



He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Psychological Services & Psychiatric Services Report Guidelines

Report guidelines for quality standards

Effective from May 2026

This is a living document and will be updated as required



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Purpose

These report guidelines provide information to help suppliers and named service providers (both assessment and treatment) create high quality, clinically appropriate and fit for purpose reports under the Psychological Services and Psychiatric Services contracts. These guidelines should be used in conjunction with the guidance in each report template. The guidelines provide:

- additional information and clarification to support completion of a report template;
- general quality criteria that apply to all reports; and
- quality criteria that apply to each report

To complete a report:

- Follow the instructions and guidance in each report template;
- use these guidelines and follow any additional information and guidance
- ensure the report meets all the general quality criteria, and
- meets the quality criteria in these guidelines that is specific to the report being completed.

All report templates are word documents that can be downloaded from the [Resources](#) section of our website.

Once completed, reports must be returned to the ACC recovery team member within the timeframes specified for each report in the Service Schedule for the Psychological Services and Psychiatric Services contracts.



General Report Quality Criteria

All reports must meet the criteria below:

- The report is completed on the correct report template. ACC will not accept reports that are handwritten or submitted on an incorrect report template.
- All information is specific to the correct kiritaki (client).
- Information has not been copied or duplicated from reports for other kiritaki. If verbatim text from other reports for the same kiritaki is required, this text must be in quotation marks and used only when needed.
- The report must be written succinctly and in plain language for a non-clinical audience.
- All relevant sections of the report template must be completed.
- Kiritaki must be informed of the information contained in the report and be offered an opportunity to provide feedback or participate in a feedback session before the completed report is sent to us.
- The last face-to-face meeting date with kiritaki has been noted.
- The provider declaration has been completed.
 - Note that when the declaration asks you to confirm that you have informed the kiritaki that the information collected for this report will be sent to ACC to support cover and/ or treatment and rehabilitation needs, this means that you are confirming that the kiritaki has been fully informed as to the purpose of the report, who the information will be shared with, and that the kiritaki understands this.
- Reasonable steps must be taken to ensure all information gathered and disclosed in reports is accurate, up to date, relevant and does not mislead the reader.

Reports that do not meet our quality standards will be returned to the supplier for resubmission. ACC will provide information to the supplier on the aspects of the report that need to be addressed or require more clarity. The supplier is expected to address the issues raised with the named service providers in a timely manner and resubmit the report to ACC once the issues have been addressed.



Psychological Services Contract

ACC266 Psychological Services Action Plan

This report should be completed during the Early Intervention and Planning stage by the named treatment service provider in collaboration with the kiritaki.

Part B: Event and injury details

- **Section 2: Event and injury details**

The following aspects must be included in the report:

- details of the covered physical and mental injuries
- Information about other active claims which may need to be considered as part of rehabilitation planning and support.

- **Section 3: Kiritaki current situation, background and treatment needs**

- specific reference, with examples, of the symptoms and functional impact of these.
- If risks are identified, a risk assessment should identify any situations (eg at work, in public, at home), where kiritaki may be more likely to present issues of risk. You should include information on how all identified risk issues will be monitored and mitigated.

- **Section 4: Treatment planning and functional objectives**

This section requires clear identification of treatment needs that are specific to the individual symptoms and functional difficulties of kiritaki. This includes:

- The question(s) outlined in ACC's referral for Psychological Services outlined
- A goal clearly related to the covered injury(s) and how this goal will improve functioning
- goals are outline as SMART (specific, measurable, achievable, relevant and time-bound). See appendix for more information.
- The description of what interventions are proposed
- Pre-intervention measures are included and expected outcomes are described. For example, currently the kiritaki is doing X, and it is anticipated in six sessions they will be doing Y. This could be an indication of frequency of symptom/behaviour, or psychometric rating measures, or descriptions of behaviours.
- The goals seem possible to be achieved within the approved block of treatment sessions



- If a Mental Injury Assessment is requested, the name, Provider ID and supplier of the proposed assessor are noted in the report.

ACC267 Psychological Services Progress Report and ACC268 Psychological Service Completion Report

- Information has been clearly and succinctly provided and includes any changes to the presentation and life situation of kiritaki. Any changes to vulnerability, risk, treatment barriers, and/or non-ACC provided treatment is noted and explained. Any actions taken on newly identified risks have been explained.
- For each recovery goal, a summary of progress to date has been provided, with reference to the measures in the Psychological Services action plan, including an explanation of any barriers to progress and the currently expected next steps.
- If any new goals are added they meet the criteria as per the goal expectations in the Psychological Services action plan.
- Requests for further sessions correspond to the maximum amounts available depending on the kiritaki cover status.
- If further sessions are requested and the client does not have MICPI/WRMI cover, a reason why a Mental Injury Assessment or another ACC Assessment is not indicated has been provided.
- If further sessions are requested, a clear injury-related rationale for any further input is provided. If a Mental Injury Assessment is requested, the name, Provider ID and supplier of the proposed assessor are noted in the report.



Psychiatric Services Contract

ACC2061 Psychiatric Services Progress Report/Completion Report

- Information has been clearly and succinctly provided and includes any changes to the presentation and life situation of kiritaki . Any changes to vulnerability, risk, treatment barriers, and/or non-ACC health conditions and treatment are noted and explained. Any actions taken on newly identified risks have been explained.
- For each recovery goal, a summary of progress to date has been provided, with reference to the measures in the initial treatment plan, including an explanation of any barriers or other primary treatment needs that impede progress and the currently expected next steps.
- If any new goals are added; each goal is clearly related to the covered mental injury/physical injury and will improve functioning of the kiritaki, and each goal is a SMART (a structured framework for setting treatment objectives that are Specific, Measurable, Achievable, Relevant, and Time-bound) goal (please see attached framework below).
- Requests for further sessions correspond to the maximum contractual amounts available
- If further sessions are requested, a clear injury-related rationale for any further input is provided.



SMART Goals

SMART Goal	What needs to be considered
Specific	SMART goals need to be specific goals : <ul style="list-style-type: none">• What would kiritaki be able to do differently or better if their flashbacks reduced?• What would improve in their day-to-day functioning or interactions if their altered mood and altered cognitions were improved?• What are the specific goals regarding the desirable and functional outcomes?
Measurable	SMART goals should include measurable goals . <ul style="list-style-type: none">• How can you measure change?• How often will you measure the effects? <i>For example, frequency counts of pleasant activities/ walks/ relaxation exercises, practiced/ observing without judgement, psychometric measures, response/ delay times and duration of time spent exercising.</i>
Action-Oriented	Action-oriented goals can be behavioural (pleasant activity), communicative (sharing an emotional need) or cognitive (mindfully observe without judgement and balancing negative thinking). <ul style="list-style-type: none">• What specific actions/ strategies/ techniques will be done to achieve the goal?
Realistic	A realistic goal is essential for achieving progress enhancing engagement and promoting the possibility of further positive outcomes. <ul style="list-style-type: none">• Is the developed goal realistic for this kiritaki? Consider pace, intensity, duration, resources, and the personal context of kiritaki.• Are there barriers that need addressing first?• What might get in the way of a positive outcome?
Timebound	SMART goals need to be time-bound : <ul style="list-style-type: none">• What timeframe seems realistic and achievable for kiritaki to complete the goal or succeed in coping differently/ better?• Will the goal timeframe foster hope or overwhelm? If the latter, reconsider if the goal is realistic and review any barriers that might yet to be disclosed.• Will the goal be worked on concurrently or sequentially to other recovery goals?



ACC4247 Mental Injury Assessment

Section 2. Consultation Information and sources of information

- a. Outline date(s) and duration of consultations including any feedback sessions.
- b. List and number all sources of information used in undertaking the assessment. These should identify the nature of the information (eg document, interview, etc), the origin or author of the information, and the date of the information. Please note if undated. Information that is known to be available, yet was not available to the assessor, should also be acknowledged here.
- c. Confidentiality and competence: please record the kiritaki consent and competence to participate in the assessment, including their ability to understand the purpose of the assessment, and their capacity to provide valid information.

Section 3. Event and injury detail

Outline a description of the event and associated injuries including covered and non-covered injuries. Outline any other relevant claims that are active and may have a bearing on this claim.

Fully describe the accident or event resulting in this claim as presented to you by the kiritaki. This section may include a summary of historical issues, which serves to set the platform for the assessment. This must include an account of the physical injury, work-related incident or event that resulted in the claim, so that the context can be set for the current assessment.

