**CONFIDENTIAL**

DHSS POLICY MEMORANDUM #46 PRESCRIBES THE STANDARDIZED REPORTING AND INVESTIGATION OF SUSPECTED ABUSE, NEGLECT, MISTREATMENT, FINANCIAL EXPLOITATION AND SIGNIFICANT INJURY OF RESIDENTS/CLIENTS RECEIVING SERVICES IN RESIDENTIAL FACILITIES OPERATED BY OR FOR DHSS.

Information contained in the standardized PM-46/Critical Incident Investigative Report is CONFIDENTIAL AND PRIVILEGED under 24 Del.C. Section 1768 and the governmental executive privilege for investigative files.

Distribution of this Investigative Report, and the information it contains, must be restricted to only those persons who are authorized to see it.

**SELECT INCIDENT TYPE BELOW:**

PM46  Critical Incident

|  |  |  |  |
| --- | --- | --- | --- |
| **ALLEGED INCIDENT** | | **INITIATOR OF REPORT** | |
| Date: |  | Name: |  |
| Time: |  | Title: |  |
| Location: |  | Report Date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **PM46 ALLEGATION OR CRITICAL INCIDENT TYPE:** | | | |
| Mistreatment | Abuse | Neglect | Critical Incident |
| Financial Exploitation | Physical |  |
| Significant Injury | Emotional |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Victim Name: | |  | | | Diagnosis (list below) | |
| Age: | |  | D.O.B.: |  |  | |
| Assigned Gender: | | M  F Other: | | |
| Gender Identity: | |  | | |
| Facility Admission Date: | | |  | |
| Provider & Program Name: | | |  | | | |
| Communication Style: | | |  | | | |
| Race: |  | | Weight: |  | Height: |  |
| Other Identifying Marks: | | |  | | | |

**Accused Person 1**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Accused Name: | |  | | | | |
| Assigned Gender: | M  F Other: | | | | D.O.B.: |  |
| Gender Identity: |  | | | | License/ Certificate #: |  |
| Address: |  | | | | Occupation: |  |
| Email: |  | | | | Phone #: |  |
| If accused information requested above is NOT known please provide: | | | | | | |
| Race: |  | | Weight: |  | Height: |  |
| Other Identifying Marks: | | |  | | | |

**Accused Person 2**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Accused Name: | |  | | | | |
| Assigned Gender: | M  F Other: | | | | D.O.B.: |  |
| Gender Identity: |  | | | | License/ Certificate #: |  |
| Address: |  | | | | Occupation: |  |
| Email: |  | | | | Phone #: |  |
| If accused information requested above is NOT known please provide: | | | | | | |
| Race: |  | | Weight: |  | Height: |  |
| Other Identifying Marks: | | |  | | | |

**Accused Person 3**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Accused Name: | |  | | | | |
| Assigned Gender: | M  F Other: | | | | D.O.B.: |  |
| Gender Identity: |  | | | | License/ Certificate #: |  |
| Address: |  | | | | Occupation: |  |
| Email: |  | | | | Phone #: |  |
| If accused information requested above is NOT known please provide: | | | | | | |
| Race: |  | | Weight: |  | Height: |  |
| Other Identifying Marks: | | |  | | | |

|  |  |
| --- | --- |
| **ALLEGATION/INCIDENT SUMMARY-**  **DESCRIPTION OF ORIGINAL REPORT RECEIVED BY INVESTIGATOR:** | |
| Nature of allegation/incident (Who, What, When, Where, How): |  |
| Source of allegation/incident (Name & Title): |  |
| Date and time of allegation/incident: Reason for delay between time of incident and time reported, if any: |  |

**INVESTIGATORY PROCESS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Investigation Started Date: |  | Time: |  | AM | PM |
| Completion Date: |  | | | | |
| Investigator Name: |  | | | | |

**SUMMARY OF INVESTIGATION**

1. **Manner in which the investigator became involved in the incident:**

|  |  |
| --- | --- |
| Notified by: |  |
| When: |  |
| How: |  |

|  |  |
| --- | --- |
| Date and time the investigation began: |  |
| Date and time the investigation ended: |  |
| If investigation did not start immediately, explain: |  |

