CRITICAL INCIDENT REPORT

State Form 53808 (R / 8-12)

Indiana Family and Social Service Administration
Division of Mental Health and Addiction
402 West Washington Street W353
Indianapolis, IN 46204
Fax: 317-233-1986

Complete only one setting/program section.

Legal Name of Agency:

Location/Address of Incident *(Number, Street, City, State, ZIP Code)*:

Date of Incident*: (mm/dd/yyyy)*_____ **Time of Incident: _____ am _____ pm**

Residential Setting/Type:
*Report is required within 24 hours of incident. Check only **one** box.*

- ☐ **1**. Transitional Residential **(TRS)**
- ☐ **2.** Semi Independent Living **(SILP)**
- ☐ **3**. Alternative Family for Adults **(AFA)**
- ☐ **4**. Sub Acute Stabilization (**Sub Acute)**
- ☐ **5.** Supervised Group Living **(SGL)**
- ☐ **6.** Agency owned building /structure **(Agency Apt.)**
- ☐ **7.** Other *(Specify)* _____

Residential Incident: 440 IAC 7.5 *Check only **one** box.*

- ☐ **1.** Fire
- ☐ **2.** Injury
- ☐ **3**. Suicide attempt
- ☐ **4.** Emergency room visit
- ☐ **5**. Elopement
- ☐ **6.** Police response
- ☐ **7.** Alleged exploit., abuse, neglect
- ☐ **8.** Suicide
- ☐ **9.** Death
- ☐ **10**. Assault
- ☐ **11**.Other *(Specify)* _____

Outpatient/Community Based Setting/Type:
*Report is required within 72 hours of incident. Check only **one** box.*

- ☐ **1**. Office
- ☐ **2.** Consumer's residence (apartment, house, etc.)
- ☐ **3.** Foster care home
- ☐ **4**. Other (*Specify*) _____

Outpatient/Community Based Incident:
*Check only **one** box.*

- ☐ **1**. Serious Bodily Injury
- ☐ **2**. Suicide attempt
- ☐ **3.** Suicide
- ☐ **4.** Death
- ☐ **5.** Homicide
- ☐ **6**. Other *(Specify)*_____

A.C.T.: 440 IAC 5.2
*Report is required within 48 hours of incident. Check only **one** box.*

- ☐ **1.** Suicide/Suicide attempt
- ☐ **2**. Death of consumer
- ☐ **3**. Documented violation of consumer rights
- ☐ **4.** Other *(Specify)* _____

Hospital /Private Mental Health Institution: 440 IAC 1.5 *Incidents 1-5 require a verbal report within 24 hours of incident and a written report within ten (10) working days. Incidents 6-11 require a written report within ten (10) working days. Check only **one** box.*

- ☐ **1**. Death of consumer not related to seclusion or restraints.
- ☐ **2.** Death while consumer was in restraint or seclusion; within 24 hours after being removed from restraint or seclusion; within one (1) week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to that consumer's death ("reasonable to assume" includes, but is not limited to, death related to: (A) restrictions of movement for prolonged periods of time; (B) chest compression; (C) restriction of breathing; or (D) asphyxiation.).
- ☐ **3.** A serious, unexpected consumer injury resulting in or potentially resulting in loss of function and/or marked deterioration in a consumer's condition.
- ☐ **4**. Chemical poisoning resulting in actual or potential harm to the consumer.
- ☐ **5**. Disruption of Service exceeding four (4) hours caused by internal disasters, external disasters, strikes by health care workers, or unscheduled revocation of vital services.
- ☐ **6.** Consumer missing more than 24 hours
- ☐ **7**. Kidnapping of consumer
- ☐ **8**. Admission of child (14 & under) to an adult unit
- ☐ **9.** Documented violation of rights
- ☐ **10**. Unexplained loss or theft of a controlled substance
- ☐ **11.** Fire/ Explosion with emergency response
- ☐ **12**. Other *(Specify)* _____

