

Weeroona Association Inc.  
Reference number:

**CRITICAL Incident Report**  
*to use when injury requires medical attention,  
or incident has serious effect*  
**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 Co-ordinator/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.

PLEASE PRINT CLEARLY - COMPLETE ALL SECTIONS

**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) \_\_\_\_\_

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Critical Incident Report (continued)

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

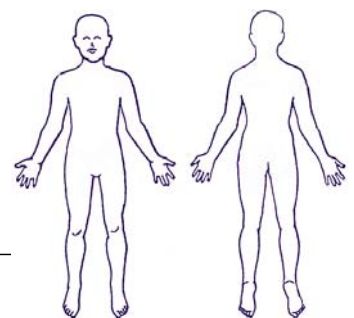
Action taken: (Tick boxes where applicable)

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: (Tick box where applicable)

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Critical Incident Report (continued)

**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 \_\_\_\_\_

Risk 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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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

Co-ordinator/Facilitator comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Co-ordinator/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: \_\_\_\_\_