To use when injury requires medical attention or incident has serious effect	Register Number:

STRICTLY CONFIDENTIAL

To comply with legislation a record of all incidents (injuries, work caused illnesses and dangerous events/hazards etc) must be reported to a Coordinator/Facilitator by the end of a shift or working day. The incident report must be completed within 24 hours. **Where an injury requires medical attention or a serious incident (e.g. Abuse, serious accident) has occurred contact has to be made with Weeroona's senior staff immediately** and recorded on this **CRITICAL Incident Form**. All information in relation to this report is to remain confidential.

Incident ☐ **Harm** **(abuse, assault, neglect)** ☐ **Injury**

Immediate action to be taken due to critical risk to person: _____

Date and Time of Incident: _____am/pm. Date and time Incident reported: _____

To Whom incident initially reported to (by phone): _____Position:_____

Full name of person completing the report: _____Position:_____

Senior Staff member receiving this report:_____Position:_____

1. Full name of person reporting the incident: _____

- Residential address: _____
- Phone number/s:_____mobile: _____
- Relationship to workplace (please tick appropriate box): ☐ employee ☐ service user ☐ visitor ☐ other (please specify)_____

2. Full name of person identified as being injured/harmed/ill: _____

- Residential address: _____
- Phone number: _____ mobile: _____
- Relationship to workplace (please tick appropriate box): ☐ employee ☐ service user ☐ visitor ☐ other (please specify) ……

3. Full name of witness to incident/harm/injury: _____

- Residential address: _____
- Phone number: _____mobile: _____
- Relationship to workplace (please tick appropriate box): ☐ employee ☐ service user ☐ visitor ☐ other (please specify)_____

Please attach details of any further witnesses. ☐ Yes ☐ No

4. Location/address where incident/harm/injury occurred (e.g. home/community/vehicle etc)_____

_____

_____

Type of incident : ☐ Manual handling ☐ Chemical/poison ☐ Fall/trip/slip ☐ Motor Vehicle/Transport

(tick where applicable) ☐ Repetitive movements ☐ Electrical/fire ☐ Projectiles ☐ Workplace bullying

☐Other (please specify)_____

Description of incident (factual only):

Lead up to the incident:_____ _____

_____

_____

_____

Sequence of events:_____

_____

_____

_____

Action taken: (Tick boxes where applicable)

☐ First Aid treatment applied Ambulance contacted 000 ☐ Weeroona Senior Staff contacted by phone

☐ Parents/Guardian/next of kin contacted Went in ambulance with injured person

Private vehicle taken to hospital to stay with injured person until Parent/Guardian arrived

☐ Police contacted

Details:

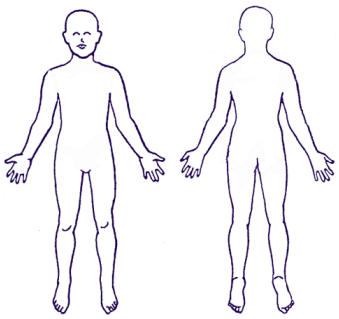
_____

_____

_____

_____

Part of body injured/affected:



☐ Head ☐ Eye ☐ Ear ☐ Nose ☐ Teeth

☐ Neck ☐ Arm/Shoulder Hand ☐ Chest ☐ Back

☐ Abdomen ☐ Hips ☐ Legs Knees ☐ Ankle

☐ Feet ☐ Toes ☐ Multiple locations ☐ Psychological

☐ Internal organs Other (please specify)_____

Nature of injury/illness/harm

☐ Laceration Bruise ☐ Dislocation ☐ Strains/sprains ☐ Burns/scalds ☐ Fracture

☐ Foreign body Fume inhalation ☐ Infection/disease ☐ Puncture wound ☐ Poisoning

☐ Heat/cold stress ☐ Skin irritation ☐ Multiple ☐ Deafness

Other (please specify) _____

_____

Description of injuries/harm/illness: _____

_____

_____

_____

Assessment and responses

In your opinion, what contributed to the incident? _____

_____

_____

_____

_____

- What conditions contributed to this incident? _____

_____

- What were the reasons for these conditions existing? _____

_____

- What are your recommendations to prevent it from re-occurring/minimize risk of re-occurring:_____

_____

_____

Signature of person reporting the incident _____Date_____

Signature of senior staff member _____Date _____

If further risk assessment is required complete the Risk Assessment and Management Form.

Risk Assessment and Management form completed?
YES NO

OTHER DETAILS:

- Additional comments: _____

_____

_____

- Police involvement (details):_____

_____

_____

- Hospital/Doctor's report attached YES/NO
- Management Committee notified of incident YES/NO Date of notification: _____

Managements recommendations:_____

_____

_____

Details of immediate action to be taken to prevent recurrence _____

_____

_____

Further action recommended:_____

_____

_____

- Person making recommendations:_____Position:_____
- Person accountable/responsible to action recommendations: _____ Position: _____
  Signature: _____ Date: _____
- Anticipated completion date: _____ • Action completed? YES/NO (please circle)
- Reported to the Division of Workplace Health & Safety: YES/NO Date:_____
- Reported to Department of Child Safety: YES/NO Date:_____
- Loss of work time due to injury/harm: YES/NO Return to work: YES/NO

Coordinator/Facilitator comments: _____

_____

_____

_____

Coordinator/Facilitator signature: _____Date:__/__/_____

REVIEW: Date: ___/___/_____

- Hazard/Harm eliminated and/or controlled? YES/NO

Detail: _____

- Are controls minimising the risk? YES/NO

Detail: _____

- Are there any new problems with the risk? YES/NO

Detail: _____

- Further Action required? YES/NO

Detail: _____

Closed date: _____

Name _____ Signature _____ Position: _____