|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | [ ]  **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:       |