# Client Incident Report Form

Complete this form to report incidents involving and/or impacting upon clients in services delivered by DHS and funded CSO services. Incidents are categorised according to actual/alleged impact on clients.

Use the Incident Report Guide to assist in completing the form.

If completing paper copy, please use **black or blue** pen only. If more space is required for any section, please attach an additional clearly labelled page/s.

*Parts 1 – 4 are to be completed by the most senior staff member present at the time of the incident, the 'reporter'..*

## Part 1: Reporter details

| | |
|---|---|
| Reporting officer's name: | |
| Telephone number: | |
| Position title: | |
| DHS Service Area:<br>*Refer to Service Areas (list A)* | |
| Funding DHS Program:<br>*Refer to Programs (list B)* | |
| Reference number:<br>*(f applicable)* | |
| Reporting organisation:<br>*DHS / CSO name* | |
| Facility/Program name:<br>*E.g. ABC Day Centre* | |

## Part 2: Incident details

| | | | |
|---|---|---|---|
| Date of incident: *DD/MM/YYYY* | / / | Time of incident: | ☐ AM ☐ PM |
| If you did not see the incident:<br>Date you were first told about the incident: *DD/MM/YYYY* | / / | Time first told of incident: | ☐ AM ☐ PM |
| Address/location of incident:<br>*Where did it happen?* | | | |

Incident type
*Refer to the Incident types (list C). Choose and write down ONE (**the most serious**) incident type only. Copy exact wording from the list.*

For incidents involving **assault**:
*Please mark one only.*
*'Other' refers to those who are not clients, staff or carers but who were involved in the incident.*

- ☐ client to client
- ☐ client to staff/carer
- ☐ staff/carer to client must be marked as Category 1 below
- ☐ client to other
- ☐ other to client

Incident category:
*Refer to Incident types list (C). For items with an asterisk * you must select Category 1.*
*To make further decisions about which category to select, refer to the DHS Incident Reporting Categorisation Table (list D)*

☐ Category 1 ☐ Category 2

## Part 3: Who was involved?

### Clients: details

*Please complete for each client involved in the incident. This includes client witnesses.*

| | Family name | First name | Sex (M/F) | Aboriginal or Torres Strait Islander *(circle one)* | Date of Birth | Address | Participant/ Witness/ Victim/ (P/W/V) *(circle one only*)* | Injured *(circle one)* | Medical professional required *(circle one)* |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | Y N | | | P W V | Y N | Y N |
| 2 | | | | Y N | | | P W V | Y N | Y N |
| 3 | | | | Y N | | | P W V | Y N | Y N |
| 4 | | | | Y N | | | P W V | Y N | Y N |

* Only mark 'victim' when incident involves assault.

### Staff/carer or others: details

*Please complete for each staff member/carer or others involved in the incident, including any witnesses.*

| | Family name | First name | Position/title or Kinship/foster carer or other | Paid staff/ Carer *(circle one)* | Participant/ Witness/ Victim/ (P/W/V) *(circle one only)* | Injured *(circle one)* | Medical professional required *(circle one)* | DINMA completed *(DHS only)* |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | P C | P W V | Y N | Y N | Y N |
| 2 | | | | P C | P W V | Y N | Y N | Y N |
| 3 | | | | P C | P W V | Y N | Y N | Y N |
| 4 | | | | P C | P W V | Y N | Y N | Y N |

## Part 4: What happened?

Describe the incident and the immediate response of staff.

*This section should be a brief, factual account of the incident. Include impact to client who was involved; how, where and when the incident occurred; who did what; who (if anyone) was injured and the nature and extent of injuries (if applicable).*

Was any property or equipment damaged? ☐ Yes ☐ No

Details of damage: _____

Signature of reporter: _____ Date: / /

## Part 5: Manager's report

*Part 5 to be completed by house supervisor/coordinator, line manager, CEO, or agency manager.*

Print Name: Telephone:

Position:

**Brief summary of incident** (for all incidents)

*Provide a brief summary of incident in 20 words or less.*

**What actions have been taken and what follow-up actions will be taken in response to the incident?**

*Please describe what actions have been taken to address safety risks and what will be done to prevent recurrence of the incident.*

**Staff to client assault** and/or **Abuse in care**

*These refer to alleged or actual physical or sexual assault where a client in care is the victim, and the perpetrator is a staff member, a carer or a member of the carer's household.*

| | | | |
|---|---|---|---|
| Is this an incident of staff to client assault? | ☐ Yes | ☐ No | *If yes, complete remaining items in this section.* |
| Have immediate client safety needs been met? | ☐ Yes | ☐ No | |
| Has an investigation been initiated? | ☐ Yes | ☐ No | |
| Is this an incident of abuse in care? | ☐ Yes | ☐ No | |

Please provide details:

*e.g. staff or carer stood down or client removed from placement, Quality of Care review or other review recommended.*

**Compulsory treatment** (*for Disability Services clients only):*:

Are any of the clients subject to compulsory treatment under the Disability Act (2006)? ☐ Yes ☐ No

**Other areas informed**

| | | | | | |
|---|---|---|---|---|---|
| Local CASA support offered: | ☐ Yes | ☐ No | | | ☐ N/A |
| Line manager/CEO informed: | ☐ Yes | ☐ No | Date: / / | Time: | ☐ N/A |
| Police contacted: | ☐ Yes | ☐ No | Date: / / | Time: | ☐ N/A |
| Police officer's name: | | | | Telephone: | |
| Police investigation: | ☐ Yes | ☐ No | Date: / / | | ☐ N/A |
| Coroner contacted: | ☐ Yes | ☐ N/A | Date: / / | Case number: | |
| WorkSafe Victoria notified: | ☐ Yes | ☐ No | Date: / / | | ☐ N/A |

Report quality checked: ☐ Yes

Signature of Manager: Date: / / Time:

Forward completed incident report to the Designated Point in DHS Office

# Internal DHS Review - Incident Report Form

*Parts 6 – 8 are to be completed by DHS staff once completed incident report form has been approved by the relevant manager (Part 5).*

IRD # ref: *(insert the TRIM reference for this IR)* _____

## Part 6: Endorsement DHS Manager

*To be completed by manager for example disability accommodation manager, disability area manager, child protection manager, housing manager, youth justice manager, housing services manager.*

Name:

Position:

Telephone:

| | | | |
|---|---|---|---|
| Incident report quality checked: | ☐ Yes | ☐ No | |
| Immediate needs of the client are being suitably addressed: | ☐ Yes | ☐ No | |
| All appropriate immediate actions have been taken in response to the incident: | ☐ Yes | ☐ No | |
| Any identified program management failures are being addressed: | ☐ Yes | ☐ No | ☐ N/A |
| Follow-up action required: | ☐ Yes | ☐ No | |

What actions have been taken and what follow-up actions will be taken?

*Please describe what actions have been taken to address safety risks and what will be done to prevent recurrence of the incident.*

Signature of Director: _____ Date: / /

## Part 7: Endorsement Area/Child Protection Director

Name: Position:

Comments (optional):

| | | |
|---|---|---|
| Disability Services Commissioner should be informed: | ☐ Yes | ☐ No |
| Child Safety Commissioner should be informed: | ☐ Yes | ☐ No |
| Property Portfolio informed: | ☐ Yes | ☐ No |
| Email alert required: | ☐ Yes | ☐ No |

Signature of Director: _____ Date: / /

## Part 8: Endorsement Executive Director

Quality of support/care review is recommended: ☐ Yes ☐ No

Comments (optional):

Signature of Executive Director: _____ Date: / /