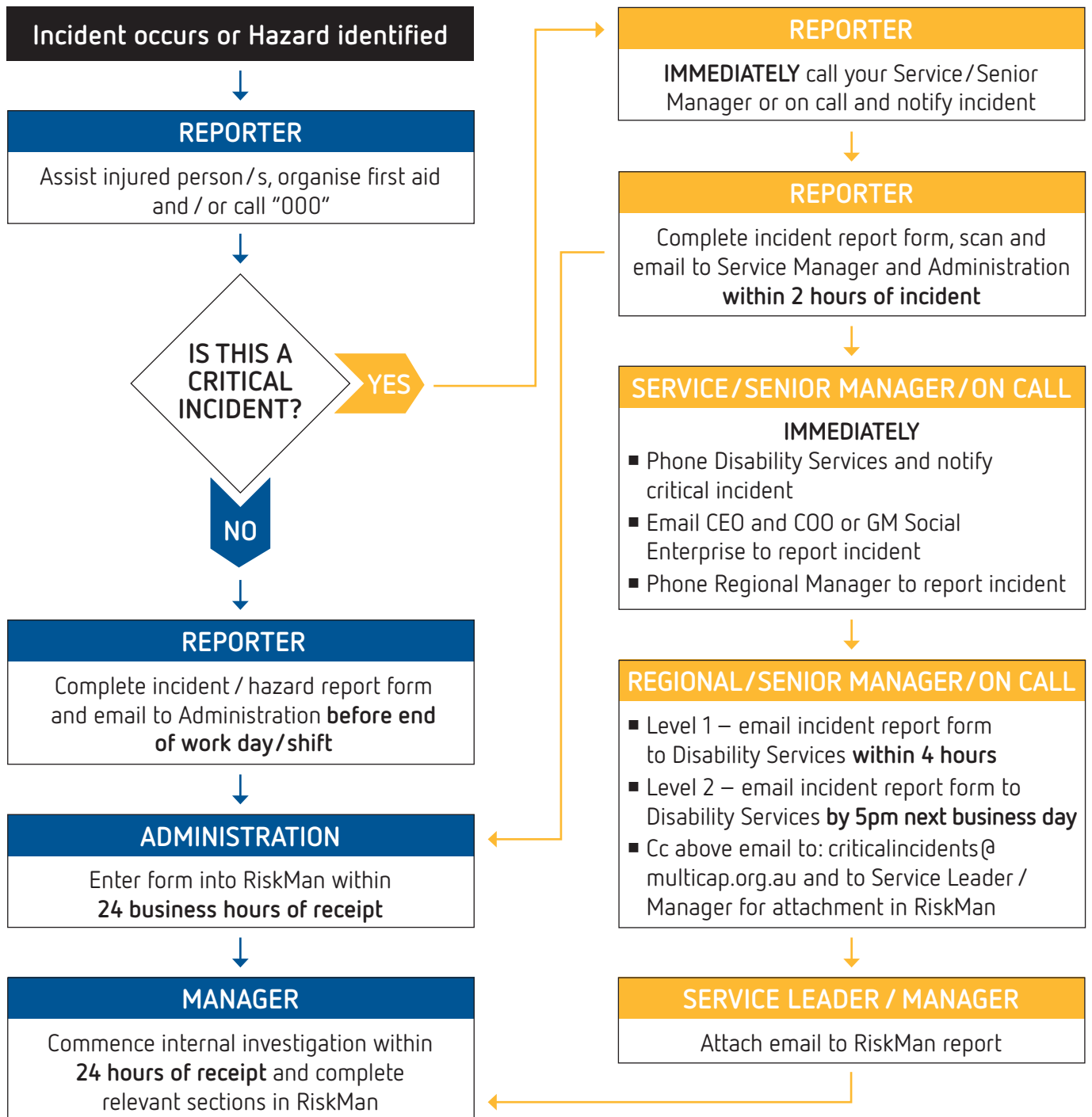


INCIDENT & HAZARD REPORTING

Please follow the below flowchart when reporting all types of incidents and hazards. Critical incident definition is outlined on the next page. The **Reporter** is the Multicap person reporting the incident either for themselves or on behalf of someone else.



Document name	Document owner	Version date	Review date	Page
6.2.2 Incident Report Form - CARS	Manager, WHS & Risk	January, 2017	January 2020	1/6

CRITICAL INCIDENT DEFINITION

Multicap are required to report the below types of critical incidents to the Department of Communities, Child Safety and Disability Services within specified timeframes.

Please follow the flowchart on the previous page when reporting critical incidents.

