State of Delaware
The Department of Services For Children, Youth and Their Families

REPORTABLE EVENT SUMMARY

(Completed Reportable Event Summary is due within 72 hours of the time of the event.)

Making 3rd Party Report ☐

Revised Event Summary ☐

Last Name	First Name	Middle Initial	Date of Birth

Date of Event	Time of Event	Location of Event

Provider Name	Type of Service	Admission Date

Provider Address: *Street* *City* *State* *Zip*	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 program staff member or foster/adoptive parent(s)
☐	☐	2. Alleged sexual assault or rape of or by a Delaware child
☐	☐	3. Child/youth death or death of a program member staff while on duty or foster/adoptive parent(s)
☐	☐	4. Escape, AWOL or runaway from any 24-hour facility, foster/adoptive care, or day treatment program
☐	☐	5. Injury, illness or event requiring medical or psychiatric hospital admission beyond emergency room
☐	☐	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
		Events for which voice mail messages are acceptable.
☐		8. Arrest of an employee for criminal offenses occurring at the program site or involving a Delaware child
☐		9. Communicable disease of any child or staff in program (e.g., tuberculosis, hepatitis, meningitis)
☐		10. Community, facility or employee issues which may or may not relate directly to any 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 emergency room visit or requires outside medical attention(exclude follow-up appts.)
☐		14. Medication error/lapse
☐		15. Pattern of self-harm
☐		16. Police called for assistance with youth or youth arrested on new delinquency charges
☐		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) ☐ Physical ☐ Chemical ☐ Mechanical
☐		19. Injury resulting from physical restraint
☐		20. Seclusion
☐	☐	21. Suicide attempt
☐		22. Vehicle accident involving DSCYF client (child or family member) in a provider vehicle
☐		23. Physical peer to peer aggression
		Events to be reported to the DSCYF Contract Manager or Program Administrator only.
☐		24. Allegation of institutional abuse lodged against provider's staff but not involving a Delaware child
☐	☐	25. Allegation of abuse/neglect by persons outside the agency (parent, coach, etc)
☐		26. Arrest of provider staff for violent felonies against person(s) occurring away from the program site
☐		27. Charges of DUI of a provider staff member with responsibility for transporting children

Client Name:_____ **DOB:** _____ **Event Date/Time:** _____

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:
Start Time: End Time:

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)**

Client Name:_____ **DOB:** _____ **Event Date/Time:** _____

NOTIFICATION RECORD				
CONTACT CATEGORY	**NAME**	**CONTACT (Y / N)**	**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 <u>non-residential service or program</u> 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**

<u>Indicate contact person for additional information if different from above.</u>

Name:	Title:	Phone Number: