Department of Human Services

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 Areas:	- Please Select -
Funding DHS Program: *Refer to Programs (list B)*	- Please Select -
Reference number: *(if applicable)*	
Reporting organisation: *DHS / CSO name*	
Facility/Program name: *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: Date you were first told about the incident: *DD/MM/YYYY*		Time first told of incident:	☐ AM ☐ PM
Address/location of incident: *Where did it happen?*			

Incident type *Select ONE (**the most serious**) incident type only.*	A – L M - Z
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. 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		Aboriginal or Torres Strait Islander		Date of Birth	Address	Participant/ Witness/ Victim/ *(select one only*)*			Injured		Medical professional required	
			M	F	Y	N			P	W	V	Y	N	Y	N
1			☐	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
2			☐	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
3			☐	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
4			☐	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐

* 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		Participant/ Witness/ Victim/			Injured		Medical professional required		DINMA completed *(DHS only)*	
				P	C	P	W	V	Y	N	Y	N	Y	N
1				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 on 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

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 e.g. 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 Manager: ______________________ 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: ______________