Level 1	1.1 Death of a person	<ul style="list-style-type: none"> ■ who was a child or young person known to Child Safety in the previous 12 months; ■ with a disability which is defined as a 'death in care' under the Coroners Act 2003; ■ where another client, foster or kinship carer or staff member is allegedly involved in the death; ■ while attending or using department provided or funded services, facilities or activities
	1.2 Life threatening injury to a person	<ul style="list-style-type: none"> ■ where another client, foster or kinship carer or staff member is allegedly involved in the injury; ■ while attending or using departmental provided or funded services, facilities or activities
	1.3 Serious injury to a child that results in hospitalisation	<ul style="list-style-type: none"> ■ when a child or young person, currently known to Child Safety or known to Child Safety in the previous 12 months, is believed to have an injury that meets the definition of a serious physical injury under the Child Protection Act 1999
	1.4 Abduction	<ul style="list-style-type: none"> ■ abduction of a child or young person subject to departmental intervention from their carer/service provider
	1.5 Major security incident	<ul style="list-style-type: none"> ■ a major security incident involving an emergency response to a hostage situation, fire, power failure, bomb threat or discovery of a bomb
	1.6 Alleged rape, sexual assault or serious assault of a child under 14 years	<ul style="list-style-type: none"> ■ with a disability while attending or using departmentally provided or funded services, facilities or activities; ■ of or by a child or young person subject to departmental intervention; ■ while attending or using department provided or funded services, facilities or activities
Level 2	2.1 Serious injury to a person that results in hospitalisation	<ul style="list-style-type: none"> ■ where another client, foster or kinship carer or staff is allegedly involved in the injury; ■ while attending or using department provided or funded services, facilities or activities
	2.2 Alleged rape, sexual assault or serious assault	<ul style="list-style-type: none"> ■ of a person with a disability while attending or using department provided or funded services, facilities or activities; or ■ of or by a child or young person subject to departmental intervention; or ■ of or by a person while attending or using department provided or funded services, facilities or activities; or ■ of a departmental staff member whilst performing their duties
	2.3 Attempted suicide	<ul style="list-style-type: none"> ■ of a person in a departmental facility; or ■ of a person who is a client of accommodation support provided or funded by the department; or ■ of a child or young person in care
	2.4 Missing Child	<ul style="list-style-type: none"> ■ any child whose location is unknown and there are fears for the safety or concern for the welfare of that child
	2.5 Missing person	<ul style="list-style-type: none"> ■ clients who are missing from their place of residence where there are serious concerns for their safety or wellbeing due to their vulnerability
	2.6 Alleged abuse, neglect or exploitation of a person with a disability	<ul style="list-style-type: none"> ■ where another client, staff member or direct carer is allegedly involved; or ■ who is a client of accommodation support provided by the department

Document name	Document owner	Version date	Review date	Page
6.2.2 Incident Report Form - CARS	Manager, WHS & Risk	January 2018	January 2020	2 / 6

INCIDENT / HAZARD REPORT FORM

Please complete the following parts of this form for each type of report	WHS	All Parts except for Parts K, M and N
	Customer Behaviour	All Parts except for Parts M and N
	Medication	All Parts except for Part N
	Motor Vehicle	All Parts except for Parts M and N. Must complete motor vehicle incident checklist
	Property	All Parts except for Parts K to N
	Hazard	Parts A to F, Part J, Parts N and O

PART A Details of person reporting incident/hazard (person completing the form)

Full name:	
Primary Cost Centre:	Payroll Number:

PART B Who was involved and type of incident – tick the appropriate box/s

Incident involved	<input type="checkbox"/> Customer	<input type="checkbox"/> Employee	<input type="checkbox"/> Agency Staff
	<input type="checkbox"/> Contractor	<input type="checkbox"/> Volunteer / Student	<input type="checkbox"/> Family / Representative
	<input type="checkbox"/> Property / Equipment	<input type="checkbox"/> Visitor	<input type="checkbox"/> Member of Public
Type of Injury	<input type="checkbox"/> Incident	<input type="checkbox"/> Hazard	
Incident Category	<input type="checkbox"/> WHS Incident	<input type="checkbox"/> Customer Behaviour Incident	
	<input type="checkbox"/> Medication Incident	<input type="checkbox"/> Motor Vehicle Incident	
	<input type="checkbox"/> Property incident	(ensure vehicle incident checklist completed)	

PART C When did it occur

Date of Incident:	Start time:	End time:
-------------------	-------------	-----------

PART D Associated Service Details (cost centre of where incident occurred or of person affected)

Service:	Cost Centre No.:
----------	------------------

PART E Who was affected

Customer or Employee incidents ONLY	Customer ID:	Payroll Number:
	First name:	Surname:
OR all other types eg agency staff, volunteer, visitor etc.	First name:	Surname:
	Gender: <input type="radio"/> M <input type="radio"/> F <input type="radio"/> Not specified	Contact number:
	Address:	
	Suburb:	P/code:
	Company / Agency (if applicable):	

Document name	Document owner	Version date	Review date	Page
6.2.2 Incident Report Form - CARS	Manager, WHS & Risk	January 2018	January 2020	3/6

PART F Where did it occur – tick the appropriate box

At cost centre premises In the community In transit In home support

Address (if not at cost centre premises):

Suburb: _____ P/code: _____

Location at cost centre premises (eg bathroom, bedroom):

PART G What happened – description of incident (factual not opinion)

Lined area for describing the incident.