1. **Securing the scene of the alleged incident:**

|  |  |
| --- | --- |
| Individual who secured scene (Name & Title): |  |
| Date and time scene was secured: |  |
| Manner in which scene was secured: |  |
| If scene was not secured, explain: |  |

1. **Interviews conducted during the investigation:**

(Note Reasons for Delays)

|  |  |  |  |
| --- | --- | --- | --- |
| Name & Title of Interviewee | Date of Interview | Time of Interview | Interviewee's Role  (i.e. Accuser Subject, Witness, etc.) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Interviews which could not be conducted:**

|  |  |  |
| --- | --- | --- |
| Name & Title of Individual | Individual's role (i.e Accuser, Subject, Witness, etc.) | Reason interview not conducted |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Mental and physical status of client prior to incident:**

|  |
| --- |
| Click or tap here to enter text. |

1. **Any change in client’s mental and physical status since this incident took place:**

|  |  |  |
| --- | --- | --- |
| Yes | | No |
| If yes, explain: |  | |

|  |  |
| --- | --- |
| Yes | No |

1. **Report to Family/ Guardian:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Family/ Guardian Notified | Relationship | Date | Time |
|  |  |  |  |

1. **If Family/ Guardian not notified, give reason:**

|  |
| --- |
| Click or tap here to enter text. |

1. **Was medical attention required for client?**

|  |  |
| --- | --- |
| Body check completed by nurse? | Yes  No |
| Physician evaluating client: |  |
| Describe treatment: |  |

1. **Summary of testimonial evidence:**

(Summarize the KEY points of interviews you conducted)

|  |
| --- |
| Click or tap here to enter text. |

1. **Summary of documentary evidence:**

(Summarize the SIGNIFICANCE of applicable patient records, medical reports, employee records)

Click or tap here to enter text.

|  |
| --- |
| Click or tap here to enter text. |

1. **Summary of physical evidence and demonstrative evidence:**

(Summarize the SIGNIFICANCE of any objects, arrangement of objects, substances, or conditions of a person’s body. Also, review the significance of applicable photographs, diagrams, etc.)

|  |
| --- |
| Click or tap here to enter text. |

1. **Investigation Summary:**

|  |
| --- |
| Click or tap here to enter text. |

**NOTIFICATIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Name | Date | Time | Reported By |
| Facility Director |  |  |  |  |
| PM 46 Manager |  |  |  |  |
| Doctor |  |  |  |  |
| Division Director |  |  |  |  |
| DHSS Secretary |  |  |  |  |
| DHCQ Investigative Supervisor |  |  |  |  |
| Medicaid Fraud Unit |  |  |  |  |
| CLASI |  |  |  |  |
| Other |  |  |  |  |

**SIGNATURES**

***Investigator***

Unsubstantiated:   The Investigative Section did not conclude, by a preponderance of the evidence that the alleged incident or violation had occurred.

Substantiated:  The Investigative Section did conclude by a preponderance of the evidence, that the alleged incident or violation had occurred, however the alleged incident or violation was the result of systemic issue and could not be associated with any individual culpability.

Verified: The Investigative Section did conclude, by a preponderance of the evidence, that the alleged incident or violation had occurred, that an accused person is culpable and could potentially be placed on the Adult Abuse Registry.

Click or tap here to enter text.Click or tap here to enter text.

Investigator Signature Date

***Facility/ Program Director***

*Reviewed and approved*  YES  NO

Unsubstantiated:   The Investigative Section did not conclude, by a preponderance of the evidence that the alleged incident or violation had occurred.

Substantiated:  The Investigative Section did conclude by a preponderance of the evidence, that the alleged incident or violation had occurred, however the alleged incident or violation was the result of systemic issue and could not be associated with any individual culpability.

Verified: The Investigative Section did conclude, by a preponderance of the evidence, that the alleged incident or violation had occurred, that an accused person is culpable and could potentially be placed on the Adult Abuse Registry.

Click or tap here to enter text.Click or tap here to enter text.

Facility/ Program Director Signature Date

***Division Director***

*Reviewed and approved*  YES NO

*If NO, please explain:* Click or tap here to enter text.

*Referred to the Adult Abuse Registry*  YES  NO

Click or tap here to enter text.Click or tap here to enter text.

Division Director Signature Date