

# Law Enforcement (Charged, Incarcerated, Arrested) Form

Individual's Name:

Date Form Filled Out:

Incident Date:

MUI Number:

Name of Person filling out Form:

Title:

Agency:

Contact Information:

## HISTORY / ANTECEDENTS:

Please list what led to the individual being charged, incarcerated, or arrested. Provide a timeline and whether this individual has a history of this behavior. Provide details of prevention measures from prior incidents.

## CRIMINAL CASE INFORMATION:

Law Enforcement Entity:

Outcome of Criminal Case:

Contact Information for Arresting Officer:

Incarceration Location

General Population?

Probation

Parole

## SUPERVISION LEVEL:

Did the individual have a supervision requirement? If so, describe the supervision level. Was the supervision level met? Did the staff know about the supervision required? Was the staff trained on the implementation of the supervision requirements?

## INJURIES / MEDICAL NEEDS:

Were there any injuries to the individual or anyone else involved in the Law Enforcement MUI? Did the individual receive timely medical attention? Are the individual's medical needs known – especially if the individual is incarcerated?

**DESCRIPTION:**

Describe in detail the incident.

**CAUSE AND CONTRIBUTING FACTORS:**

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Supervision not met</li><li><input type="checkbox"/> Staff ratio was not appropriate</li><li><input type="checkbox"/> Diet not followed</li><li><input type="checkbox"/> Asked to complete task</li><li><input type="checkbox"/> Change in Routine</li><li><input type="checkbox"/> Excessive Noise</li><li><input type="checkbox"/> 1:1 Attention unavailable</li><li><input type="checkbox"/> Peer aggression</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> Outing Cancelled</li><li><input type="checkbox"/> Control Issues-staff/family/peers</li><li><input type="checkbox"/> Medication Change</li><li><input type="checkbox"/> Illness</li><li><input type="checkbox"/> Possible Hallucination</li><li><input type="checkbox"/> Loss of Important Relationship</li><li><input type="checkbox"/> ISP/BSP Not followed</li></ul> |
|--|--|

Other:

**PREVENTION MEASURES:**

- |   |  |
|---|--|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Physical/Social Environmental Change</li><li><input type="checkbox"/> Agency Policy/System Change</li><li><input type="checkbox"/> Staff Training</li><li><input type="checkbox"/> Counseling</li><li><input type="checkbox"/> Team Meeting to address ISP Changes</li><li><input type="checkbox"/> Appointment with Medical Care Provider</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> Medication Changes</li><li><input type="checkbox"/> Follow up Appointment Scheduled</li><li><input type="checkbox"/> PT/OT/Speech Referral made to address communication or mobility concern</li><li><input type="checkbox"/> Diet Change Ordered</li><li><input type="checkbox"/> Home Health Care</li></ul> |
|---|--|

Other:

**INVESTIGATIVE AGENT REVIEW:**

Comments & Questions:

REVIEW COMPLETED DATE:

IA NAME: