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|  | | | **Making 3rd Party Report** | | |  | | | | | | **Revised Event Summary** | | |  | | |
| Last Name | | | | | | First Name | | | | Middle Initial | | | DOB | |
| Event Date | | | | Event Time | | Location of Event | | | | | | | | |
| Provider | | | | | | | Service | | | | | Admission Date | | |
| Provider Full Address: | | | | | |  | |  |  | | | Provider Phone | | |
| **1st**  Hand | **3rd** Party | | **EVENT TYPE**  *(Check all that apply)* | | | | | | | | | | | | |
|  |  | | **Events requiring person-to-person voice contact.** | | | | | | | | | | | | |
|  |  | | 1. Allegation of institutional abuse of a Delaware child by (check one)  Program Staff Member or  Foster/Adoptive Parent(s) | | | | | | | | | | | | |
|  |  | | 1. Alleged sexual assault or abuse of or by a Delaware child: Delaware youth is (check one)  Suspect  Victim | | | | | | | | | | | | |
|  |  | | 1. Death of:  Child/Youth Active w/DSCYF or  Child/Youth Active w/DSCYF in the past 12 months; Provider Staff While on Duty or  Foster/Adoptive Parent(s) | | | | | | | | | | | | |
|  |  | | 1. Escape, AWOL or runaway from any (check one)  24-Hour Facility,  Foster/Adoptive Care,  Home Pass or  Non-Residential service program | | | | | | | | | | | | |
|  |  | | 5. Injury, illness or event requiring medical or psychiatric hospital admission beyond emergency room  Admitted **from** any 24 hour placement  Reported to Hotline  Suicide Attempt  3rd Psychiatric Admission in 90 days since discharge from 1st - Current Medical Condition:  Stable  Observation  Critical (Detail Police investigation and officer/department in **Description of Event** section) | | | | | | | | | | | | |
|  |  | | 6. Disturbance that has the potential for harming a child or causing major program disruption such as a natural disaster, bomb threat, hostage taking, etc. | | | | | | | | | | | | |
|  |  | | 7. Abduction of youth - (check one)  Provider/Program Facility  Non-Provider/Program Facility  Other | | | | | | | | | | | | |
|  |  | | **Events for which voice mail messages are acceptable.** | | | | | | | | | | | | |
|  |  | | 8. Arrest of an employee for criminal offenses occurring at the program site  Involving a Delaware child | | | | | | | | | | | | |
|  |  | | 9. Communicable disease of any child or staff in program (e.g., tuberculosis, hepatitis, meningitis, COVID, etc.) | | | | | | | | | | | | |
|  |  | | 10. Community, facility or employee issues which (check one)  Do  Do not directly involve a Delaware child, but could lead to media attention or inquiries (e.g., employee strike, protests about program location) | | | | | | | | | | | | |
|  |  | | 11. Contraband (e.g., weapons, drugs, and other illegal or dangerous items) | | | | | | | | | | | | |
|  |  | | 12. Infection/illness that may have been caused by conditions in the program facility | | | | | | | | | | | | |
|  |  | | 13. Injury or illness that results in ER visit or requires outside medical attention (exclude follow-up appts) | | | | | | | | | | | | |
|  |  | | 14. Medication error/lapse – Responsible Party (check one):  Parent/Guardian  Pharmacy  Staff  Other | | | | | | | | | | | | |
|  |  | | 15. Pattern of self-harm | | | | | | | | | | | | |
|  |  | | 16. Police called for assistance with youth or youth arrested on new delinquency charges Result:  Charges Pressed  No Arrest  Youth transferred to Detention | | | | | | | | | | | | |
|  |  | | 17. Removal of employee from duty as a result of a performance issue that may affect security or child safety (i.e., intoxication or drug use while on duty, etc.) | | | | | | | | | | | | |
|  |  | | 18. Restraint (specify type of restraint)  Mechanical  Chemical  Physical **If Physical indicate type**  (check one)  Prone,  Side,  Standing,  Sitting,  Redirect,  Other | | | | | | | | | | | | |
|  |  | | 19. Injury resulting from physical restraint | | | | | | | | | | | | |
|  |  | | 20. Seclusion | | | | | | | | | | | | |
|  |  | | 21. Suicide attempt | | | | | | | | | | | | |
|  |  | | 22. Provider vehicle accident involving (check one)  Delaware client/child or  family member | | | | | | | | | | | | |
|  |  | | 23. Allegation of institutional abuse lodged against provider’s staff but not involving a Delaware child | | | | | | | | | | | | |
|  |  | | 24. Allegation of abuse/neglect by non-agency person (parent, coach, stranger, etc.) | | | | | | | | | | | | |
|  |  | | 25. Arrest of provider staff for violent felonies against person(s) occurring away from the program site | | | | | | | | | | | | |
|  |  | | 26. Provider staff responsible for youth transportation charged with DUI (check one)  On-duty or  Off-duty | | | | | | | | | | | | |
|  |  | | 27. Physical peer to peer aggression | | | | | | | | | | | | |
|  |  | | 28. Youth involved:  Stabbing  Shooting Youth is:  Victim  Perpetrator | | | | | | | | | | | | |
|  |  | | 29. Special Incident – Includes any other event for which DSCYF has **requested** a report be submitted. | | | | | | | | | | | | |

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| Last Name: |  | First: |  | DOB: |  | Event Date: |  |

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| **Description of Event: Person(s) involved, situation preceding the event, action taken, outcome:** |
|  |
| **Steps taken to evaluate or treat the child and assure child safety:** |
|  |
| **If reporting restraint or Seclusion state time: If staff were debriefed following a restraint complete the following:**  Start Time:       End Time:       Debrief Date/Time:       Facilitator: |
| **What are the implications of the event for change in the child’s treatment or case plan?** |
|  |
| **What are the implications of the event for program or policy change(s)?** |
|  |
| **Did event prompt a staff retraining?** |
| **Yes  No (Explain below)** |
|  |
| **Is this an event that has or will be reported to the program’s licensing agency or accrediting body?** |
| **Yes**  **No (Explain below)** |
|  |
| **If abuse or neglect by staff is alleged, has involved staff been removed from the direct child care setting?** |
| **Yes  No (Explain below)** |
|  |

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| Last Name: |  | First: |  | DOB: |  | Event Date: |  |

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| **CONTACT CATEGORY** | | **NAME** | | | | **CONTACT**  **(Y / N)** | | **Phone/Voice Mail, Email or In Person?**  **Include # If Called** | | **DATE** | **TIME** |
| **Child/Client**  **(for medication error)** | |  | | | |  | |  | |  |  |
| **Parent/Guardian** | |  | | | |  | |  | |  |  |
| **Foster/Adoptive Parent(s)** | |  | | | |  | |  | |  |  |
| **DSCYF Case Manager** | |  | | | |  | |  | |  |  |
| **DSCYF Program Administrator or Contract Manager** | |  | | | |  | |  | |  |  |
| **DE Abuse Hotline** | |  | | | |  | |  | |  |  |
| **DE Office of Child Care Licensing** | |  | | | |  | |  | |  |  |
| **Child Protection Agency**  **(other state)** | |  | | | |  | |  | |  |  |
| **Police** | |  | | | |  | |  | |  |  |
| **Other** | |  | | | |  | |  | |  |  |
| **Other** | |  | | | |  | |  | |  |  |
| **MOST RECENT CHILD/FAMILY CONTACT INFORMATION** | | | | | | | | | | | |
| **For events involving a child(ren) occurring in a non-residential service or program only, give the date and description of the provider’s most recent contact with the child(ren) prior to this Reportable Event.** | | | | | | | | | | | |
| **Date of last contact** | **Time of contact** | | **Person who made the contact** | | | | **How was the contact made?** | | | | |
|  |  | |  | | | |  | | | | |
| **Description of contact:** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **PERSON COMPLETING FORM** | | | | | | | | | | | |
| **I understand that DSCYF has the option of requesting additional and/or periodic written follow-up information regarding corrective actions, administrative investigations, policy or program changes, and/or a written Plan of Safety as a result of this Reportable Event.**    **I affirm and attest that all information provided is complete and accurate to the best of my knowledge.** | | | | | | | | | | | |
| **Printed Name** | | | | **Title** | | | | | | | |
|  | | | |  | | | | | | | |
| **Email Address** *(e-mail address where confirmation of receipt will be sent if submitting electronically)* | | | | | | | | | | | |
| **Signature** *(required if NOT submitting electronically)* | | | | | **Date Report Completed** | | | | **Time Report Completed** | | |
|  | | | | |  | | | |  | | |
| **Indicate contact person for additional information if different from above.** | | | | | | | | | | | |
| Name:       Title:       Phone Number: | | | | | | | | | | | |