South Carolina DAODAS

INCIDENT REPORTING FORM

SOUTH CAROLINA DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES

This section is to be completed by SC DAODAS
Log Number:

FACILITY INFORMATION

Date/Time of Telephonic Report (if completed):

Date/Time of Electronic Report:

County Authority: Select Agency

Contact Name:

Telephone: | **E-mail Address:**

KEY PERSON INFORMATION

Please use this section to describe the individuals involved. This may include but is not limited to staff, visitors, clients, client family members. If a client is involved, please provide CareLogic identification number, the client's age, and the client's gender.

Number of clients directly affected by incident:

Client Identification Number:	**Age:**	**Gender:** ☐Male ☐Female Other
Client Identification Number:	**Age:**	**Gender:** ☐Male ☐Female Other
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Client Identification Number:	**Age:**	**Gender:** ☐Male ☐Female Other

Number of staff directly affected by the incident:

Number of visitors directly affected by the incident:

Witness Name(s):

INCIDENT INFORMATION

Type of Incident:

- ☐ Homicide involving clients, staff or visitors.
- ☐ Death of active client (including clients discharged within the past year) or staff member.
- ☐ Any elopement or unauthorized absence from a residential treatment facility.
- ☐ Major injuries to clients or visitors sustained on-site.
- ☐ Arrest, criminal violation, or suspected abuse, neglect, or exploitation that allegedly occurs on agency premises or involving agency staff.
- ☐ Any disaster or event (e.g., fire, tornado) that substantially interferes with service delivery.
- ☐ Any other major occurrence or tragic event that the director of the county authority feels should be reported.
- ☐ Any sudden change in the local provider's ability to provide services.
- ☐ Suspected overdose and/or naloxone administration

Date/Time the incident occurred:

Incident Location: ☐ On-site ☐ Off-site

In what county did the incident occur? Select County

Give a brief description of the incident including the location and naloxone distribution/administration, if appropriate.

Please select all suspected causes of death in the event of a fatality. Utilize the free response space to note other causes not listed.

Cause of death:

- ☐ Intentional self-harm
- ☐ Assault
- ☐ Cardiac Event
- ☐ Transport/Vehicle Accidents
- ☐ Other external causes of accidental injury
- ☐ Infectious disease
- ☐ Overdose/Poisoning (accidental)
- ☐ Overdose/Poisoning (intentional)
- ☐ Overdose/Poisoning (unknown)
- ☐ Unknown

Other cause of death/Additional information:

ADDITIONAL AGENCY INVOLVEMENT

Please select all agencies/law enforcement groups that are involved:

- ☐ Department of Social Services
- ☐ Department of Justice
- ☐ Probation, Parole and Pardon Services
- ☐ Department of Juvenile Justice
- ☐ Department of Mental Health
- ☐ Local Law Enforcement

Please include additional agencies not included in the selection above:

Please describe the response by the involved agencies:

POST INCIDENT FOLLOW-UP

Was the cause investigated and/or identified? ☐ Yes ☐ No

Please describe the response of the County Authority. This may include any action plan, follow-up, debriefing, reviews to be completed, steps to prevent future occurrence etc.

Has there been media involvement/interest? ☐ Yes ☐ No

Please describe any media involvement/interest:

☐ **By checking this box, I hereby attest that all information is accurate to the best of my knowledge.**

THIS SECTION IS TO BE COMPLETED BY DAODAS

DAODAS comments: **Review** ☐