PART H Immediate action taken

Lined area for describing immediate actions taken.

PART I Witness

Witness 1: First name, Surname, Contact number, Multicap Employee/Other options.
Witness 2: First name, Surname, Contact number, Multicap Employee/Other options.

PART J

Who was contacted

Verbal notification (number who was contacted and include their details below)	<input type="checkbox"/> Immediate Manager	<input type="checkbox"/> Service Leader	<input type="checkbox"/> Service Manager
	<input type="checkbox"/> Regional Manager	<input type="checkbox"/> On Call	<input type="checkbox"/> Executive Manager
	<input type="checkbox"/> Procurement / Fleet	<input type="checkbox"/> Injury Management Advisor	
	<input type="checkbox"/> Manager WHS & Risk	<input type="checkbox"/> Other	

Person 1 contacted	Name:	Contact made: <input type="radio"/> Yes <input type="radio"/> Attempted	
	Contacted by:	Date:	Time:

Person 2 contacted	Name:	Contact made: <input type="radio"/> Yes <input type="radio"/> Attempted	
	Contacted by:	Date:	Time:

Family / Guardian notified	<input type="radio"/> Yes <input type="radio"/> Attempted <input type="radio"/> No <input type="radio"/> N/A	Date:	Time:
	Name of person:		

GP notified	<input type="radio"/> Yes <input type="radio"/> Attempted <input type="radio"/> No <input type="radio"/> N/A	Date:	Time:
	Name of GP:		

Emergency Service(s) called?	<input type="radio"/> Yes <input type="radio"/> No (if yes, please select type)	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Police	<input type="checkbox"/> Fire
-------------------------------------	---	------------------------------------	---------------------------------	-------------------------------

PART K

Restrictive Practice (Customer behaviour incidents ONLY)

Was a restrictive practice used? Yes No NA (under 18)

PART L

Injury Details

Was an injury sustained? Yes No Name of affected body part(s):

Type of injury (circle affected body parts)		<input type="checkbox"/> Abrasion <input type="checkbox"/> Bite <input type="checkbox"/> Bruising <input type="checkbox"/> Burn <input type="checkbox"/> Crushing <input type="checkbox"/> Electric Shock <input type="checkbox"/> Dislocation <input type="checkbox"/> Foreign Body <input type="checkbox"/> Fracture <input type="checkbox"/> Laceration <input type="checkbox"/> Medical condition <input type="checkbox"/> Needle stick <input type="checkbox"/> Psychosocial <input type="checkbox"/> Sprain / Strain <input type="checkbox"/> Other:
Type of treatment <input type="checkbox"/> No treatment <input type="checkbox"/> First Aid <input type="checkbox"/> Doctor <input type="checkbox"/> Ambulance <input type="checkbox"/> Hospital Admission <input type="checkbox"/> Other medical professional		

Transported to	IF THIS IS A CRITICAL INCIDENT HAVE YOU CALLED YOUR MANAGER / ON CALL? <input type="radio"/> Yes <input type="radio"/> No
-----------------------	--

PART M Medication Incident Details (medication incidents ONLY)

Medications Involved	Brand/ Generic Names:		Dose:
	Brand/ Generic Names:		Dose:
	Brand/ Generic Names:		Dose:
Immediate medical advice received from	<input type="checkbox"/> 13HEALTH	<input type="checkbox"/> Doctor	<input type="checkbox"/> Medical advice
	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Poisons Hotline	<input type="checkbox"/> Not applicable
	Person giving advice:	Date:	Time:
	Advice given:		
	Action taken:		

PART N Hazard Identified

Description (factual not opinion)	
Immediate action taken	

PART O Reporter's Declaration

Signature:		Date:
------------	--	-------

SCAN AND EMAIL COMPLETED FORM (PAGES 3 - 6) TO YOUR ADMINISTRATION TEAM (email address below) FOR ENTRY INTO RISKMAN SYSTEM

SERVICE	AREA	EMAIL ADDRESS
Disability Services	South Queensland	sqincidents@multicap.org.au
	Brisbane	brisincidents@multicap.org.au
	North Coast	ncincidents@multicap.org.au
	North Queensland	cqincidents@multicap.org.au
	CARS	carsincidents@multicap.org.au
Specialist Services	Specialist Services	
Corporate Services	Systems/Marketing	corporateservices@multicap.org.au
	Facilities	
	Finance	
	Human Resources	
	Specialist Services	