

Critical Incident Notification

Select one: ☐ Initial Notification ☐ Update

SECTION I. CRITICAL INCIDENT INFORMATION AND TYPE		
COMPLETE SECTIONS I AND II FOR INITIAL NOTIFICATION		
Select any which apply to this critical incident as defined in PPM 0510:		
<input type="checkbox"/>	Child death Provide to FACTS Data staff the following:	
	Child name:	Date of death:
<input type="checkbox"/>	Child near death	
<input type="checkbox"/>	Child in the custody of the Secretary who attempted suicide	
<input type="checkbox"/>	Child in the custody of the Secretary with severe injuries	
<input type="checkbox"/>	Foster parent with criminal proceedings related to abuse or neglect	
<input type="checkbox"/>	Any child in the custody of the Secretary who spent the night in a Child Welfare Case Management Provider's (CWCMP) office (Complete Sections I & II only)	
<input type="checkbox"/>	Media-incident which has drawn public media attention or become legislative concern	

FACTS CASE HEAD: (last, first)		FACTS CASE #:	
Child(ren) Name(s): (last, first)		DOB(s):	
Is the child(ren) in the custody of the Secretary?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Date of Custody:		Date of out of home placement:	
DCF Region:		County:	
Local DCF Office:		Assigned DCF Staff:	
Provider:		Assigned Provider Staff:	
Date of last PPS/Provider in person contact with child:			
Agency name who completed last contact:			
Completed by:		Date:	

SECTION I.A. At the time of the incident, did PPS have an open case? (Completed by DCF only)		
<input type="checkbox"/> No	If no, skip to Section II.	
<input type="checkbox"/> Yes	If yes, select the type of open case (Select all that apply) and provide the date of referral:	
<input type="checkbox"/>	Investigation and Assessment	Date of Referral:
<input type="checkbox"/>	Family First Prevention Services	Date of Referral:
<input type="checkbox"/>	Family Service	Date of Referral:
<input type="checkbox"/>	Family Preservation	Date of Referral:
<input type="checkbox"/>	Reintegration/Foster Care/Adoption	Date of Referral:

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Briefly describe the family's situation which led to the current open case:	
CARE Referral(s) completed (Completed by DCF only):	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please provide details including date(s) and recommendation(s):	

SECTION II. CRITICAL INCIDENT DESCRIPTION	
Date of incident:	Date of knowledge of incident:
Was a report made to the Kansas Protection Report Center reference this critical incident? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, provide Intake Event #:	
Describe the critical incident (Include the condition of the child):	
Describe immediate action(s) taken following the critical incident:	
How was safety ensured following the critical incident?	

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Describe the current status of the case (Including status of law enforcement involvement and legal status of child including, but not limited to, legal custodian of child(ren), adjudications, status of court proceedings):
Other:

SECTION III. CASE INFORMATION
List all applicable children whose safety is a concern or select N/A.
<input type="checkbox"/> N/A (Select when incident involved a child(ren) in the custody of the Secretary spending the night in a CWCMP office)

Child Name:		DOB:	
Current Placement:			
Relationship to identified child:	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> Half-sibling <input type="checkbox"/> Not Related <input type="checkbox"/> Relative (Specify):		

Child Name:		DOB:	
Current Placement:			
Relationship to identified child:	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> Half-sibling <input type="checkbox"/> Not Related <input type="checkbox"/> Relative (Specify):		

Child Name:		DOB:	
Current Placement:			
Relationship to identified child:	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> Half-sibling <input type="checkbox"/> Not Related <input type="checkbox"/> Relative (Specify):		

Child Name:		DOB:	
Current Placement:			
Relationship to identified child:	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> Half-sibling <input type="checkbox"/> Not Related <input type="checkbox"/> Relative (Specify):		

Child Name:		DOB:	
Current Placement:			
Relationship to identified child:	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> Half-sibling <input type="checkbox"/> Not Related <input type="checkbox"/> Relative (Specify):		

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Name(s) of all others involved: (Caregivers, others involved in the critical incident, other individuals living in the home, non-residential parent, etc.)	Other individual's relationship to identified child:

PPS Administrator Review:	
The information described in this incident meets the definition of a critical incident. <input type="checkbox"/> No <input type="checkbox"/> Yes	
PPS Administrator Signature:	Date:

SECTION IV. UPDATES
Date:
Update: