, please attach an additional sheet with their details.

Is any client listed above of Aboriginal or Torres Strait Islander origin? If so, please list their name:

_____

Details of Injuries

Immediate Response of Staff to Incident

Section B

To be completed by Line Manager, CEO, Program Manager, Agency Manager or Children's Services Licensee Representative

Response to Incident

Further Local Action:

Action planned to prevent recurrence:

Suggested media response (if appropriate):

Section C

To be completed by Unit/House Manager/Supervisor/Agency Manager/CEO/ Children's Services Licensee Representative

Name: **Telephone:**

Line Manager/CEO informed: ☐ Time: Date:

Police Contacted: ☐ Yes ☐ No Time: Date:
Police Officer's Name: Number:

Police Investigation: ☐ Yes ☐ No

Disease/Injury/Near Miss/Accident (DINMA) completed: ☐ Date:
(DHS Employees only)

WorkSafe Victoria notified: ☐ Date:

Incident report checked: ☐ Date:

Signed:……

Section D: For completion by Department of Human Services staff

To be completed by Departmental Line Manager/CEO/Program Manager

Name: **Telephone:**

Regional Director informed: ☐ Date:

Debriefing approval requested: ☐ Date:

Coroner contacted: ☐ Date:

Incident Report Checked: ☐ Date:

Category 2 Report noted ☐ Date:

Follow up action required: Date:

Signed:
……..

Date:

Section E

Regional Director

Name: (contact person) **Telephone:**

Date and time incident report received:

Category 1 incident* without *the potential to involve the Minister or produce a high level of public or legal scrutiny

Program Director informed: ☐

Executive Director informed: ☐

Executive Director Operations informed: ☐

Legal Services Branch informed: ☐

Capital Management Branch informed: ☐
(major fire/serious property damage only)

Entered in information system: ☐

Additional requirements for Category One incident* with *the potential to involve the Minister or produce a high level of public or legal scrutiny

Secretary to the Department informed ☐

Minister informed: ☐ Date:

Ministerial brief required as soon as possible and within 72 hours.

Inquiry recommended ☐**No** ☐ **Departmental** ☐**Ministerial**

Debriefing approved: ☐

Incident report checked: ☐

Date:

Signed: ……..…

(Regional Director)