Section 4. Current kiritaki information

- a. Identify demographic and general social circumstances of the kiritaki at the time of assessment including housing, relationship status, employment/study. If other people accompanied the kiritaki, note their name and relationship to the kiritaki. Some authors may include this information in some other section of their report.
- b. Outline general presentation and presenting issues
- c. It's important to identify complaints made by the kiritaki and to give a comprehensive account of any clinical signs or symptoms described.



Section 5. Background information

If any mental health disorders are identified, then a more comprehensive account of the personal history is appropriate.

- a. Family/whānau and personal history: a summary of family relationships and functioning is useful. Record any family history of mental health, alcohol or drug problems.
 - b. Education or employment history: record any relevant issues the kiritaki has in their workplace that could influence their presentation.
 - c. Relevant medical history: include any past medical history if it is relevant to this referral. Include your professional opinion if there is any information in the medical history (including medical notes) that suggest any relevant psychological themes.
 - d. Alcohol and drug history: please record a full alcohol and drug history if relevant. Include the nature, frequency, pattern of use or behaviour over time and amounts of any alcohol and substances that might be used. Record whether the kiritaki describes any symptoms or signs of abuse or dependence, what problems their alcohol or drug use may have caused them, whether they have accessed previous treatment or rehabilitation programmes, and whether these were successful. It's particularly important to record the current pattern of use, and what difficulties this might be causing the kiritaki in areas that might be important for occupational rehabilitation. If a diagnosis of any alcohol or drug related problem is made, please include the raw data to support your diagnosis.
 - e. Forensic history: this includes the kiritaki contact with the legal system (eg arrests, charges, incarceration). This contact can reflect or contribute to mental health issues, and helps distinguish between symptoms related to mental distress, situational stress, and behavioural concerns. This information also helps inform your risk assessment and aids in treatment planning.
 - f. Summarise mental health history: summarise any past psychological and/or psychiatric history delivered within community, private, ACC or any other services. Give a detailed account of when treatment was administered, what the treatment was, its effects, and any problems that were identified.
- List all current medications and dosages and any relevant past medication.



- Summarise the status of their mental health prior to the injury and any psychosocial stressors at the time of injury.

Section 6. Strengths and vulnerabilities

- a. Outline strengths: this can include factors such as cultural or spiritual identity, significant relationships, family/whānau connectedness, employment, etc.
- b. Outline vulnerability: consider aspects of vulnerability that affect the kiritaki ability or capacity to engage in or participate effectively in treatment. Vulnerabilities may include disability, socioeconomic factors, age, housing arrangements, social supports, etc.
- c. List the agencies involved, eg Community Mental Health and Addiction Services, Concussion Services.

Section 7. Evaluation of symptom validity and/or psychometric assessment

- Evaluation of symptom validity can include administration of structured psychometric tools, behavioural observation/clinical judgement (eg noting inconsistencies between reported symptoms and actual functioning, different forms of symptom enquiry, checking for false positives), and data triangulation (reviewing different data sources to check for consistency, obtaining third-party reports and collateral information). You should inform kiritaki that the assessment includes checks for accuracy and consistency. Your findings should guide further evaluation.
- The decision to use psychometric measures is informed by the needs of the assessment. These may be requested by ACC or you may choose to use tools which you are qualified to administer and interpret where you think these are necessary and/or helpful. You should not rely wholly on the results of assessment tools for your conclusions; rather, these should be integrated into your assessment and considered together with other information. Do not reproduce unedited computer-generated reports of psychometric results, as these reports do not present integrated, individualised conclusions and are therefore not helpful and insufficient. Rather, you should integrate the findings and tailor them to the unique circumstances of the kiritaki.



- You may find it helpful to identify other tests or assessments that may have been undertaken previously, particularly if there were findings relevant to the current assessment. This is also an opportunity to identify other tests or assessments that may be helpful in further clarifying aspects of the kiritaki presentation.

Section 8. Diagnosis and formulation

- a. Personality assessment: clinical and/or standardised testing may be undertaken to identify relevant aspects of personality function.
- b. Mental state examination: a full mental state examination (MSE) should be undertaken, and relevant findings recorded in each report. This should include all areas of an MSE using an accepted format with a comprehensive account of any relevant abnormal phenomena. It should also include a comment on suicide risk, any thoughts of harm towards others, cognitive function, and assessment of insight and judgement.
- c. Diagnosis: outline any formal psychiatric or psychological diagnoses that you think are appropriate and reference them clearly to the classification system used. Consider the following questions:
 - In your opinion, does the kiritaki have a clinically significant mental condition? If so, what factors indicate this?
 - What is the diagnosis? Please define precisely and outline the classification system used.
 - If in your opinion your diagnosis differs from the mental condition being applied for, please give reasons for the difference.
- d. Formulation/summary: provide a clear formulation explaining how the client has developed the presenting difficulties. “Formulation” refers to an explanation of all individual factors acting on an individual client that clearly sets out **why** and **how** the person has developed their difficulties, and **why** these difficulties have persisted.

The formulation is a working hypothesis that outlines the factors contributing to an individual’s situation, including their characteristics and experiences. It should include mention of causal, maintaining, and protective factors, as well as barriers to recovery or returning



to previous functioning or occupation. Do not repeat details already provided in previous sections, or cut and paste material from elsewhere in the report.

This section is one of the most important parts of the report, as the formulation provides a professional explanation of how a person presents with the specific identified disorder at a specific time. It informs opinion on causation and contributes to the development of a treatment plan.

- e. Risk assessment: where appropriate, undertake a risk assessment that formulates risk. This includes risk of harm to the kiritaki (eg suicidality, self-harm, neglect, risk of exploitation or abuse from others) or risk of harm to others (based on past or current indications of violence, aggression, threats, impulse control, anger issues, etc). Please identify any particular situations in which the kiritaki may present issues of risk. Consider risk in terms of imminence and risk severity, and suggest ways in which these risks can best be monitored and mitigated. Please note that it is not appropriate simply to report immediate risks to ACC. Rather, it is your professional responsibility to act on serious or imminent risk.

Section 9. Opinion

- a. Relationship between the physical injury or event and the mental condition

Answer the question ‘has the physical injury, work-related event, event, or treatment injury *materially contributed* to the diagnosed mental condition(s)?’

For the purpose of cover, the precipitating injury must be considered *material* in the development of a mental injury. Arguably, all mental health conditions are multifactorial, with predisposing, precipitating, and maintaining factors all influencing the development and course of a diagnosed condition. For the purpose of ACC cover, the injury need only be one (albeit a material, meaningful, or nontrivial) contributing factor.

A precipitating injury or event is often described as a ‘trigger’. However, the meaning of this term requires clarification. In ACC case law, a trigger has been defined as being an event that uncovers or renders symptomatic an underlying condition, which points to the event being potentially minor contribution in itself. This is different from using the term to describe an event



or injury that precipitated the diagnosed mental health condition, and which, by virtue of its nature, may or may not be a significant factor in contributing to the development of the condition. Assessors should explain the use of this and other terms to make their meaning clear.

Assessors must also differentiate between predisposing factors and a pre-existing condition. A client with several predisposing factors may be given mental injury cover if the injury itself is considered to have contributed in a meaningful or nontrivial way to the development of the diagnosed condition. Previously recorded diagnoses, or significant pre-injury history of complaints of the same or related symptoms (that suggest the condition is pre-existing) must be distinguished from predisposing factors, risk and vulnerabilities (that do not suggest the condition is pre-existing, only that it is more likely to develop). Risk does not, in itself, imply causation, but must be incorporated into the causal formulation and balanced against other contributing factors.

If there is more than one diagnosis, consider each diagnosis separately and provide a rationale for your conclusion(s). Consider the guidelines provided.

Note that the 'mental injury caused by physical injury' criteria allow for cover for PTSD (or another similar trauma-related condition) in circumstances in which a physical injury was minor but was accompanied by the threat of serious injury or death. Whilst the injuries themselves may not have been directly life threatening, they often cannot be separated from the totality of the experience which may have been perceived as involving the threat of serious injury or death.

For definitions of 'event', 'materially contributed' and 'mental injury', see the appendix.

- b. Describe any ongoing impact of the proposed 'mental injuries caused by physical injury' on kiritaki functioning, including daily living and work activities.
- c. Outline presenting difficulties related to non-injury/pre-injury factors:



d. Relationship between other life events and the mental condition

Outline other issues, life events, or incidents, separate from the injury or events of this incident, if any, that may have contributed to the current mental condition of the kiritaki.

Indicate what effect these are having on their mental state.

e. Outline pre-injury difficulties that have been exacerbated by the index injuries (physical, psychological, relationships, stressors, personality etc).

Section 10. Treatment

Outline recommendations for treatment for kiritaki/whānau and service providers. For any proposed mental injury, this may include suggestion of modalities, additional supports and services and for other non-injury difficulties, this may include recommendations for assessment and non-ACC services.

Section 11. Prognosis

What is the prognosis for this mental injury? If applicable, please indicate your prognosis for this mental injury and the severity of the condition.

Section 12. Other Information

Please provide any other relevant information that may help ACC determine whether the kiritaki has suffered a mental injury as a result of a physical injury or as a result of experiencing, seeing, or hearing a traumatic event at work.

A note about your obligation as a third-party assessor: Writing a third-party clinical assessment report carries significant ethical, legal, and professional obligations. Assessors are expected to base opinions on verified clinical information, identify any gaps in information,



and document their reasoning transparently to support fair, accurate, and defensible ACC decision-making.

Reports must remain independent, free from financial or organisational influence, and written in plain, neutral language that non-clinicians can easily understand. Clinical opinion must be balanced, neutral, objective, free from conscious bias, and should not be swayed by questions of entitlement, eligibility, or funding. An assessor's duty is to clinical objectivity, not ACC policy or procedures. If an assessor factors in funding decisions, this can lead to bias such as over-pathologising to align with funded services, under-recognising injury to avoid perceived ACC liability, tailoring conclusions to fit the cover status, and reduced credibility of assessments in reviews or the district court.

While ACC's cover decisions are heavily informed by clinical evidence, including professional clinical opinion, cover decisions do not provide evidence of causation. Rather, in addition to clinical information, ACC's decisions are also informed by legislative, policy, and structural factors.

Glossary of general key terms for assessment of mental injury

Cover - Deciding cover for mental injury involves establishing that the physical injury, event, or work-related traumatic event has materially contributed to the development of 'a clinically significant behavioural, cognitive or psychological dysfunction,' which is how a 'mental injury' is defined in the Accident Compensation Act 2001.

Mental injury caused by physical injury (MICPI) - ACC covers mental injury caused by physical injury if:

- the kiritaki is assessed as having a clinically significant mental injury, and
- an ACC covered physical injury is a material cause of the mental injury.

Work-related traumatic event (WRMI) - Deciding cover for work-related mental injury requires establishing that a kiritaki has a clinically significant mental injury, caused by an event that meets the criteria for a 'traumatic event' that is directly experienced, seen or heard by the kiritaki.

To be considered a work-related 'traumatic event', the event must meet all the following criteria.



The event:

- was a single, sudden event or the direct outcome of a sudden event
- could reasonably be expected to cause mental injury in people generally because it:
 - is outside the range of normal experience (normal human experience would include bereavement, business loss, or divorce)
 - is capable of provoking extreme distress in most people
 - involves a real threat of significant harm to self or others
 - would induce feelings of horror, alarm and shock in most people
- occurred during work
- occurred when the person was in close proximity to the event itself and experienced it directly (eg not seeing it on TV or hearing about it on the radio or from others).

Mental injuries that develop gradually due to ongoing workplace stress, such as harassment or bullying, are not eligible for cover.

Treatment injury mental injury (TIMI) - ACC allows cover for a mental injury that has been caused by a non-covered physical injury, provided the mental injury meets the criteria for a treatment injury. To be considered a treatment injury mental injury, the event must meet all the following criteria:

- there must be a clinically significant mental injury
- the mental injury has been caused by a physical injury sustained during treatment, even though the physical injury is not covered (ie the injury was sustained as a necessary part of treatment, such as an incision wound)
- the mental injury also meets the following treatment injury criteria:
 - it was caused by treatment
 - it was not a necessary part of treatment
 - it was not an ordinary consequence of treatment.



Sensitive claim – A sensitive claim is a claim lodged with ACC in relation to a possible or confirmed mental injury caused by an event that falls within the description of offences listed in Schedule 3 of the Accident Compensation Act 2001.

Clinically significant - To be considered a clinically significant mental injury, ACC must be satisfied that the person is experiencing a significant behavioural, cognitive, or psychological dysfunction. ACC prefers providers to use a recognised classification system to describe this dysfunction, such as DSM-IV or DSM5, or ICD-11. This ensures clarity, consistency, and effectiveness in diagnosis and treatment across various professional contexts. The mental injury assessment must differentiate between a normal distress response and a persisting response, which is associated with dysfunction, impairment, or disability.

The following items should be included in the assessment:

- Collateral information about the signs and symptoms and resulting dysfunction or impairment

Collateral information can be in the form of past medical records or accounts from family, friends, educational providers or employers pre-and post-injury. This information helps provide an accurate and full picture of pre-and post-injury presentation. It might also help to determine the clinical significance of any dysfunction or impairment resulting from injury in the kiritaki social, occupational and other relevant environment.

- Consideration of symptom validity

You are expected to include an evaluation of symptom validity in every assessment. This is a crucial part of any mental health assessment because it helps ensure that the information gathered is accurate, reliable, and reflective of the individual's true psychological functioning. If symptoms are misrepresented, the resulting diagnosis may be incorrect; and treatment plans may be inappropriate or ineffective. In settings such as forensic, disability evaluations, or personal injury claims, there may be an incentive to misrepresent symptoms, and providers in such contexts should take additional care to provide an accurate evaluation of reported symptoms.

- Evidence that supports the clinical formulation

Clinical interview is the main tool used in mental injury assessments. However, you should use several methods and sources of information to support your diagnosis and causal formulation. This may include self-completed checklists or questionnaires,



functional assessments, review of medical records, collateral information, third-party reports, and objective, standardised psychometric tools.

Examining medical records such as discharge summaries, ambulance reports, GP notes, occupational health records or other notes from relevant health professionals are important for obtaining evidence supporting your diagnosis and causal formulation. These are particularly important in assessing claims where the physical injury or event occurred some time ago. Your assessment should include a careful review of symptoms both before and after the injury.

- Diagnosis of mental injury and its relationship to the physical injury or event (‘material contribution’)

In the mental injury assessment, you should demonstrate that the physical injury or work-related event contributed materially to the development of the diagnosed condition (or clinically significant symptoms). In this context, ‘material contribution’ means that the physical injury or work-related event played a meaningful, substantial, or non-trivial role in causing the identified mental injury. A consideration of ‘material contribution’ is especially important in cases where causation is multifactorial. Note that a temporal relationship is insufficient to meet the test of causation. Also, an injury that serves merely as the ‘final straw’ or ‘tipping point’ in precipitating a disorder, or which worsens an already existing disorder, may not meet the test of causation.

List of relevant legislative terms and phrases used by ACC to determine cover for a mental injury claim

Term	Definition and explanation
Mental injury	<p>A clinically significant behavioural, cognitive, or psychological dysfunction (defined in section 27 of the Accident Compensation Act 2001). ACC usually considers that a psychological dysfunction is considered clinically significant if it meets the diagnostic criteria specified in currently available diagnostic tools.</p> <p>All diagnostic formulations must be made with reference to the diagnostic tool used.</p>



Materially contributed	To satisfy s 26(1)(c) of the Act, the physical injury or work-related event must be a cause of the mental injury in some genuine or meaningful way, rather than just in a trivial or minor way.
Event	<p>An event means:</p> <ul style="list-style-type: none"> • an event that is sudden; or • a direct outcome of a sudden event; and • includes a series of events that: <ul style="list-style-type: none"> • arise from the same cause or circumstance, and • together comprise a single incident or occasion; • but does not include a gradual process. <p>In the context of a sensitive claim, an event means:</p> <ul style="list-style-type: none"> • an offence that fits within the description of offences listed in Schedule 3 of the Accident Compensation Act 2001.
Experience directly (including involved)	To be directly involved in an event that happens to a person directly.
See or hear directly (including witnesses)	Experiencing, seeing or hearing an event firsthand, and not through a secondary source. Secondary sources include television, closed circuit television, telephone, seeing pictures, reading or hearing about it in news media, or from another person.
Close physical proximity to the event at the time the event occurs	To be physically present at the place where the event takes place or close enough to be able to experience, see or hear, and be affected by the event.
A direct outcome of a sudden event	The event can be the direct outcome (aftermath) of the sudden work-related event, eg what happens at the scene of the event or immediately after being moved away from the scene. For example, emergency workers who attend the scene after the event or hospital staff treating injured people.