

SERIOUS INJURY REPORT

CONFIDENTIAL



- Information is collected and reported to the Manitoba government under the authority of The Serious Injury Reporting Regulation.
- Serious injury reports will be shared with the Manitoba Advocate for Children and Youth (MACY) under the authority of section 21 of The Advocate for Children and Youth Act for the purposes of identifying and analysing recurring circumstances or trends, improving the effectiveness and responsiveness of reviewable services, or informing improvements to public policies relating to designated services.

This form is to be used to report serious injuries of children (age 0-17) who was receiving, or whose family was receiving, one of the following reviewable services at the time of the injury or in the year before the injury:

- publicly funded mental health services for children and/or
- publicly funded addictions services for children.

Serious injuries are those that are:

- (a) life-threatening;
- (b) require admission to a hospital or other health care facility and are reasonably expected to cause serious or long-term physical or psychological impairment; or
- (c) are the result of a sexual assault that causes serious physical harm or is reasonably expected to cause long-term psychological impairment.

Complete this serious injury report form promptly after becoming aware of a serious injury to a child in the circumstances noted above. Include as much of the information requested as is known at the time of making the report.

A person, organization or entity that provides a reviewable service funded by a health authority or government department must submit completed forms to the appropriate health authority or to the relevant, department, which funded the services, as instructed.

REPORT COMPLETED BY	
Organization:	
Full name of staff:	Phone:
Position of staff	Email:
Date report completed:	

CHILD INFORMATION	
Full name:	
AKA (if applicable):	Date of birth (DD/MM/YY):
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/other <input type="checkbox"/>	
Does the child identify as Indigenous?: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
If yes, identify: First Nations <input type="checkbox"/> Métis <input type="checkbox"/> Inuit <input type="checkbox"/>	
If First Nations: Treaty Status <input type="checkbox"/> Non-Status <input type="checkbox"/>	
Address:	
City/town/community:	Postal code:

REVIEWABLE SERVICES
Which reviewable service(s) was the child (and/or their family) receiving at the time of the serious injury or in the year prior to the serious injury (select all that apply)?
Mental Health Services for children <input type="checkbox"/> Addictions Services for children <input type="checkbox"/>

INJURY DETAILS	
Date of serious injury:	Time of serious injury (24-hour clock):
City/town/community where injury occurred:	Place serious injury occurred (e.g., home, school):
How did the reporting service provider become aware of the serious injury? Include when and by whom the service provider was informed of the serious injury.	
Please provide a description of the serious injury, including: how the injury occurred, how the injury was discovered, what occurred in follow-up to the injury, whether the injury is the result of abuse or suspicious circumstances, and any other details that may be considered relevant.	
What is the expected outcome?	
Is law enforcement investigating? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
If yes, provide:	
the name of the responsible law enforcement agency:	
the incident number:	
have criminal charges been laid? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	

PRIMARY CAREGIVER(S) INFORMATION	
Full name:	
Address:	
City/town/community:	Postal code:
Phone:	Alternate phone (if applicable):
Relationship to Child:	
Full name:	
Address:	
City/town/community:	Postal code:
Phone:	Alternate phone (if applicable):
Relationship to Child::	

FOR GOVERNMENT DEPARTMENT OR HEALTH AUTHORITY USE ONLY	
REPORT REVIEWED BY	
Name of department or health authority:	
Full name of staff:	Phone:
Position of staff:	Email:
Date report received:	Date report reviewed:

July 1, 2023