Consumer or Alleged Victim Name:	**Sex:** ☐ **Male** ☐ **Female**	**Age:**	☐ 1. Consumer ☐ 2. Staff/Volunteer ☐ 3. Guardian/Caregiver ☐ 4. Other *(Specify)* _____	Multiple Consumers or Alleged Victims ☐ Yes ☐ No
Alleged Perpetrator Name:	**Sex:** ☐ **Male** ☐ **Female**	**Age:**	☐ 1. Consumer ☐ 2. Staff/Volunteer ☐ 3. Guardian/Caregiver ☐ 4. Other *(Specify)* _____	Multiple Alleged Perpetrators ☐ Yes ☐ No

CRITICAL INCIDENT REPORT *(continued)*

State Form 53808 (R / 8-12)

Notification Made to:

Adult Protection Services (APS) **Child Protective Services (CPS)** **If yes, indicate the date notified:** ***(mm/dd/yyyy)***

☐ **Yes** ☐ **No** ☐ **N/A** ☐ **Yes** ☐ **No** ☐ **N/A** **Date:** _____

Consumer Status: *Complete all applicable fields. Each item requires a response. If a field does not apply, enter N/A.*

1. Date last seen for service(s) *(mm/dd/yyyyy)*:_____
2. Pending Legal Charges Related to Incident: ☐ Yes ☐ No Type: _____
3. Prior Precautions *(Specify)*: _____
   Current Precautions *(Specify)*: _____
4. Significant medical history *(primary medical condition)*: _____
5. Services received *(check all that apply)*
   - ☐ Individual therapy
   - ☐ Group therapy
   - ☐ Medication Management
   - ☐ ACT
   - ☐ Detoxification Inpatient /Outpatient
   - ☐ Other *(Specify)*: _____
   - ☐ N/A

Description of Events/Incident:

Incident Resolution and/or Agency Plan of Action:

Is an internal review pending or completed? ☐ **Yes** ☐ **No**

Name of Person Completing Form: _____ **Date:** *(mm/dd/yyyy)* _____

Name of Agency Contact for DMHA Follow-Up: _____ **Telephone Number:** ( )

DMHA Only

Liaison/Staff Initials: _____ **Date Follow-Up Completed:** *(mm/dd/yyyy)* _____

DMHA Only

Date Forwarded to Liaison/Staff: *(mm/dd/yyyy)* _____

Agency Number: _____ **Incident ID Number:** _____ **Date of Report Closure:** *(mm/dd/yyyy)* _____

Report Submitted by Agency Within Time Parameters: ☐ Yes ☐ No

Reviewed by Medical Director: *(initials)* _____ **Date:** *(mm/dd/yyyy)* _____

Definitions and Instructions for State Form 53808, Critical Incident Report

Identifying Information

Legal Name of Agency:	Name under which the agency has been certified
Location Address of Incident:	Address and/or location where the incident occurred
Date of Incident / Time of Incident	Indicate the date the incident took place and the time the incident occurred

Setting and Type of Incident – ***Select only one setting or program section from the following four.***

Residential Setting/Type and Residential Incident	Check one box under Residential Setting to specify the type of residential setting in which the consumer(s) involved in the incident resides. Then specify what type of incident occurred by selecting one box under Residential Incident. If the type of residential setting is not represented on the form, please check the Other box and specify the type of setting. If the type of incident that occurred is not represented please check the Other box and specify the type of incident that occurred. **Residential Incidents Are To Be Reported Within 24 Hours.**
Outpatient/Community Base Settings and Outpatient/Community Base Incident	Check one box under Outpatient/Community Based Setting to specify where the incident occurred involving the consumer of outpatient services. Then specify what type of incident occurred by selecting one box under Outpatient/Community Based Incident. Incidents captured in this category would include serious bodily injuries, deaths, and/or potential media related issues. If the type of setting is not represented please check the Other box and specify the type of setting. If the type of incident that occurred is not represented please check the Other box and specify the type of incident that occurred. **Outpatient and Community Based Incidents Are To Be Reported Within 72 Hours.**
A.C.T.	Check one box to specify the type of incident that occurred with a consumer of ACT services. If the type of incident is not represented please check the Other box and specify the type of incident that occurred. **ACT Incidents Are To Be Reported Within 48 Hours of Occurrence.**
Hospital/Private Mental Health Institution (PIP)	If the incident occurred during the consumer's admission to a Hospital/Private Mental Health Institution, check one box to specify the type of incident. If the type of incident that occurred is not represented please check the Other box and specify the type of incident**. For incidents 1-5, a verbal report is required within 24 hours and a written report within 10 days. For incidents 6-12, a report is required within 10 working days.**

Consumer/Alleged Victim Information ***(Alleged Perpetrator, if applicable)***

Consumer or Alleged Victim Name:	Name of the consumer or name of alleged victim involved in the incident. For data collection purposes, only list one consumer/alleged victim per report. If no consumers or alleged victims were involved leave this section blank (Name, Sex, Age, Category, and Multiple).
Sex:	Check the box that applies to the gender of the person named as the Consumer or Alleged Victim.
Age:	Indicate the age of the person named as the Consumer or Alleged Victim.
Category:	Check only one box to identify the relationship of the Consumer/Alleged Victim. If the category to which the consumer or alleged victim belongs is not represented, please check Other box and specify the relationship.
Multiple Consumers or Alleged Victims	If there are more than one consumer or alleged victim involved in the incident indicate Yes and also complete additional critical incident reports for each individual involved. DMHA will link these reports when received when you indicate Yes. If the incident involved a single consumer or victim mark No.

Definitions and Instructions for State Form 53808, Critical Incident Report *(continued)*

Alleged Perpetrator Name:	Name of the alleged perpetrator involved in the incident. For data collection purposes, only list one perpetrator per report. If there were no perpetrators involved leave this section blank (Name, Sex, Age, Category, and Multiple).
Sex:	Check the box that applies to the gender of the person named as Alleged Perpetrator.
Age:	Indicate the age of the person named as the Alleged Perpetrator.
Category:	Check only one box to identify the relationship of the Consumer/Alleged Victim. If the category to which the consumer or alleged victim belongs is not represented, please check Other box and specify the relationship.
Multiple Alleged Perpetrators	If there are more than one perpetrators involved in the incident indicate Yes and also complete additional critical incident reports for each individual involved. DMHA will link these reports when received when you indicate Yes. If the incident involved a single perpetrator mark No.
Notification Made to:	Indicate if Adult Protection Services or Child Protective Service were notified of the incident. If yes, indicate the date each agency was notified.

Consumer Status: ***Complete all fields. Each item requires a response. If not applicable enter N/A.***

Date Last Seen for Service(s)	Date the consumer was last seen for any mental health or addiction services by the mental health agency noted at the top of page one. Service date may reflect a psychiatrist appointment, case management, group, etc.
Pending Legal Charges & Type	Indicate Yes or No if charges are pending against the consumer as a result of the incident. If Yes, specify what type.
Precautions	Specify any precautions were in place related to the consumer prior to the incident. These may include medical, safety, high risk behavior, etc. Specify any precautionary measures that were put in place as a result of the incident.
Significant Medical History	Note substantial medical conditions for which the consumer is currently being treated that may be impacted by the incident or require increased monitoring. This may include conditions pains, injuries, medical issues currently being tested, etc.
Services Received	Check all services the consumer was receiving from the noted agency at the time of the incident. If the consumer was receiving a service not listed, check the Other box and list the service. If no services, were being received mark N/A.

Description and Resolution of Incident

Description of Event/Incident	Write a detailed and concise description of the incident that took place including any significant events that led up to the incident. Specify names of those involved including staff related to the event/incident.
Incident Resolution and/or Agency Plan of Action	Write a detailed description of steps the agency has taken (or will take) to review or resolve the issues pertaining to the event/incident. This may include efforts to reduce future occurrences of such incidents. Specify if an internal review is pending or has been completed by the agency for this incident by marking Yes or No.
Person Completing Form and Agency Contact for DMHA Follow-Up	Print the name of person who completed the report and note the date completed. Print the name of an agency contact and telephone number DMHA may contact if clarification/further information is needed.
DMHA Only	**The information in this section is to be completed by DMHA staff only.**
DMHA Only	**The information in this section is to be completed by DMHA staff only.**

Procedure: **Complete the Critical Incident Report and fax to DMHA within Stated Timeframe.**
DMHA Secure FAX Number: 317-233-1986
Please remember to fax both pages of the completed form.