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| Information for out-of-home carers of funded organisations |
| Client incident management system  January 2020 |

# Introduction

Children and young people who are removed from the care of their parents because of abuse or neglect need the best care that society can provide. It is the shared responsibility of carers, funded organisations and the Department of Health and Human Services (the department) to ensure the safety, stability and wellbeing of these children and young people.

The great majority of children and young people residing in out-of-home care receive good quality care from dedicated carers. However, occasionally an incident may occur that has a direct impact on a child or young person that requires reporting and management.

The new client incident management system (CIMS) will be implemented from 15 January 2018 across all in-scope department-funded organisations, including out-of-home care providers, and will replace existing incident reporting and management policies and procedures. CIMS focuses on the safety and wellbeing of clients and outlines what needs to happen when an incident occurs that alleges abuse, unexplained injury or poor quality of care of a child or young person in out-of-home care.

# Scope of CIMS and out-of-home care

All department-funded out-of-home care organisations are in scope of the CIMS. A funded organisation is the out-of-home care service that a carer is registered with. This includes home-based care (foster care & kinship care), residential care and lead tenant.

# What is an incident in out-of-home care?

An incident is an event that has a direct impact on a child or young person in out-of-home care. In the CIMS, an incident is assessed as having either a major impact or a non-major impact on a child or young person. All major and non-major impact incidents need to be reported within three business days of the funded organisation learning of the incident

A **major impact** incident includes:

* The unanticipated death of a client
* Severe physical, emotional or psychological injury or suffering which is likely to cause ongoing trauma
  + A pattern of incidents related to one client which, when taken together, meet the level of harm to a client defined above. This may be the case even if each individual incident is a non-major impact incident.

A **non-major Impact** incident includes:

* Incidents that cause physical, emotional or psychological injury or suffering, without resulting in major impact as defined above
* Impacts to the client which do not require significant changes to care requirements, other than short-term interventions (for example, first aid, observation, talking interventions or short-term medical treatment)
  + Incidents that involve a client but result in minimal harm
  + Incidents that do not otherwise meet the criteria for ‘major impact’ above.

Whether an incident has a major or a non-major impact on a child or young person, it is important that carers, funded organisations and the department work collaboratively to keep children and young people safe and promote their wellbeing.

# What is the new approach for client incident management?

The new CIMS involves a five step, end to end process that aims to make sure we deliver better outcomes for our clients. The five steps are:

1. Identification and response
2. Reporting
3. Incident investigation
4. Incident review
(Stage 3 or 4 is required for major impact incidents)
5. Analysis and learning

A copy of the *Client Incident Management Guide* can be found at the [department’s provider webpage](https://providers.dhhs.vic.gov.au/cims) <https://providers.dhhs.vic.gov.au/cims>.

# Specific procedures

All major impact incidents will be followed by either an incident investigation or an incident review to ensure the appropriate response and learning is undertaken to keep children and young people in out-of-home care safe from harm.

## Incident Investigations

The guide specifies that all major impact incidents alleging abuse, unexplained injury or poor quality of care must be investigated.

The guide outlines the possible actions that can occur if a major impact incident alleging abuse, unexplained injury or poor quality of care is raised about a carer. These are:

* **No further investigative action:** In a small number of cases, it can be clearly shown that the report is inaccurate or there is no basis for concern about the safety of the child or young person or the quality of care the child or young person is receiving.
* **Monitoring and support required:**  Certain information may raise issues that do not warrant an investigation but highlight the need for enhanced support and supervision of the carer. In this situation, a Carer Development Plan is usually developed between the funded organisation and the carer to work on any identified concerns. The Carer Development Plan process is intended to be focussed on promoting practice improvement by carers and funded organisations working together to overcome any identified quality of care concerns and reducing the chance of a similar incident happening again. A copy of the Carer Development Plan can be found at the [department’s provider webpage](https://providers.dhhs.vic.gov.au/cims) <https://providers.dhhs.vic.gov.au/cims>.
* **Internal investigation:** In some cases, screening finds there is enough information to warrant a formal investigation to decide if a client has been abused by a staff member or carer. When this happens, the funded organisation has to make sure the person chosen to conduct the internal investigation has the right skills and independence from the incident to meet the standard of investigations set out in the guide.
  + **External investigation:** In some cases, there is enough information to show that the only way to make sure the investigation is objective, and expert is to commission an appropriately skilled external investigator. An example of when this might happen is in smaller funded organisations that don’t have staff in separate areas that can act independently and without bias.

## Incident Reviews

The guide says that all major impact incidents that do not meet the threshold for investigation must be followed up with an incident review. There are two types of incident reviews that can happen under the guide. These are:

* **Case review**: This is a review led by the funded organisation after a client incident to identify what happened and any process and system issues. A case review is less intensive than a root cause analysis review.
  + **Root cause analysis (RCA) review**: This is a structured review process for client incidents where it is suspected that major systems or process issues contributed to the incident happening. It requires trained staff and appropriate resourcing and time, and therefore is only required in certain defined cases.

Carers may be interviewed as part of an incident review to help in gathering the information needed to find out why the incident happened and what can be done to reduce the chance of similar or related incidents happening again in the future.

# The role of carers

Carers are one of the most crucial parts of a child or young person’s care team. If a carer has any reason to believe that an incident has had a direct impact on a child or young person in their care, they should contact the case worker at their funded organisation to advise them of what has happened.

If the client incident raised is about a carer’s conduct toward a child or young person in their care, they will have the opportunity to have their voice heard regarding any concerns raised about them. In this instance, carers can expect to be treated fairly, honestly, with respect and to be given as much information as possible regarding the allegations and any incident investigation process that might occur.

# Support for carers

It is the role of the funded organisation to provide support and assistance to carers. This involves providing carers with:

* information about the investigation or review process including timelines for completion
* the outcome of an investigation or review
* the implications for the carer
* advice about support options (if applicable)
  + information about the relevant decision review process.

A carer can choose a person to provide support through the incident investigation or review process, including support at interview. This support person may be from the carer’s own personal network or can be another carer available and willing to provide support. If the carer is an employed staff member, this support person could be a person from a relevant union. If the carer is a foster carer, this support person could be a person from the Foster Care Association of Victoria. The carer’s support person cannot be someone who has direct involvement with the incident under consideration.

# CIMS and Quality of Care

The guidereplaces the *Guidelines for responding to quality of care concerns in out-of-home care technical update 2014.* This means that from 15 January 2018, when an incident is reported by a funded organisation, the guide will be used to outline the reporting and management of the incident.

An addendum to the guide that provides specific guidance when an incident occurs in out-of-home care has also been developed. This is called the *Client incident management guide addendum: out-of-home care*. While the guide is the primary policy for the management of client incidents, this addendum provides additional information about the management of client incidents that involve children and young people in out-of-home care.

# The role of child protection

The management of all client incidents is the primary responsibility of the funded organisations. In most cases, the department will only play an oversight role to ensure any incident investigations and incident reviews meet the standards of the guide.

While it is the primary responsibility of funded organisations to manage incidents, child protection still has legal responsibility for case planning and placement decisions for children and young people in out-of-home care. This means that the funded organisation will be consulting with child protection throughout the client incident management process and the outcome of any incident investigation or incident review will inform child protection’s case planning and placement decisions.

# Incidents involving Aboriginal or Torres Strait Islander children or young people in out-of-home care

If an incident is related to an Aboriginal or Torres Strait Islander child or young person in out-of-home care, the relevant Aboriginal Child Specialist Advice Support Service (ACSASS) will be informed and consulted during the CIMS process. If an Aboriginal or Torres Strait Islander child or young person is placed with a non-Aboriginal carer, consultation with the local Aboriginal Community Controlled Organisation (ACCO) or a respected community member will occur in addition to consulting with ACSASS.

# Parallel processes

There are a number of ways that children and young people in out-of-home care are safeguarded. The guide does not replace these safeguarding mechanisms and the obligations of these can occur in addition to, or alongside, the CIMS. Some of these safeguards include:

## Reporting to Police

A report to Police should always be made when there is an allegation of physical or sexual abuse of a child or young person in out-of-home care. All other investigations of this alleged incident will be put on hold while a police investigation is underway.

## Independent Investigation & Suitability Panel

The *Children, Youth and Families Act 2005* provides for disqualification of an out-of-home carer from the Register of Carers if, following an independent investigation, the Suitability Panel determines physical or sexual abuse has occurred, and the carer poses an unacceptable risk of harm to children and young people in out-of-home care.

An allegation of physical or sexual abuse of a child or young person in out-of-home care by a foster or residential carer must be reported to the Secretary of the department to be considered for independent investigation by completing a s. 81 or s. 82 report of abuse.

For further information, please see the [department’s provider website](https://providers.dhhs.vic.gov.au/registration-out-home-carers) at <https://providers.dhhs.vic.gov.au/registration-out-home-carers>.

## Reportable Conduct Scheme

The reportable conduct scheme (the scheme), commenced on 1 July 2017 and has been introduced to improve oversight of how organisations prevent and respond to allegations of child abuse. The scheme requires centralised reporting to the Commission for Children and Young People of allegations of child abuse made against workers or volunteers in relevant services with a high level of responsibility for children and young people, such as out-of-home care services.

For further information, please see the [Commission for Children and Young People website](https://ccyp.vic.gov.au/reportable-conduct-scheme/) at <https://ccyp.vic.gov.au/reportable-conduct-scheme/>.

## General staff performance and conduct

Funded organisations will have their own policy and procedures for the management of staff performance or misconduct.

While every attempt will be made to minimise duplication and reinterviewing of children and young people and carers, the processes listed above may occur in parallel with a CIMS incident investigation.

# Resolving differences

If a carer disagrees with a decision or recommendation of an incident investigation or incident review, they can make a written request for a review of the decision to the chief executive office or delegated authority of their organisation. This written request for a review of a decision must be submitted within 14 working days of parties being notified of the decision. The funded organisation then has 28 working days from when the carer’s written request was received to complete the review.

Funded organisations that are supporting carers have written policies for the resolution of disputes or complaints. Carers are encouraged to contact their nominated contact person at their funded organisation should they require additional information about the process of seeking a review of a decision or recommendation about them.

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